Confusion in Parity and Sex Preferences: Yoruba Thoughts and Challenges for Population Control in Nigeria

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Abstract

Family size was an indicator of family wealth and wellbeing until the latest hypothesis linking larger family size and poverty. This paper juxtaposed the family size and poverty hypothesis and explored the experiences of multiparous pregnant women in Nigeria, a country in dire need of demographic transition process. Case study design, through a qualitative method, was adopted. Through quota sampling and snowballing, seven cases were studied. Although all women in the cases examined claimed to be healthy and relatively stable financially, they had some indicators of poverty. Also, spousal dispute or inconsistency, no prior plan about the desired number of children; spousal irresponsibility for conceptions, cultural beliefs about family planning and external influence, were responsible for the large family. This confirms that a large family is likely to be poor and faced with financial instability in Nigeria. This paper recommends that young people should be sensitised about the challenges of large family size.

Keywords: demographic forces, family size, multiparous women, pregnancy, population dynamics
INTRODUCTION

In the sleepy Ephugbu, an Okpoitumo Community in Abakaliki, Ebonyi State, Nigeria, Nkechi, sat on a long, brown, raffia mat breastfeeding her triplets. She irregularly exchanged her breasts among the babies as they cried uncontrollably. While doing this, she struggled to keep at bay a fly that kept buzzing at her feet weakened by the stress of farming. She covered herself with a brown wrapper while caressing the face of one of her triplets, this producing smiles from a joyful mother. According to her, the triplets came through a natural course, not drug induced. In all, she has eight children. She assists her husband on the farm for survival. The husband recounted excitingly that ‘God had blessed me beyond measure’. We shall call this virtual case #1.

Virtual case #2: The Etoors are also farmers and indigene of Eleme in Rivers State, Nigeria. Blessing Etoor was 34 years, a housewife who was delivered of her triplets (2 males and 1 female) at home. This was contrary to her doctor’s instruction -delivery by caesarean section. In all, she has 10 children (six girls and four boys). She left her hairdressing job to take care of her children. Since the birth of their triplets, her husband, aged 44, has been reportedly asserting that ‘life has been challenging for his family’… He spent about N30, 000 monthly to cater for the babies, but he has taken this as his cross… The children are God’s will. The only thing he can say is that his wife came from a family of twins, maybe that was why they ended up having triplets.

The two virtual cases shared similar denominators considering issues like health, psychosocial effect, economy and demography; but a different experience was found in Kampala, Uganda. Thus, this contradiction calls for a holistic discourse of the position of a woman, her health, emotions, parity decisions and role in the context of Nigerian demographic transition.

Virtual case #3: Nalongo of Kabimbiri village in Kampala Uganda, was married off at 12 years to a 40-year-old man… At 37, she has 38 children in 15 births. She was delivered of all at home except her last born (4 months old), delivered through caesarean section. The oldest is 23 years old, while the youngest is four months. Her husband was polygamous with many children from his past relationships. He was violent… the wife was battered, assaulted, harassed and violated in many instances. In 1994, when she was 13, she gave birth to twins. Two years later, she gave birth to triplets and a year and seven months after that she had a set of quadruplets. This was not strange to her since there was a similar report in her patrilineal route. According to gynaecologists, she is genetically predisposed to hyper ovulation and any attempt to stop giving birth may terminate her life. She tried Intrauterine Device (IUD) but she got sick to the point of death. She asked her doctor to stop her from more births and the doctor had cut her
uterus, possibly before her request. She administered local herbs for various illnesses because of her financial challenges: she could only support herself with what she earned from plaiting hair, decorating at events, and styling brides.

“I cry deeply in my heart wondering whether I produced these children on my own,” she said.

**Reflections on Virtual Cases**

Virtual cases #1 and #2 present a familiar terrain for discourse and analysis in family procreation context. In this sense, procreation within families is seen as an art of God, which exempts spouses from being responsible for family size. Thus, they may not be able to ascertain when the family is complete and no more addition of members is sustainable. In a more tenable explanation, family sizes are controlled by sexual urges and menopause. The personal effects of the two mothers in the cases above were in poor households, although their husbands supported the status, which was at least evidenced in the cases. In demographic and economic interpretations, Malthus foresaw multifaceted doom and trap for this kind of population growth. This is nature-driven population growth and it shall be called ‘pre-classic fecundity family’ in contemporary time.

However, virtual case #3 represents a classic fecundity kind of population growth in the contemporary world characterised by interactions between rapid fecundity and experts’ corrective interference. Also, the acceptance of that ‘hyper-ovulation’ notion (Natural cycles, 2018) precluded her gynaecologist from interfering in her biological makeup. Apart from that, the woman grew within a circle of multidimensional abuse. For example, she was married at 12 years without a proper understanding of her consent to marriage, an event in false self-consciousness. Similarly, her husband, 28 years older, reportedly battered her many times. Reasonably, why must she suffer such frequent violation? In a study, Azeez (2016) maintained that such abusive cases are not usually reported but left for God’s intervention. This could explain the repeated violation of women by the same culprit. Such experience will likely distort the concept of motherhood. For Reddy, Mistry and Jacobs (2016), relational support remains crucial in the adoption of motherhood and mother-foetus survival among adolescents with rapid, repeated births. The woman survived in the midst of confusion, which included all her rhetoric about her real identity, economy, and social realities cum personal interpretation of life.

**Social Forces and Vices**

In *Confusion and Personification in Yoruba Thought and Practice* by Salami and Guyer (2015), participants attributed confusion to Satan (*Eshu*). According to them, Satan causes confusion, which puts a strain on social relationships. Despite increased financial capacity among participants in this study, to nurture the
children, confusion may not be obvious in virtual cases #1 and 2, since according to them, the grand multiparity is God’s driven (this is similar to Emechebe et al, (2017)’s finding), while the mothers enjoyed spousal support. However, the third case expressed her confusion. Biologically, she experienced hyper ovulation which incapacitated her from adopting contraceptives. In fact, professional advice negated her move for birth control. For instance, she became severely ill when she tried IUD. Sometimes, she also suffered some form of violence from her absentee husband, which we called nocturnal male sex partner. This reduces the dignity of women (Anderson and Oppong, 2016). Amidst spousal humiliation and torture, she continued to grant his sexual advances which led to procreation. This may not represent her character flaws, but she was advised to endure and maintain one husband policy, which has kept her in this abusive relationship.

It will be difficult to question her rationale for grand multiparity. Idoko, Nkeng and Anyawu (2016) reported the most common reasons given for the current pregnancy among grand multiparous mothers. The reasons were the desire for another child (Rabiu, et al., 2016), the replacement of a dead child and the unplanned pregnancy—“mistake” (Umeora, Nzerem, Eze 2013). The first two reasons present a controllable desire regardless of attendant health, economic and population traps. Obviously, in all our cases, multiparity was not planned. As a matter of fact, its emergence brings about confusion especially when there are no secured means of livelihood.

Health Concerns

In Nigeria, contraceptive prevalence remains <15% while grand multiparity is associated with pregnancy complications (Rabiu, et al., 2016). Grand multiparity as a high-risk pregnancy is a common phenomenon (Oshodi and Salami, 2017) coupled with low socioeconomic status in the country. This significantly increases the risks of obstetrics (Emechebe, 2016). For multiparous mothers, increased occurrence of gestational diabetes mellitus, hypertension, and heart disease anaemia was recorded in Kano (Omole-Ohonsi & Ashimi, 2011). Similarly, the health status of these mothers was compromised (Emechebe, 2016). This was evident in all the cases in this study. Apart from that, they all experienced stressors. For example, ‘feet weakened by the stress of farming’ and ‘cry’ from a neglected mother of 38 children were identified (see virtual case #3). By implication, the high quality of life may be a mirage for these women.

Jennifer, Harms, and Harman (2017) maintained that although parity did not affect the quality of life (QoL) of mothers in their own study, parental stress, optimism, and health-promoting behaviours (HPBs) significantly affected their QoLs. Birth preparedness and complication readiness (BP/CR) is a strategy that encourages pregnant women, their families, and communities to effectively plan for births and deal with emergencies (Sumankuuro, Crockett, & Wang, 2016). In
our cases, there was little or no evidence of birth preparedness.

In fact, pregnant women had poor knowledge of danger signs (Ekabua, et al, 2011). Similarly, case #2 went contrary to doctor’s advice for caesarean section (CS) and gave birth to a triplet at home. No preparation for complications or emergencies may be responsible for increased preventable maternal mortality among pregnant mothers. Parity-specific maternal mortality ratio was highest in the grand multiparous women, while illiterate women recorded high mortality (Ujah, et al., 2005). For general health care, mother in virtual case #3 reportedly used herbal medicine owing to her financial status. Clearly, the minimum cost of treatment and affordability promote high patronage of herbal medicine (Azeez and Isiugo-Abanihe, 2017). However, the mother in virtual case # 3 expressed her need for support when herbal medicine could not restore her child’s ailment.

Population Concerns: Family Size-Economy Discourse

Currently, Nigeria has the seventh largest and most rapidly growing population in the world. Consequently, the population of Nigeria is projected to surpass that of the United States by the year 2050. By that, it would become the third largest country in the world (United Nations, 2015). Family size has always been linked with poverty which was evidenced in Yoruba cultural saying, ‘omo bere osi bere’ (literally ‘many children, plenty of poverty’). The impact of population increase on economic growth has always being a subject of engagement among economists. However, Eli and colleagues (2015) found a positive relationship between economic growth and population, fertility and export growth. However, this impact is not felt in Nigeria as the level of inequality is equally high in the country.

Poverty remains evident in Nigeria (Ademade, 2016), hence, a possible reason for home birth in pre-classic fecundity (Virtual Case #2) and classic fecundity (Virtual Case #3) kind of family. Montagu et. al. (2011) have established that home birth is common among the poor due to socio-cultural factors and a lack of access to health facilities. In the developing world, apart from poor pregnancy outcome - child mortality- among women with high parity, poverty and deprivation are also visible (Harrison & Bergstrom, 2001). There is a probability that population explosion via large families could plunge poor developing countries into further poverty and helpless wretchedness (Arthur, 2005).

Women, at the centre of procreation, are most times denied the opportunity to determine their family size. Culturally, traditional perceptions of women’s role in some societies make it difficult for them to contribute to population control (Arthur, 2005). Arthur also has maintained that among most women in Africa, there is a persistent belief that the most important role for a
woman is to have as many children as she can continue to bear any number of children. This portrays why women are kept within the house shed. Arthur (2005) identifies three conditions responsible for grand multiparity.

First, the family relies on manual labour since farming is the main sustenance. Also, the large family provides social security for the aged coupled with inadequate family planning information. For example, eight children in Case #2 will contribute to the farming business of the family, hence, an advantage over families with smaller sizes in that setting. However, the father registers his financial concern and required commitment, which he labels ‘cross’. This metaphoric allusion presents an imagery of unpreventable hardship. The hardship is economical since the emphasis is placed on the amount (#30,000) spent monthly. Similarly, Arthur (2005) observes that large families are usually described with words like poor, inability and low. Evidently, the three cases express traces of poverty within the families.

To draw the relationship and establish the effects of the nexus between multiparty, health, poverty, demography and gender, this study explores the situation beyond online sources in order to understand what influence state of parity, health status, psychological preparedness and realities of multiparous women and grand multiparous women along Sasa axis in Akinyele area, Ibadan, Oyo State, Nigeria.

MATERIALS AND METHODS

Qualitative case studies were conducted. There were cases of two grand multiparous women and five multiparous pregnant women. A large concentration of Hausa ethnic group is found living in Sasa community. We leveraged on the existing neighbourliness to approach the grand multiparous women. Through snowballing, we were introduced to a mother of five children, with two-month-old twins. The cases of pregnant multiparous mothers at the verge of being grand multiparous were also considered, which encouraged the documentation of trends, beliefs, reasons and experiences in the process of becoming grand multiparous. Two primary health care (PHCs) facilities were selected purposively since there existed the largest patronage of maternal care and availability of a gynaecologist in one of the PHCs. Through the snowball approach, pregnant multiparous women were traced for interviews. In the clinic, medical personnel were consulted to review case notes of pregnant women as a way of identifying and selecting pregnant women with at least two children.

This was done on one of the days for the antenatal clinic. All participants were duly informed about the intent of the case study. Also, participants were made to understand that participation was voluntary and that there was freedom to
discontinue at any time they so wished. Seven participants consented while those who were not interested were politely left.

In all, seven cases were studied. The interviews were conducted in Yoruba, the local language, and in the English language for those who felt more convenient in that language. The longest interview session took about one hour. On permission, interviews were recorded. These were later transcribed, translated into English and processed for analysis. Apart from careful reading, data were cleaned to ensure proper and smooth interpretation and construction of accurate meaning. Codes were developed deductively for data analysis with attention paid to the thematic and content orientations.

Narratives from interviews were transcribed verbatim and a thematic analysis was undertaken (Braun and Clarke, 2006). A deductive thematic analysis was engaged along with inductive identification. These two phases enhance both theory-driven and data-driven analysis (Fereday and Muir-Cochrane, 2006). Thematic analysis derived its benefit from the perspective of Braun and Clarke (2006) that the method is appropriate ‘when investigating an under-researched area or while working with participants whose views on the topic are not known’. The patterns that emerged from the themes in this study were identified using word frequency. With the aid of Atlas.ti software, codes were generated into nodes tree to enhance analysis. The overall analysis was copied and pasted on a word document before the discussion. The trend of the discussion exposed latent experiences and meanings from the key themes. In our narrations, Case # was used to represent woman persona and this made the discussion more comprehensible.

FINDINGS AND DISCUSSION

The socio-demography of the respondents revealed that cases #1- #5 were pregnant. Only case #7 did not have formal education, cases #5 and #6 had second degrees, while others attained secondary school education. The age of the cases studied ranged between 27 years and 57 years, and all participants were married. Cases #2, 5 and 6 were teaching while others were trading. Also, cases # 1, 3, 4 and 7 were Moslems and others were Christians.

Initial preferences for family size by Multiparous Women

In all cases studied, the initial preference for family size was examined. Most of the cases had prior plans about the expected number of children their families preferred to have. This prompted the identification of factors that interplayed in the preferences. Pressure from extended family members and from the in-laws was apparent in the discourse of parity in most cases. Although the Yoruba saying, *Igba omo ko to Olorun lu pa leekan* (It does not take God much time to kill 200
children once (Case #1) could pose a threat to initial family size plans, such could not hold any influence stronger than the couple’s decision. In case #2, the woman saw the plan as her personal plan with specific conditions.

She mentioned child care with a futuristic view, which has to do with the capacity to educate the child. Jennifer, Harms, and Harman (2017) saw this as parental stress which could affect the quality of life. She had 3–4 children in mind and according to her, the husband accepted her proposal. She maintained: “what encouraged me was that my husband accepted what I had in mind to do before”. Case #5 had 3 children in mind before marriage which she discussed with the husband. “We made it a decision to have 1 boy and 2 girls or 2 boys and 1 girl but if we have three same-sex children, we have to give birth to another one”, she said. This plan remains flexible since there is a possibility that the couple may not have their expected sex combination as stated earlier on. She maintained that the plan was still active. The extract below captured the discussion of initial parity plan before marriage between would-be spouses. Yes, we had a plan. When my husband and I met each other, we sat together that we wanted to have four children. We did not allow any family members to dictate to us. You know that they are not the ones that will take care of them. For some men, it is the family that will call their son and tell him… (Muslim/no formal education/Hausa/57Years/Trader/).

For cases #3 and #4, there was no initial plan. To her, there was no reason at that time to think about a number of children. This conclusion aligned with her beliefs on childbearing. She believed that there would be some financial requirements as one gives birth to a child, however Olorun l’on w’omo (God is the one that takes care of the children), she concluded. This is a replica of cases #1 and 2. Case #6, a mother of five children, had no initial plan about her parity before marriage. In fact, she was not prepared for the married life before she started having children. She recounted: I was at 100 level, at the age of 19, when I got pregnant, by age 20 I gave birth to my first born…. Case #7, a grand multiparous woman, never thought about any plan towards her parity in marriage. She identified changes in time because in her youth, things were good; she did not know that there would be economic changes eventually, although she believed in grand multiparity. Then to substantiate her view and manage her dissonance, she talked about couples who, regardless of the present worldview about multiparity, still have many children. However, she could not hide her regret for having seven births. The following extract registers her confusion about opposing realities which was resolved in God-determinism factor:

I gave birth to many children but for our children that are getting married this day, they can’t give birth to as much as I did since the economic situation has changed. Also, there are several broadcast programmes on radio and television advising against multiparity. I
just switched off my radio now. Well, there are some people that are still giving birth to many children based on their capacity to care sufficiently for these children. But if we had known how the present situation would be, then we would have reduced the number of children we gave birth to. But I believe God has done it the way He likes it to be (Muslim/No formal education/Hausa/57 years/Trader/9th Pregnancy).

Birth Spacing System and Family Planning by Multiparous Women

Case #6 narrated that she had her first baby at age 20 which was her second year in the University. She had a 4-year interval before the second born. This showed that she had a control over the child spacing, probably she had to hold on since the first pregnancy was not planned. She gave birth to her third child three years later, now her third child is 4 years old, while the fourth pregnancy produced twins. However, she maintained that there was no initial plan about her parity before and after the first child. According to her, one thing I usually tell my husband is that I want to space my children and I am following my spacing plan. Should I say it is God? Because I don’t believe in family planning. Her case shows the desire to build a healthy family life. However, she had a reservation for family planning which could serve as a means to achieving desired childbirth spacing. The reservation was borne out of her personal experience about what the side effect of family planning could be. To her, the side effect outweighed the potential benefits of family planning. Similarly, Solanke (2017) found that the majority of elderly and grand multiparous women refused contraceptives owing to expected risks but preferred traditional method. This is similar to Case #3’s negative conclusions about family planning. She maintained that continuous breastfeeding had helped in child spacing while Arthur (2005) advised for family planning advocacy. However, the scene that influenced the negative attitude in case #6 was captured in the excerpt below:

My in-laws’ first born is a herbalist. He treats people with STDs, other infections and they treat people who need children. So there was a day I was with him when a woman came who had been barren for about 8 years and they have to treat the woman. Imagine the blood that was coming out of her private part. There was blood and this woman had given birth to a child before adopting family planning. I saw the blood. Immediately, I promised myself I will not do the family planning and I don’t want something like that delay in birth (Christianity/2nd degree/Edo/30 Years/Teacher-housewife/).

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1 It represents the contraceptives used to achieve parity plan in a typical family.
Also, she rejected the use of contraceptives such as condoms. Specifically, she did not believe in condoms and this led to a question about how she achieved her desired birth spacing. Based on evidence of spacing among her children and her report, she maintained that she usually used salt and water solution after each sex. She reported, “that is what I use and it works for me”. She did not demonstrate any form of awareness about the effect of excess consumption of salt solution. However, studies have established an association between high salt intake and the risk of high blood pressure with damage to other body organs (Nerbass, Calice-Silva & Pecoits-Filho, 2018; Sung Kyu Ha, 2014).

For case #5, she had a 3-year child spacing plan in-between her children, although she did not have much good information about family planning. Also, her mother did not like family planning and she advised her not to use it. Consequently, she did not use it. She stated reasons that might be responsible for achieving the desired spacing between her children. For instance, there was no regular sexual relationship between the couple, since her husband was not always around. She maintained, “he does night shift and he is not always around in the night”. Even during sexual intercourse, according to her, “he does not pour it into my body”. These kinds of work and sexual practice helped in case #5. However, there was a disagreement between the couple over the adopted birth spacing. The husband was older than the wife. He wanted her to procreate as many times as possible owing to the age difference between the couple. He was not considering other health and economic implications of such a desire. He almost got his desire until the pregnancy got threatened and aborted. Case #5 symbolises circumstance-driven child spacing which shares some characteristics with virtual case #3. She shared her experience of spacing their children’s birth:

…there was a misunderstanding over childbirth. I was not interested when I gave birth to my firstborn, then my husband wanted another child within a year and a month. I said I was not interested. We quarrelled. He was angry and that did I not know that he was growing older, because, he is 20 years older than I am. He said he wanted to give birth to his children quickly and later I reconciled with him and got pregnant. I did not know that the pregnancy would come down. Then I was not with him, rather, he was far away from me. I had problems with my grandmother. I had miscarriage…The pregnancy came down in September and I got pregnant in October. This made it three years after the first child (Christianity/2nd degree/Yoruba/27Years/Teacher/4th pregnancy)

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2 It means semen
Case #1 asserted emphatically that she had not used family planning. But she was using confidence, a daily drug, which was from the government. She did not know that the drug confidence is either Postinor-2 or combined oral contraceptive (Ezebialu and Eke, 2013). She mastered the usage of the drug for birth spacing as explained in her practices. She usually stopped the drug for 3 months prior to the time she expected her menstruation. Also, she would confirm her body’s readiness before pregnancy, while others may not practise likewise. After, forty-first day of birth, she resumed using her confidence since they (husband and wife) might desire sexual intercourse. She shared her experience and ability to manage the situation by using condoms in order to protect the husband and prevent spousal infidelity.

…the body is not like a stone if my husband asks for a sex today and I say no, he will go out. But if I have protected myself and my husband knows about it, there is no problem. But if we don’t have that drug at home, I give a condom to my husband, since I am selling it. I tell him to take and we use it (Christianity/2nd degree/Edo/30Years/Teacher).

She maintained that family planning gives rest of mind coupled with long life. She explained that the family planning personnel would check their clients to know whether they were capable to use the specific type of family planning or not. She could trust their prescription. Idoko, Nkeng and Anyawu (2016) suggested that improvement in access to effective family planning methods remains one of the cardinal “quick fix” strategies available for maternal mortality. Also, there must be a family plan before acceptance and adoption of the mechanism of family planning. For her, “if I want to give birth to ten children what is key is planning on how to give birth to them so that we can accomplish our focus”. The number of children born to a family is not the problem but how to achieve family set goals. Similarly, she could see that family planning attracts good things of life. She emphasised her family plan which has enhanced spousal cooperation and made the couple to invest more in business.

In case #7, there was a two-year spacing plan between her children. She weaned them at two years, believing her husband would be patient at least. But she exercised fear similar to case #1. The woman should be readily available for sexual relation when the husband wants it. This would be done to prevent the husband from going out. Perhaps, when the woman gets pregnant, then there would be much to be done which may strain the nursing mother. This further explains her concern for the nursing mother and how she would cope with the situation. In her own time, there was no condom and according to her, ‘we would

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3 This is a nickname given to a drug based on its effectiveness as contraceptive pill
4 Having extra marital affairs


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use a cloth to collect the semen to prevent pregnancy’. This is usually done when a man wants to have sexual intercourse with a woman without expecting pregnancy. She said, “two of us would have discussed how we would handle that prior to the time”. Every participant was aware of the benefit of spacing and thereby devised suitable child spacing mechanism. Also, the cultural mechanism has potentials but they (the women) may not know when to stop giving birth.

**Reasons for Multiparity among Women**

The belief system has a great influence on the multiparity of a woman. This was evident as Case #5 described her social milieu. She had time for her children though she was still a student, and there was sufficient economic provision for her. Although she affirmed that individual economic status could also influence parity, she reportedly had sufficient economic supply which did not affect her tendency to give birth. Also, she believed in her plan but submitted to the ‘God-factor’ that superseded all other factors (case #5). This corroborates Emechebe et al’s, (2017) finding. For Oshodi and Salami (2017), grand multiparous remained inevitable because of cultural values and the influence of religion. In case #7’s explanation, multiparity is not accidental but God destined. For her, ‘everything is in God’s hand’. She believed her limited control over her parity. Similarly, in case #1, she was encouraged divinely in previous conceptions. Specifically, ‘God didn’t inflict me with pain in my first two pregnancies’, she said (case #1).

Sex preference leads to multiparity which most of the time, does not come from the women. In case #1, there was a sense of acceptance of her multiparity since, though her husband displayed a preference for a male child, it was contrary to her reality which was her fate. She jokingly registered her concern for attendant care for their female children anytime her husband expressed the male-gender preference. However, she maintained that affluence could lead indirectly to multiparity. Some women would bear many children based on their husbands’ wealth status and possession of physical structures which can transcend to sufficient inheritance.

…I am happy because good gifts that befit me God has given me. When my husband would say girls, girls, girls, I just told him to go and tighten his belt well for the children’s upkeep. Go and build four big buildings where you will keep your children. We joke with that. This takes away the pressure of preference for a male child. If you see what good things/fortunes female children attract, you may not want to give birth to male children (Moslem/SSCE/Yoruba/35Years/trading /6th pregnancy).

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5 Similar to case #5 ‘did not pour it into my body’
6 Having three girl children already
For case #2, her husband had agreed with her to bear three children, but she had borne three girls. This altered their previous parity plan as her husband needed a boy and that was why they were giving birth to more. This is similar to the findings of Oshodi and Salami (2017). According to her, “I don’t have a boy yet and this pregnancy is a girl and I am likely to give birth to another child” (case #5). Based on her explanation, her husband’s preference for a male child demonstrated a level of violence against her persona. She was held responsible for the female sex she conceived as if she could pick from the two sex alternatives.

Also, she did not mention her psychological trauma, despite the fact that the husband verbally relinquished the pregnancy the moment he knew the sex of the fetus. She gave a supporting argument that might justify her husband’s position: indirect influence of sex preference and realities of the paternal family of orientation, which leads to intergenerational sex preference. By implication, her supposed inability to conceive a male child posed a threat of polygyny to her home. The excerpt below vividly captures her experience after returning from a pregnancy scanning centre.

   …In fact the day I went for my second scan, he asked me, was it a male or a female. When he knew the sex, he was so angry to the extent that he said he did not want it again. He asked why it was a female again. He said, he was the only male or did I want his father’s name dead7. These could have prompted such statements. That is why I said I have to give birth to a male child, if not, he can decide to marry another woman. He may not tell me. I pray that the fourth pregnancy is a male. Although I don’t want the fifth child, if the fifth child is female, then my husband can go out if he wants (Christianity/2nd degree/Yoruba/27 Years/Teacher/4th pregnancy).

However, case #7 displayed differentials in her experience. For instance, she gave birth to a male child first and her second child was a female, third and fourth children were males, 6th was a female, 7th born were twins (both sexes) but she lost them. Again, she conceived and had a male child. After a while, she gave birth to two children, before the last twin. Also, she had some miscarriages. In her case, she recounted that only God knew the child that would take care of her at old age. Thus, personal desire for more children could be responsible for multiparity. Similarly, the mother in case #6 personally wanted many children, regardless of her education. However, Afolabi and Adeyemi (2013) reported that multiparity was less likely among women with tertiary education. After giving birth to her twins in her fourth pregnancy, there were anti-parity suggestive informal

7 Go on extinction

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comments from her associates. These could not deter her from having more children. However, she reportedly laughed at such comments since she believed in many children. According to her, “now, this is not my full stop in childbearing; I wish to have 6 – 9 children (case #6).

Her conclusion was not different from that of case #7. Relying on Yoruba’s cultural thought, “no one knows whom among one’s children that will care for one, then there is safety in multiparity”, she said. She had reservations for male children owing to the belief that male children are not likely to take care of their parents. By her explanation, “when my son gets married now, he won’t have time for me again. He will have time for the wife while girls will have time for their mother”.

Also, the influence of the significant others indirectly determines family parity level. Considering case #1’s experience, her parents (external parity driver) demanded more children in her daughter’s nuclear family coupled with silent demands from her husband (internal parity driver). Her father believed that child spacing was a waste of time and other resources. Similarly, the father suspected a decline in family sizes, aligned it to metaphysical forces against the family and consequently campaigned and challenged the system.

Coincidentally, her husband made several similar requests. She was able to manage external parity drivers, however, she succumbed to the spousal demand but with a deferred response. She shared her experience: “I was vexing for them. I wanted to give birth since my husband was begging me at home. I said let it be next year. And you know when husband and wife understand each other. If my father insisted more than that, will he help take care of them? If my mother-in-law is angry, then let her sign an agreement that she will take care of the child after I give birth (Moslem/SSCE/Yoruba/35Years/trading/6th pregnancy).

Social Support and Experiences of Multiparous Women

Case one explained the present trend of social support available for multiparous mothers by comparing time-bound experiences. She established the disparities between the 1980s and present-day social support systems. She mentioned some factors that boosted social support in decades ago. Material things for child care were easily accessible since they were jointly provided by a family’s social networks. Today, there is a predominant sense of individuality in caring for the mother and the children. Case #1 maintained that parents must ensure self-sufficiency before giving birth to children. This follows the expectations of the in-laws, who may not be ready to share /give cultural/material support to the multiparous mothers.

Apart from material supports, she identified laziness cum dirtiness as another major challenge of multiparous mothers. She recognised her self-
employment status as another factor that aided her ability to care for the family, labelling some nocturnal mothers, who would go in the morning and return late at night, as uncaring mothers who would not be aware of their children’s wellbeing. This would make it difficult for them to curtail the misbehaviours of their children. She visited her children’s schools twice in a week and shared her experience on her support role in the children’s upkeep as follows:

Sometimes, I would have woken up by 3.30am, because of the kind of food I want to prepare. By 5.00am their food is ready, by 6.00am they have had their baths.

It is easy for me because I am self-employed. After they have gone to school, I clean the house and sleep for like one hour then I go to work. I recover my sleep with that one hour. And when the child came back from the school, you were to wash the uniform. You would have cooked before the child’s arrival. If she/he disliked cold food, put it in a device that will keep it warm (Moslem/SSCE/Yoruba/35Years/trading/ 6th pregnancy).

Case #1 recounted care for nursery-school-age children, while case #7 focused on preschool children. She painted similar individuality picture in childcare like in case #1. Prior relationship between the mother and her in-laws would help her in weaning the children. Also, extended family caregivers would advise on childbirth spacing. The children would be carried to a distant location from the parents because of an affirmed, trusted and good care available to the children.

Consequently, this would relieve a couple of stress associated with childcare. However, in her last birth, she weaned her child without consulting in-laws or other close relatives for usual help because, recently, parents were not willing to release their children to the care of extended family members and other associates. She explained as follows:

But now, parents are the ones taking care of their children and weaning them. The social world has changed. Some parents do not want to give their children to the grandparents to wean. They would say they would take care of the children themselves. They would not see what the child would be given to eat. It was not so at that time. At that time, we had rest of mind, knowing our children were with those that would take good care of them (Muslim/no formal education/Hausa/57Years/Trader/).

Also, nocturnal mothers illustrated in case #1 would prefer to engage the service of nannies to care for their children. This suggested reduced level of trust.
placed on the social relationship between families and their in-laws in recent times. Apart from that, parents with healthy children would enjoy better social support which is not limited to carrying and playing with the child, which invariably relieve the parents. However, case #6 did not enjoy social support when she was delivered of her twins. Her mother came and left eight days after the birth of the baby, while the mother-in-law left the family two days after the wedding.

**Health Outcomes of Multiparous Women**

Idoko, Nkeng and Anyawu (2016) observed that grand multiparous women are highly susceptible to obstetric complications. For case #5, pregnancy poses health threats to the expectant mother and such women require maximum care from their husbands since they are experiencing an uncertain situation. Based on her experience, it would be difficult for the husbands to express genuine positive emotions, since they become agitated during their wives’ gestational period. Case #1 mentioned that multiparous with un-spaced childbirth is a risk.

She believed that women should recuperate after childbirth before being pregnant with another child. She stated the correct spacing period and the purpose of that period which would herald wellbeing. She also asserted that couples that compromise this are exposing their women to health challenges. The following excerpt vividly captures her thought and experience:

… once a child is one year and a half or less, some women would become pregnant. They don’t like themselves; because the blood used up during the previous birth experience has not been replenished. A woman needs inner strength or energy to conceive again. For me, I allow my children to really grow before another pregnancy. For this one, my husband and I have agreed to space our children by 3 years (Muslim/SSCE/Yoruba/35Years/Trader/6th Pregnancy).

However, she related her health threatened experience as she compared her different times of labour. She described her painful labours in the past saying, “the pain I experienced was much more than the ones in my previous births. After 9 years of spacing, my labour period increased from 30 minutes to 1 hour. And at another time I had stillbirth”. With her experience, she submitted that a long birth spacing plan was not healthy for women (case #1). Case #6 revealed that she had several monologues reflecting on what brought her into another pregnancy. This affected her physically and psychologically, coupled with her husband’s annoyance. She was unable to stay in her home during pregnancy as she instead preferred travelling to stay with her parents. The travelling was possible because she was a full housewife. Her health became more compromised.
In her last pregnancy i.e. the twins, she reported: ‘my mother and mother-in-law left her on the day of christening and the following day respectively’. After two weeks of birth, she was seriously ill. She recounted: “It was one of my neighbours that was bathing the children for two weeks. It was more than a stress. In fact, it was not easy taking care of them. I had to introduce “Indomie noodles” at three months. I could not handle the rate at which they were sucking breasts”. Three months after their birth, she introduced noodles to the twins. Apart from her physical stress and distress, the children were exposed to a higher level of risk through feeding (case #6). Also, she consistently exposed herself to high blood pressure owing to her salt intake.

The Economy of Multiparous Women: Omo bere osi bere

In 2011, Okech, Wawire, and Mburu reportedly concluded that family planning would reduce poverty, hunger and maternal mortality. Case #1 alluded to African musicology to explain how music had been used to explain the parity/poverty thesis. She stated, “a singer sang that many children will become a financial burden. Many children within a family are rarely taken care of”. She related another case of a woman who adopted a family planning method which later failed. Case #1 gave a personal explanation of what could be responsible for the failure- the wrong timing of injection. This mother of 7 children came for an ultrasound, only to discover that she was pregnant. Consequently, she had a partial abortion\(^8\). After three months, she discovered in the latest scan that she had a triplet. The woman was unable to manage her emotion as she cried aloud.

Her anxiety included how to care for the children since she had meagre income earned from hawking\(^9\). Case #1 could not fathom what led to that multiparity but later advised her to try another type of family planning (arm insertion type) with longer duration. She maintained that men were usually influenced by their affluence, which leads to polygyny and multiparity within their families. She painted the thought around her discussion as follows:

But men if they have property there is nothing they cannot use their affluence for. You marry the first wife who has five children, then marry a second wife who maintains that she will have five children like the first wife since there is properties that will be shared equally. And you know someone who is gyrating will lay his hands on a third wife. However, some men have large property yet maintain a one-wife policy. He has the power and planned twenty children; no problem, he has direction. But someone who

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\(^8\) According to case, #1 one of the quadruplet was aborted, while the remaining three foetus were unknown left to grow in the uterus. The latest scan showed that there were four babies but one had been cut off.

\(^9\) Selling sachet pure water on the street.
doesn’t have anything and is living with the idea that it is 
God that takes care of children! May our children not 
become someone else’s children
(Muslim/SSCE/Yoruba/35Years/Trader/ 6th Pregnancy)

Case #1 recounted the aura of joy and happiness in her home owing to her 
husband’s financial readiness before she became pregnant. She said, jokingly I 
would ask what did he have before the pregnancy. His reply would be, was that 
what you were waiting for before pregnancy? Case #5 reportedly maintained that 
there was no relationship between parity and poverty since parity was God-driven 
and she had no choice and no pressing need for money. Considering family 
economy, case #6 explained that a family must plan on any little amount available 
at the home to meet the need of every member of the family and the unborn baby. 
For her, this financial plan would preclude depending on external support for 
family continuity. Also, she was engaged in farming in order to boost the income 
of the family. However, she had a psychological distress when she was delivered 
of the twins because her plans were not sufficient to meet the family’s needs. This 
put more pressure on the marital relationship, coupled with her husband’s aversion 
for more children. This financial distress was not a deterring factor for grand 
multiparity in this case. Salami, Ayegboyin and Adedeji (2014) observed that 
unmet social needs could result in labelling a foetus an unwanted pregnancy. 
While this was true for her husband, the financial problem, to her, was only 
temporal since she still had an intention to have more children. She related her 
experience in the following excerpt:

When I was delivered my twins, should I say my last born, 
I cried. Because I didn’t believe in having twins then and 
there was no money, everything was dry. Where am I or my 
husband going to get money to care for these children? And 
anytime I was pregnant, I would be asking myself who 
asked me to be pregnant, how will this be delivered? How 
do I tell my husband? When I told him of previous 
pregnancies, he was angry. When I told my parents, they 
were angry too. This affects our relationship. For instance, 
my husband was always angry for the first four months of 
the pregnancy (Christianity/2nd degree/Edo/30Years/
Teacher-housewife).

Experience in case #1 depicts that response to family financial needs as a 
result of multiparity requires financial cooperation between a couple. She traded 
in a single product (patent medicine vendor) before, but when there was a more 
financial requirement within the home, she added beverages. She advised her 
spouse to invest in her business for financial interest. The cooperation increased 
support for the husband and boosted her confidence level to face future realities.
She reminded her husband of the financial commitment:

… and you are a salary earner, who is working with the government. Sometimes, salary may be delayed; help me find a little money to boost my business! He gave me more money. As the children are coming, my business is growing. I am not in a business any longer but in several businesses, our financial economy cannot be discussed in isolation of my husband’s financial commitment to the family upkeep (Muslim/SSCE/Yoruba/35Years/Trader/ 6th Pregnancy).

Implications for Population Control and Health Policy

Our cases demonstrated ‘pre-classic fecundity family’ as seen in virtual cases #1 and 2 since multiparity is still driven by cultural and personal nuances. Similarly, there was evidence of desire and consciousness for child spacing among mothers. However, poor information and perceived effects with unpleasant experiences of family planning encouraged preventable multiparity.

These make multiparity inescapable. Also, none of the multiparous mothers accepted parity-poverty hypothesis by experience although they agreed it was possible in other families that practised multiparity. Thus, couples should disassociate from the aspect of culture and personal beliefs related to parity which endanger the health of women and family economy. Also, more public sensitization should be initiated to cover the challenges of large family and family planning as a way of curtailing preventable grand multiparity.

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