Motherhood and the Practice of Grand Multiparity: Responses from Grand Multiparous Women in Ibadan, Nigeria

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Abstract

Grand Multiparity (GMP), having five or more pregnancies and deliveries, has contributed to high population growth in Nigeria. While the quality of life of children and the health risks associated with GMP have dominated scholarly discourse, dearth of information exists on perception of Grand Multiparity (GMP) and its practices. This study therefore focused on the Perception of Grand Multiparous Women in Grand Multiparity Practices in Ibadan, Oyo State, Nigeria. With Health belief model as framework in this study, questionnaire was administered to 422 randomly selected GMP women identified through snowballing, while 12 Key Informant Interviews were conducted with four healthcare practitioners each from western, traditional, and faith-based patterns. Six sessions of focus group discussions were also held with GMP mothers and husbands. The age of the respondents was 43.3 years ±1.2. About 41% and 19% had secondary and tertiary education respectively. Ninety per cent of the respondents were between their 5th and 7th pregnancies. Majority (67.0%) of GMP women were influenced by: couples` desire for more children (23.8%), non-use of contraception (22.6%) and desire for male children (19.5%). The GMP was significantly associated with respondents' level of education (χ^2=365.85). The GMP was rooted in the cultural values of the respondents, hence, inevitable. ***Conclusion****: Grand multiparous practice and its attendant health-risks still exist in the rural area of Ibadan, Oyo-State, Nigeria, due to its socio-cultural influence.*

Keywords: Practice of GMP, Nigeria, Grand multiparous women, Grand multiparity practices, Women reproductive health,

Introduction

Grand Multiparity (GMP), which is the practice of women involving in phenomena of pregnancy fifth to nine deliveries (Islamaldin, 2013), is synonymous with high fertility rate and low utilisation of contraceptive methods and practices. Among the factors influencing high fertility vis-à-vis GMP practices are based on; masculinity (Birenbaum, and Inhorn, 2009; Dowd, 2010), feminism (Shah and Batzer, 2010), socio-cultural practices, level of education, age at first marriage and current age at marriage (Wusu, 2009). Grand multiparous (GMP) practices, which emanated from gynecological and obstetric background, is synonymous with categories of pregnancies in which gynecologists and obstetricians have categorized into four types: Primiparous pregnancies (PP), which are pregnant women involving in viable pregnancy and delivery for the first time. Multiparous (MP) women are those involved in delivering of the first to fourth (1st–4th) viable pregnancies, while women undergoing their tenth (or more) delivery are classified as great grand multiparous or huge grand multiparous. However, Grand multiparity refers to a phenomenon of a woman or women who had experienced five or more pregnancies going beyond the twenty-eight weeks of gestation (Islamaldin 2013; Idoko, Nkeng, and Anyanwu, 2016). Grand multiparity is common in Nigeria due to high fertility rate and low contraceptive prevalence rate of 4.0 per cent, socio-cultural factors, religion, illiteracy, value of male offspring and early marriage which expose women to a longer period of reproduction (Rayis, Dukia, Ali, Abbaker and Adam, 2011; Akwuruoha, Kamanu, Onwere, Chigbu, Aluka, Umezuruike, 2011). Furthermore, most Nigerian women spend majority of the years, usually between 15 and 50 years, conceiving, carrying, delivering and nursing babies (Isiugo – Abanihe, 2012).

Advanced maternal age is an independent risk factor for a number of antenatal medical disorders, such as hypertension, placental implantations, diabetes, mal-presentation, and prematurity (Yasir, Perveen, Ali, Shaista, and Tayyab, 2010). GMP is one of the major factors that have contributed to increasing maternal mortality (Abro, Shaikh, Shaikh and Baloch, 2009). Specifically, increased abnormalities of placenta implantations in GMP women constituted factors leading to retained placenta because uterine muscles get replaced by fibrous tissue with repeated pregnancies. This has resultant reduction in the contractile power of the uterus which may lead to uterine atony and, finally, placenta retention (Li, Tsui, 2016). Although pregnancy and child birth are not diseases, they are normal physiological and social

processes which every pregnant woman undergoes in their life time, they come with health risks and require adequate healthcare.

Culturally**,** Yoruba of the south-western Nigeria do have many children. A woman has many children to show her fecundity and thereby enhances her socio-status. This manifest in some names, such as: "`Omowunmi" (children are desirable); "Omolola" (children are affluence); "Omolere" (children are worldly gains); "Omolara" (children are ones kinfolk), "Omolaso" (children are one's clothing), "Omoniyi" (children`s are one`s honour), and "Omotayo" (children are likened to joy). The sayings: "Won ki ka omo folomo" (it is a taboo to count the number of another man`s children), "Ti a ba ku omo ni'o w'ole d'eni" (children immortalized our name when we passed on) are indications of the value of children in Yoruba status. As African culture puts premium value on the existence of children in the family (Owumi, 2002), another Yoruba adage which however, states that "Omo beere osi bere" (plenty children, plenty poverty) indicates that GMP practices is associated with poverty. Hence, people who practice GMP are usually characterized by low education, unemployment, low income, early marriage and maternal health risk/challenge, among others.

For medical reasons, GMP practices are usually discouraged because they are seen as a threat to maternal health, infant health and women's safety from various complications such as; preterm-delivery, prenatal morbidity and mortality, ante and post-partum haemorrhage, anaemia, caesarean section, induced labor, rheumatic heart diseases and mal-presentation, among others. Avoidance of these complications necessitate special antenatal care for GMP women (Asaf, 1997; Barnes, 2012; Gunnar, 2017). Furthermore, it was also observed that, the main causes of maternal mortality include problems arising from high parity; inadequate birth spacing and haemorrhage (NPC/UNICEF, 2001; Fronczak, Arifeen, Moran, Caulfield, and Baqui, 2007; Cheryl, and Manhon, 2008). All these account for almost a quarter of all maternal deaths in Nigeria (Azuh, Azuh, Iweala, Adeloye, Akanbi and Mordi, 2017) and explain some of the reasons why GMP practices are discouraged. Although, the fertility rate in Nigeria ranges between 4.3 and 6.7%, while fertility rate in South-western Nigeria was 4.6 per cent. The percentage of women aged 15-49; currently pregnant in the South-west is higher than other Southern zones (South-South and South-East) in Nigeria (NPC, 2012). Hence, women in South-western societies may face such risks with each pregnancy. Besides, the National Population Commission

(NPC) records in Akinyele Local Government revealed that the study area had prevalence of GMP practices which fluctuated between 9.7 and 10.2 per cent between 2011 and 2015, implying that the incidence of grand multiparity still exists in the area despite the risks and threats to maternal health.

Similarly, perception is equally influenced by masculinity. For instance, Jegede (2010) noted that the Nigerian social system is based on the authority of male as heads of households, therefore, the opinion, decision and authority of men is vital in most households and among married women. Equally, Isiugo-Abanihe (2012) noted that men are the main opinion leaders and their values affect behaviour of women, while Olutayo and Yusuf (2012) also expressed that Yoruba are traditionally a patrilineal descent group. Although the authors confirmed that matrilineal descent group is equally respected in the Yoruba lineage system, the fact remains that the most dominant and most officially recognised is the patrilineal group. Actually, these arguments explain the basis for the prominent role of masculinity in GMP practices in Nigerian society (Akintunde, Lawal and Simeon, 2013; Alonge and Ajala, 2013). The empirical study by Oshodi and Salami (2017) also observe that GMP men did not support family planning practices due to promiscuity and lack of trust by husbands. In effect, non-compliance/low usages of family planning were manifested among the people concerned. Hence, masculinity constitutes both a predisposing factor in perception and an indispensable nexus of GMP practices among grand multiparous women. Likewise, perception on GMP practices in Nigeria is equally influenced by polyandry and polygyny marriages, and value of male offspring (Isiugo Abanihe, 2012). Thus, remarriage by a woman for more than once may influence her perception towards GMP practices and vice versa.

The Health Belief Model (HBM) by Hochbaum (1958) provided a framework for this study because of its emphasis on person's motivation and decision making about seeking health services. Likewise, the model identifies compliers and non-compliers by examining six factors considered important to healthcare decisions including: the patient's perception of susceptibility to condition and its consequences, the patient's perception of the severity of the condition, perceived value of the treatment benefits, perceived barriers to treatment, cost of treatment in physical and emotional terms and cues that stimulate action towards treatment of illness. Consequently, GMP practices could be influenced by the factors highlighted along with the perception attached to it. As it is empirical that the positions of HBM are based on perception, it is therefore clear that the issue of perception and HBM cannot

be ignored in matters relating to GMP practice, which is the major position of this paper.

Materials and Methods

The study was carried out at Akinyele Local Government Area (LGA) of Oyo State. The LGA has its headquarters in Moniya, a semi-urban town. Akinyele LGA, being one of the six rural LGAs in Ibadan land (NPC, 2009), is bounded in the North by Afijio, to the East by Lagelu, West by Ido and Ibadan North Local Government to the South where University of Ibadan is located. The population density of the LGA constitutes 516 persons per square kilometre. Akinyele LGA has an estimated population of 211,359 as extrapolated from the 2006 census. Estimates from the population census office in Oyo state put the population of Akinyele LGA at 267,743 in 2014. Apart from being a Yoruba community and patrilineal society, it is also categorised by high level of illiteracy and people of diverse religions (Akintunde, Lawal, and Simeon, 2013). Residential unit is mostly "compounds" which is usually traditional in nature (Jegede, 2010). Data for this study were generated from following locations in the LGA: Ikereku, Olanla, Arulogun, Onidundu, Moniyi, Akinyele, Iwokoto, Ojoo, Ijaiye, Alabata, Mele and Iroko in Ibadan Oyo State. Women whose parity was not less than five (GMP), GMP women who were pregnant as at time of study, men whose wives were GMP women and healthcare practitioners participated in this study.

Multi-stage sampling technique was adopted for the study. At the first stage, purposive sampling technique was employed in the selection of a local government area which was more rural-inclined in Ibadan land. Hence, Akinyele Local Government was chosen for the study. The second stage also involved the purposive selection of wards which are more rural (according to the documentation from Akinyele classification of semi-urban and rural dichotomies). The third stage involved the use of snowballing in the selection of GMP women. The combination of survey method including questionnaire method, Focus-group-discussion (FGDs) and Key-informant-interviews (KIIs) were adopted for the study.

Quantitative data were collected using questionnaire, while qualitative data were collected using in-depth interviews and Key-informant-interviews. A total of 422 copies of pretested questionnaire were administer on women whose parity was between fifth and nine (GMP women) using Conchran's sample size formula

(Conchran, 1977). Data processing and management procedure involved retrieval of questionnaire copies, cleaned, coded, processed and presented with the aid of the Statistical Package for Social Sciences (SPSS, version 17). Administered copies of questionnaire were analysed at the univariate, bivariate and multivariate levels, while findings are presented using frequency, percentages and inferential statistics.

The qualitative data involved twelve key-informant- interviews (KIIs) which was conducted with GMP pregnant women and a health care practitioner each in faith-based (Islam and Christian facilities), traditional and orthodox healthcare centre. Six sessions of FDGs were also conducted with a group of GMP men and women separately, from six wards, to elicit information on perception of GMP and socio-cultural factors influencing GMP. Each session of FGDs consisted of 8 to 12 participants. Data were recorded, transcribed, cleaned, content analysed and ethnographic summaries for enhancement of interpretation through direct quotations of vital responses that originated during interviews were made; all these were in line with the objectives of the study. Moreover, most of the interviews involved narratives and usually in local language (Yoruba) which was later translated to English language. The study abides strictly with the international ethical standards of research. The purpose was to protect the rights and integrity of the participants. Ethical considerations were strictly adhered to, while permission to withdraw participation was allowed. In addition, respondents' anonymity and confidentiality were ensured since no information was traced to any respondents.

Findings

Socio-Demographic Characteristics of Respondents Involving in GMP practices

About 51% of the respondents were above 50 years. In terms of religious composition, majority of the respondents were Christian while, Yoruba and Igbo ethnic groups dominated the area hence, they accounted for about 91% of the respondents. Similarly, majority of the respondents have between five and seven children. In terms of level of education, respondents with primary school education accounted for almost 39%, almost 41% had secondary education, whereas, respondents with tertiary education accounted for 19.4%. Spouse education showed respondents with primary school education as 48% of the respondents, while 32% of them had secondary education and 19% of the respondents with tertiary education. Employees in the private firm (39.6%) and public civil-servant (28.4%) dominated the sampled population while, housewives accounted for 4.7% of the respondents. In

terms of spouse occupation about 54% are employed in the private sector while, about 18% are self-employed. Others are shown in Table 1. The income range of the respondent indicated that those who earned #20,001-#30,000 were almost 47% of the distribution whereas, income earners #10,001- #20,000 were almost 7% of the population sample. Furthermore, spouse monthly income revealed that respondents with > N50,000 were highest (49.2%) meanwhile; respondents with #40,001-#50,000 were least represented (17.2%).

Table 1: Sociodemographic structure of Grand multiparity women in Ibadan

Variables	Responses	Frequency	Total **(%)**
Age	20-29 years	48	11.4
	30-39 years	116	27.5
	40-49 years	243	57.6
	> 50 years	15	3.6
Religion	Islam	160	37.9
	Christianity	223	52.8
	Traditional	39	9.2
Ethnicity	Yoruba	218	51.7
	Igbo	165	39.1
	Hausa/Fulani	39	9.2
Number of children	5 -7 children	257	60.9
	8 – 10 children	126	29.9
	>10 children	39	9.2
Educational Attainment	Incomplete primary	44	10.4
	Complete primary	121	28.7
	Incomplete secondary	39	9.2
	Complete secondary	136	32.2
	Tertiary	82	19.4
Spouse's education	Incomplete primary	124	29.4
	Complete primary	80	19.0
	Complete secondary	136	32.2
	Tertiary	82	19.4
Occupation	Housewife	20	4.7
	Trading	40	9.5

	Public/civil servant Employee in private firm Self-employed	120 167 75	28.4 39.6 17.8
Spouse's occupation	Trading Farming Employee in the public sector Employee in the private sector Self employed	20 59 39 229 75	4.7 14.0 9.2 54.3 17.8
Monthly income	N10,001-N20,000 N20,001-N30,000 N30,001-N40,000 N40,001-N50,000	20 139 75 63	6.7 46.8 25.3 21.2
Spouse's monthly income	N30,001-N40,000 N40,001-N50,000 > N50,000	80 41 117	33.6 17.2 49.2

Respondents' Involvement in GMP practices and socio demographic characteristics

Table 2 shows the association between respondents` socio-demographic features and their involvement in GMP. According to the table, age 20-29 years were highest in non-deliberate in GMP practices (100%) while, age greater than fifty (> 50) years was the least (53.0%) in this category. Table 2 also demonstrated age as a significant factor (P = 0.000) in the non-involvement of GMP practices among the respondents. Educationally, Table 2 revealed that incomplete secondary (100.0%) and complete secondary (59.9%) certificate holders were highest in the deliberate involvement in GMP practices (100.0%), while the least educational group in the deliberate involvement were incomplete primary, complete primary and school certificate holders. Contrarily, the highest educational category in the non-deliberate involvement in GMP practices were incomplete primary (100.0%) and tertiary (100.0%) certificate holders, whilst, the least represented group were incomplete secondary school certificate holders. The significant values of these were revealed in Table 2 where P value=0.000 respectively for all variables involved. In terms of occupation, the association showed house-wife as highest and trading as the lowest in

the deliberate involvement of GMP practices and vice-visa in the non-deliberate involvement of the practice respectively. Similarly, income equally demonstrated strong association towards involvement in GMP practices. For instance, the income category N30,001-N40,000 (53.8%) showed highest in deliberate involvement in GMP practices, whereas, income group N10,001-N20,000 were the least represented in the deliberate involvement of the practice. Yet, income earners N10,001-N20,000 occupied the highest position in the non-deliberate involvement of GMP practices while income earners N20,001-30,000 were the lowest (29.3%) as shown in the Table. Hitherto, the p value (p = 0.000) also highlighted these significant associations in Table 2.

Table 2: Association between respondents' socio-demographic features and involvement in GMP practices

Socio-demographic variables	Deliberate involvement in GMP practices			Chi-square Value	P value
	Yes	No	Don't know		
Age					
	0 (0.0%)	21 (100.0%)	0 (0.0%)	50.657	0.000
20-29 years	3 (10.3%)	26 (89.7%)	0 (0.0%)		
30-39 years	11 (15.1%)	62 (84.9%)	0 (0.0%)		
40-49 years	51 (25.8%)	105 (53.0%)	42 (21.2%)		
> 50 years	65 (20.2%)	214 (66.7%)	42 (13.1%)		
Total					
Education					
	0 (0.0%)	46 (100.0%)	0 (0.0%)	365.484	0.000
Incomplete primary	0 (0.0%)	87 (67.4%)	42 (32.6%)		
Complete Primary	41 (100.0%)	0 (0.0%)	0 (0.0%)		
Incomplete secondary	85 (59.9%)	57 (40.1%)	0 (0.0%)		
Complete secondary	0 (0.0%)	84 (100.0%)	0 (0.0%)		
Tertiary	126 (28.5%)	274 (62.0%)	42 (9.5%)		
Total					

Occupation Housewife Trading Public/civil servant Employee in private firm Self-employed **Total**	21 (100.0%) 0 (0.0%) 41 (32.8%) 43 (24.4%) 21 (26.9%) 126 (28.5%)	0 (0.0%) 42 (100.0%) 42 (33.6%) 133 (75.6%) 57 (73.1%) 274 (62.0%)	0 (0.0%) 0 (0.0%) 42 (33.6%) 0 (0.0%) 0 (0.0%) 42 (9.5%)	203.879	0.000
Income N10,001-N20,000 N20,001-N30,000 N30,001-N40,000 N40,001-N50,000 **Total**	0 (0.0%) 62 (42.2%) 43 (53.8%) 21 (33.3%) 126 (28.5%)	21 (100.0%) 43 (29.3%) 37 (46.2%) 42 (66.7%) 274 (62.0%)	0 (0.0%) 42 (28.6%) 0 (0.0%) 0 (0.0%) 42 (9.5%)	87.865	0.000

Income was equally a significant factor in the perception and practice of GMP. The implication is that, GMP practices is likely influenced by socio-economic status. Result also revealed that there is a significant association between; age, occupation and income of the respondents and their deliberate involvement in GMP. Likewise, the type of spouse' occupation (such as farming and self-employment), influence the perception of such spouse to GMP practices as revealed in this study. The implication is that, socio-economic status of spouse income category with income greater than fifty thousand Naira (> N50, 000) (49.2%) were more favorable compared to income about thirty thousand (#30,001- #40,000) (33.6%) and above forty thousand (N40,001-N50,000) (17.2%) income groups which may partly explain their perception and practice of GMP practices. Emphasis of this was observed in the qualitative findings when one of the interviewee claimed that:

> I agree, to a very large extent, to that statement. I think when you talk about socio-economic status; you mean the earnings or income of those that engage in grand-multiparity. It is true that income can make a person to practice GMP. In most case, when the man (who is the

> husband) has little change in his hand, then he feels he can cater for the needs of his family, regardless of the number of children. He feels he has *arrived*. Then you see him getting more wives and children to show his wealth status to others (KII/Male/Orthodox health administrator/2016).

Respondents' reasons for their involvement in GMP practices

According to figure 1, the following variables contributed to the involvement of women in GMP practices: lack of knowledge of contraceptive, joint decision of couple, desire for a particular sex of a child, enhancement of social status and personal desire. Of these reasons, the highest respondents were those who agreed on 'lack of knowledge of contraceptive' (27%). To corroborate the view, one of the interviewee who also mentioned the ills of GMP as well, also affirmed the role that lack of knowledge about family planning plays in the practice of GMP:

> Truly, the environment which an individual live may determine whether that individual will have many children or not. You would notice that those that give birth to many children these days are those in the villages who may know little or nothing about family planning. Also, occupation of these people matters a lot. A good number of them still engage in agriculture. So, there is need to have many children that will assist on the farmland. Another area we can also look at this is that since it is a common practice in a society, an individual will be left with no choice but to do what others are doing (KII/Female/Christian health worker/2016).

Other factors as shown in figure 1 included: those who viewed it was joint decision of couple (24.0%) while; 22.2% respondents reported that it was their desire for a particular sex of a child. In addition, enhancement of social status was also reported by 14.6 %, while 12.2% personally desired it. Similarly, the involvement in GMP practices is sometimes due to the belief or conviction that GMP practices does not endanger the health status or has no severity and susceptibility to health/illnesses of the people concerned. This is often attributed to the Yoruba parlance on the

conviction of "ifanu'' (that is, giving birth to many children are normal in other to prevent sickness/illnesses in old age).

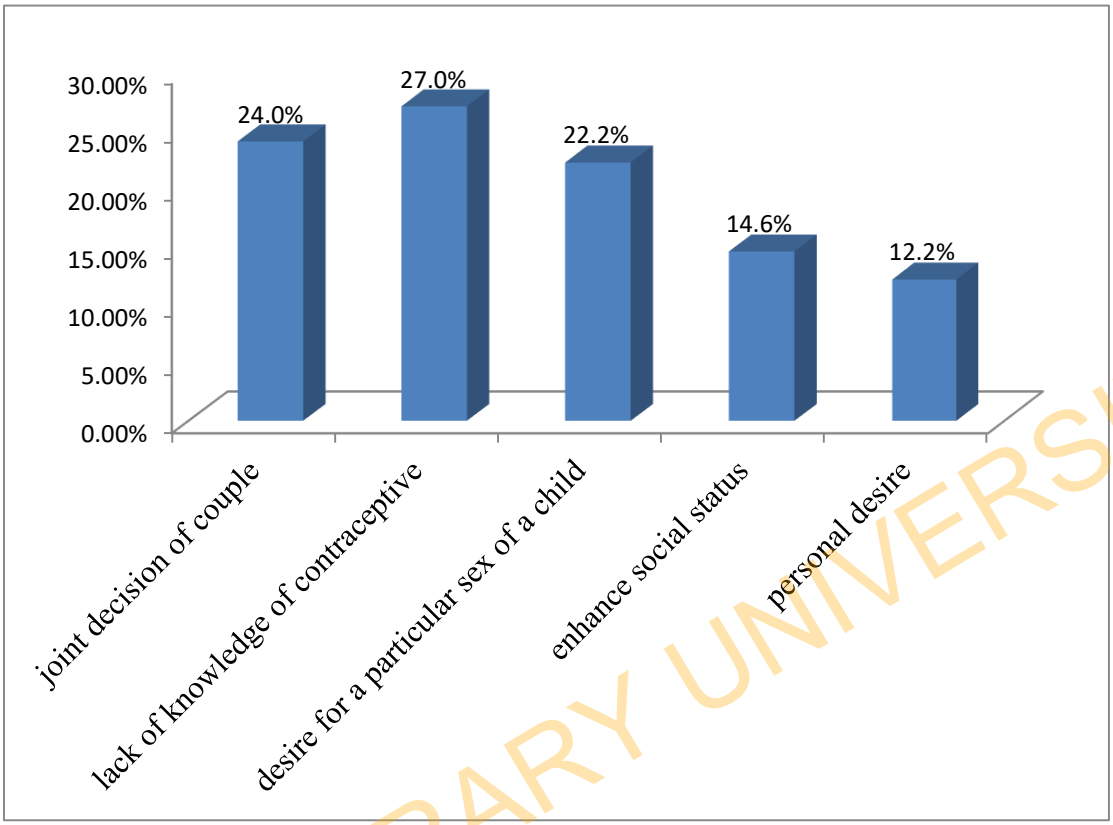

Figure 1: Respondents' reasons for women involvement in GMP practices

Figure 1 revealed lack of use of family planning as the highest /major factor influencing GMP practices in the study area. To corroborate the view, one of the participants attributed it to ignorance, and illiteracy:

> Look, GMP practice is very dangerous and for me there is no need for it. Sometimes, people don't know that some of the things we see and do in our culture are actually detrimental to our wellbeing. Even come to

> think of it, a woman having 8, 9 or even 10 children is only inviting illness or death upon herself. Well, I feel illiteracy is one of the factors responsible for this practice. This is because you won't see such practice among those women who are educated and who know about contraceptives or family planning (KII/Female/Islamic health worker/2016).

Attitude and perceptions of women towards GMP practices

Table 3 indicated the attitude of GMP women towards GMP practices where; strongly Agreed=SA, Agreed=A, Uncertain=U, Disagree=D, Strongly disagree=SD, Mean=M, Standard deviation=STD, and Decision=DCN. The arrival of Decision "High and Low" in the table was based on "Mean value". The mean value of 2.5 and above indicated High decision of a group majority in agreement to a particular statement, while, "Low" signifies mean value of below 2.5, and it implies a significant number of the respondents disagreed to the statement. In this study, the attitudinal factors was grouped into five categories namely; (i) category 1- socio-cultural, (ii) category 2 - religious factor, (iii) category 3 - personal conviction, (iv) category 4 - fear of infant mortality and (v) category 5 - belief that GMP does not pose any health risk/challenge to mothers. Table 3 indicates that besides statements on; preferences to satisfy husband and for a particular sex which are both low, all other statements had high decision value. With high decision values, respondents have positive attitude towards GMP practice in the study area.

Table 3: Attitude of GMP women towards GMP Practice.

Items	Strongly Agreed	Agreed	Uncertain	Disagree	Strongly disagree	Mean	Standard deviation	Decision
Cultural practice on GMP should be	40 (9.5 %)	224 (53.1 %)	138 (32.7 %)	20 (4.7%)	-	2.53	0.71	High

encouraged.								
Family planning methods can stop one's best children from being born.	20 (4.7 %)	165 (39.1 %)	142 (33.6 %)	95 (22.5%)	-	2.74	0.86	High
I prefer having more than four children.	197 (46. 7%)	165 (39.1 %)	20 (4.7 %)	40 (9.5%)	-	2.61	0.72	High
Having many children makes me happy.	225 (53. 3%)	97 (23.0 %)	-	80 (19.0%)	20 (4.7%)	2.62	1.38	High
Many children enhance my social status.	219 (54. 5%)	-	83 (20.6 %)	80 (19.0%)	20 (5.0%)	2.51	1.40	High
I have many children because my husband	140 (33. 2%)	85 (20.1 %)	138 (32.7 %)	59 (14.0%)	-	2.27	1.07	Low

wants me to.								
My religion supports GMP.	82 (19.4%)	44 (10.4%)	235 (55.7%)	61 (14.5%)	-	2.65	0.95	High
I can have many children because of a particular sex of a child.	145 (34.4%)	39 (9.2%)	-	61 (14.5%)	177 (41.9%)	2.36	1.10	Low
Having many children is a normal practice within my family.	215 (51.9%)	65 (15.4%)	81 (19.2%)	61 (14.5%)	-	2.97	1.13	High
Having many children can't pose any health risk to me.	219 (51.9%)	21 (5.0%)	101 (23.9%)	81 (19.2%)	-	2.60	1.23	High
Having many	161 (38.	44 (10.4	-	81 (19.2%)	136 (32.2%)	2.52	1.17	High

children helps to protect my motherhood.	2%)	%)						
I have many children in order to make-up in case any dies.	223 (52.8%)	44 (10.4%)	94 (22.3%)	41 (9.7%)	20 (4.7%)	2.53	1.25	High
Grand mean						2.56		High

Discussion of Findings

The data in Table 1 revealed that over half (57.6%) of the respondents in the study area fell within the ages of 40 to 49 years categories, while those within the ages 30-39years were over a quarter (27.5%). This implies that majority were still within their reproductive ages. This assertion confirmed the stance of most scholars about the characteristic of GMP women to be advanced maternal age. Ventura and Hamiltton (2011), observed that GMP women tend to be older in age, while other studies such as one by Isiugo-Abanihe (2006) have also shown that early marriage, age at marriage, socio-cultural practices, coupled with the recognition of high traditional family structure may likely sustain fertility/GMP practices. This view coincided with the Yoruba conviction on early marriage as a means of checking promiscuity and moral control in the society. In addition, this stance is equally accentuated by the two religions (Islam and Christianity) as they are considered to breed GMP practices (Falola and Akinyemi, 2016). Based on the foregoing findings, perception of women to GMP practices may likely be high and being attributed to advanced maternal age.

Religion is also one of the major factors that influence the perception of GMP practices in developing countries (Neda, Ozren, Srećko and Mihaela, 2009; Genesis

1:28; psalm 127:3; Quran 2:33). Most religions have codified rules and laws that govern them, and the rules are strictly adhered to by their adherents. For example, some Christian's denominations (such as, Catholic) and Islam sects (such as, Sunnis and Tablique) stress on natural family planning and non-use of contraceptive for their followers. Relative example is the case of the movement of Laestadian within the Lutheran Church in Finland, where members forbid all kinds of contraception. Meanwhile, the living habits of the members of this movement do not really differ from those of other Finnish (Hinkula, Kauppila, Nayha and Pukkala, 2005). Although, (irrespective of faith/religion) nearly 30% of the respondents in this study affirmed that their religion, notwithstanding the socio-economic implication, permits the practice of GMP. This was also confirmed by narratives from Muslim faith-based discussants.

Clearly, the view of faith-based discussants corroborated the value placed on having children in Nigerian society and Africa as a whole. One can easily infer that the Yoruba parlance of "Omo bere osi bere" (plenty children begets poverty) does not hold claim in the faith-based analogy because of the religious values of children. Furthermore, the perception of Yoruba on "Omo bibi kin se arun" (begetting many children is not a disease/illness) also demonstrated the first premise of Health belief model (Hochbaum, 1958) which base its argument on the person's perception of the susceptibility to illness hence if the GMP woman concerned did not regard having many children as disease/illness then there is tendency for such woman to be more involved in GMP practices as it is believed that such practices do not affect their susceptibility to illnesses during and after pregnancy periods.

Besides religious factors, the perception of mothers about GMP can influence their practice of it. Hence, perception/ compliance or non- compliance to GMP practices may be high among such mothers who agree to such opinion. Additionally, Hochbaum's (1958) arguments on compliance and non-compliance to GMP practices is equally valid in this instance since it enables understanding and explaining the factors that influence compliance and non-compliance to GMP practices as well as understanding individual's motivation and decision-making towards GMP. Thus, it is clear that compliance or non- compliance on issues relating to health is central in every decision making (such as GMP practices) among individuals concerned. Succinctly put, most of the perception of GMP women on GMP practices is more influenced by socio-cultural and religious factors.

Findings in this study established the nexus between religion and GMP practices which showed high decision to GMP compliance vis-a-vis other socio-cultural variables. This argument further buttressed the Yoruba parlance of "Olohun ni ki a maa bisi k'asi maa resi k'asi maa gbaa yun l'orile" as in the scripture (the holy bible), translated thus: "And God blessed them, and God said unto them, be fruitful, and multiply, and replenish the earth, and subdue it: and have dominion over the fish of the sea, and over the fowl of the air, and over every living thing that moveth upon the earth" (Genesis 1:28). Consequently, one can assert that religion played a key role both in perception and GMP practices in the study area and Nigeria society at large. As a matter of fact, this analogy fall within the fourth premise of Health belief model which accentuated on perceived barriers to treatment as applied here. Clearly, some of these hindrances/challenges usually include; socio- cultural barriers and religion, among others. In essence, it is when the GMP women considered some of these hindrances that will determine her compliance or non-compliance towards healthcare utilization she observed. This correlate with Yoruba`s belief that "Awon ohun ipenija ti ole fa idiwo fun alaboyu se Pataki ki amoju to" (meaning challenges/plight faced by the pregnant women are essential to addressed).

The major ethnic group in the study area was Yoruba (51.7%), followed by the Igbo (39.1%) and Hausa/Fulani (9.2%). There were more Yoruba respondents than any other ethnic groups because the study area is a Yoruba-speaking state. It is worthy of note to state that Yoruba placed high premium value on childbearing and rearing practices as this manifests in their naming ceremonies, music, parables/poems, folklores and mores (Gen. Prince Adekunle; King Sunny Ade; DR. Fabiyi; and Odunjo, 1975). Likewise, the Yoruba perception of value of children reflected the following saying: "Omo o l'ayole, eni omo sin l'obimo" (having a child in not yet a pride, until a child lives to bury his/her parents), "Omoniyi, omonide, omo ni aworan obi, omo o se fowora, beni omo ose paro" (children are; honourable, and of diamond in value, children are parents image, children are priceless, and above all, irrespective of their conduct still, they are in-exchangeable) and "Ako le fi omo buruku fun ekun p'aje" (no matter the notoriety of children in the sight of their parents, yet we cannot chase them to the hands of wicked peoples), among others. Vividly, the aforementioned parables/proverbs demonstrated the cultural relevance and perception of children among the Yoruba, including the case in the study area.

As majority (60.9%) of the respondents in this study had six children and above; and with minimum to be five children, while maximum size was eleven

children, it is clear that both GMP and GgMP (huge or great grand multiparous) exist in the study area. The implication was that; perception, attitude and GMP practices are still high in the area. Hence, it can be inferred that perception was largely attributed to sociocultural factor in the area despite the socioeconomic hardship currently experienced in Nigeria. Studies have also shown that African people have long valued high family size. This explains why many couples have large families (U.S. Department of Health and Human Services Centre for Disease Control and Prevention, 2000). Therefore, the insinuation of Yoruba parlance of "Won ki ka omo f'olomo" (it is forbidden to count someone`s children) is likely being cherished in the study area. Hence, the foregoing analogy reveals the sociocultural value that is placed on having children in the study area. This also supports the views of other scholars (Akintunde, Lawal, and Simeon 2013; Alonge and Ajala, 2013) who equally asserted that; sociocultural practices, early marriage, limited use of contraception, and other reasons influence GMP practices in Nigeria.

Educationally, completed secondary education was highest (32.2%) in education, and their involvement in GMP was above average (59.9%) and non-deliberate (40.1%). Although, incomplete secondary was lowest in educational raking (9.2%), yet they were highest in deliberate involvement of GMP. Thus, most categories of individuals who practice GMP were averagely educated. The insinuation of this in reference to the South-west, Nigeria was that secondary school education was valuable to Yoruba (Filson, 1991) and emphasis on secondary school certificate as an achievement to pave way to; job opportunities, an avenue to self-employment and independent, freedom to learn a trade, and marriage preparedness, and the like (Datta, 1984; Filson, 1991). Consequently, this may likely explain why complete secondary education holders were above majority (59.9%) and average (40.1%) in the deliberate and non-deliberate involvement of GMP practices in the area.

Similarly, the next in educational qualification category were those with completed primary (28.7%) level of education and majority of them found themselves in GMP practices non-deliberately (67.4%), while minority (32.6%) of them admitted they don't know. Surprisingly, incomplete primary educational qualification holders, though minute in educational categories (10.4%), were highest in GMP practices non-deliberately. Meanwhile, only few (19.4%) of the respondents had tertiary educational qualification, whereas all were involved in GMP non-deliberately. This

implies that their involvement in GMP was unplanned/accidental arrangement but that GMP practices was not strange to them based on their perception and socio-cultural believe. The implication of the latter is that, age at first marriage and early marriage as a result of low education/ illiteracy was the norm which may also influence high fertility rate in the area. As the value of education lies in its ability to give access to information especially on family planning issues, methods and practices (Wusu, 2009), women with low level of education (incomplete primary, complete primary, incomplete secondary and secondary education holders) may likely have high perception of GMP practices in the area compared to those of tertiary educational categories (Crary and Royer, 2011; Cohen, Kravdal and Keilman, 2011; Brand and Davis, 2011). Findings from this study showed clearly that GMP practices is not limited to primary and secondary certificate holders and/or uneducated alone as emphasised by Geidam, Audu, and Oummate (2011), rather it is worthy to note that tertiary educational holders do engage in GMP practices. In addition, this finding is in line with earlier studies on effect of educational attainment on large family size (Isiugo-Abanihe, 20006; Wusu, 2009; Grossman, 2017).

Conversely, findings in this study also revealed that occupation influenced the perception and practice of GMP in the area. This manifested among about 40% of the GMP respondents who are private employees and have 75.6% of them being non-deliberately involved in GMP practice. This implies that GMP was unplanned and causes of these might be due to; lack of knowledge of contraceptive, sex-child syndrome and so on as indicated in the findings of this study. The next highest occupational categories were those in the public service/civil servant (28.4%). Respondents in this category were the least in deliberate (32.8%) and non-deliberate (33.6%) of GMP practices. The indication of this is that, since most government industries have stipulated rules and regulations concerning average number of child per woman and observance of maternity cases among women which must be strictly adhered to by members of staff, hence this may not allow women to indulge in GMP practices as such in the area. Also, the self-employed categories were 17.8%, whilst 73.1% of them indulge in GMP non-deliberately. Employees who are traders (9.5%) hitherto their involvement in GMP were non-deliberate (100.0%). The explanation to this might be similar to those in self-employed categories mentioned earlier. The housewives categories (4.7%) occupied the least categories though; they were gainfully employed with sustainable income. Yet, they were highest deliberately in GMP practices. Hence, one can infer that GMP practices was highly practiced due to

their sedentary circumstances in their marital and commercial activities hence much time for child bearing and rearing practices than any other occupations. The insinuation of this is that environment played major role in GMP practices. Again, factors such as patriarchy, socio-cultural practices, occupation (such as, house-wives and farming), and presence of significant others/socio-support system, among others can influence the perception of GMP and its practice (Jegede, 2010; Olutayo and Yusuf, 2012; Saho, 2012).

Income may influence perception and practice of GMP among the category of people concerned. Although, this amount of income earned by the respondents in this study is not ideal for family man/woman involved in child-bearing presently in Nigeria due to inflationary trends in the country presently, yet the reverse has necessarily being the case in the past few decades as more low income earners were seen to have more children than high income earners. Thus, the social and demographic characteristics of respondents plays significant role in their involvement in GMP (Adam, 2014; Mwami, 2016).

Conclusion

The Phenomenon of GMP has contributed to population growth in Nigeria. This has equally affected the quality of life of women and children in the country. GMP is largely influenced by people's perception and attitude, together with other variables such as level of education, sociocultural belief and practices, religion, pressure from husband, type of occupation, environment and sometimes socioeconomic status of the people as found in this study. This, to a great extent, confirms the views of the Health Belief Model which stressed actors' intents and on decision-making, compliance and non-compliance towards issues regarding health matters and other extraneous factors that may necessitate decisions such as; sociocultural belief, health status of the people involved, religion, education, as well as the influence of significant others. In addition, the study concludes that despite the problems confronting the women with reference to their reproductive and maternal health, the practice of GMP is still in existence due to; spousal desire, ensuring motherhood security, enhancement of social status, means of happiness, fear of death of some of the living children, religious factor, and environmental influence. Improving maternal health is one of the keys to societal development, while women are significant in world's health and population issues.

Acknowledgement: The efforts of all participants in this study is appreciated.

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