SOCIAL SUPPORT AND FERTILITY LEVELS IN BENUE STATE, NIGERIA

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Abstract

Social support practices are universal, but the effects on fertility levels differ across societies. In Nigeria, these practices have been implicated as determinants of fertility levels. Benue State has shown a continuous decline in the levels of fertility. To unearth the determinants of fertility levels in the state, this study examined the effects of social support on fertility levels. The specific objective was to examine the effect of social support on fertility levels in Benue State, Nigeria. Related and relevant literature were reviewed based on the objectives of the study. Theory of Reasoned Action (TRA) was adopted in the study. The study used cross-sectional research design, with Benue state as the study area. The population of the study was all female adults who have birthed a child (ren). The formula by Cochran was used by the researcher to determine the sample size of 1,174 respondents. Multistage sampling techniques were used in the study. Questionnaire and Key Informant Interview (KII) guide were used. Face and content validity and test-retest type of reliability were used. The data were analysed with descriptive statistics and inferential statistical tools as well as manual content analysis. The analysis was done at univariate, bivariate and multivariate levels. Social support was found to have influenced fertility levels through ensuring child survival, encouraged child birth, helped in planning for next pregnancy. Others included reduced stress in child rearing, reduced workload and burden on parents, and improved child health. The list also included enhanced birth spacing and limiting, encouraged child birth, encouraged early onset of sexual intercourse and increased rate of child birth. The study concluded that social support has influenced the level of fertility in Benue State. The study recommended among others that the practise of giving social support to women after birth should be encouraged among the people. This will help to adequately care for their infants with the assurance of survival and thus avoid the birth of too many children, with the hope of having surviving ones despite mortality.

Keywords: Social support, fertility levels, Benue State, Nigeria

Introduction

Social support, usually in the form of family members caring for the new mother and her infant for a specified period of time, is almost universally provided in the early postpartum period by the mother, mother-in-law, other female relatives or husband. According to a study by Dennis, Fung, Grigoriadis, Robinson, Romans & Ross (2007), respected older female community members, traditional birth attendants or young women from the community may also be involved in providing care for the mother. The support often includes practical assistance (e.g., household chores or cooking), as well as information for the mother regarding how to care for herself and the infant. The study revealed that in Japanese culture, the practice of *Satogaeri bunben* typically involves the woman traveling to her family home at 32–35 weeks gestation to be cared for by her mother until approximately eight weeks postpartum. Similarly, in the Amish of Tennessee (USA), the new mother is provided with organized support from extended family members and the

community. Other cultures that practise a similar period of organized support include Nigerian, Jordanian, Korean, Guatemalan, Eastern Indian Hindus and Chinese societies/cultures.Emotional support is related to affection, love, empathy and respect; information support is associated with suggestions, information, advice and opinions; and instrumental support refers to financial support, time devoted and availability of resources, goods and services (Bullock, 2004).

According to a study by Cremonese *et al* (2017) in Brazil, people who offered instrumental support to adolescent mothers were part of the nuclear or extended family, from school or work, or within health services. Care of the baby was mainly given by people who lived in the same house. The adolescent's grandmother calmed the baby when she had tummy ache, and the partner/husband took over during the night. Baby bath was also shared with different people from the adolescent's social network, helped or performed by the mother, partner or aunt. Also, the mother-in-law and younger siblings took care of the baby when the adolescent mother had to leave for a few moments. The findings also revealed what adolescent mothers consider as support such as helping actions, especially words, companionship and encouragement. They feel they are being supported when they are not judged by other people due to their early pregnancy. Care of newborns requires knowledge, experience, commitment, patience and disposition, because they depend on care. However, some women, regardless of age, by lack of experience and/or insecurity, cannot provide care and need help until this adaptation period ends.

Similarly, another study found that this help in the baby's daily care comes essentially from the adolescents' mothers and grandmothers, probably due to their previous experience. Therefore, after hospital discharge, the adolescent mother traditionally has the support and companionship of a woman from her family. Older women who experienced that process are considered as a reference, since they have experience and skills to help these adolescent mothers (Teixeira, Mandú, Corrêa & Marcon, 2015). Women seek female support, because they feel safe with someone who can talk about a previous experience.

According to the study, besides the support of women from the family, they had the support of the husband/partner to take care of the child. As for fatherhood, men's participation has gone beyond economic support and is now present in feeding and care and also in following the child's growth. House chores are generally shared mostly with the mother, sister and grandmother; they can also be shared with the partner/ husband. Among the main duties, they mentioned the cleaning of the house, laundry washing and cooking. When adolescents experience motherhood, they have to organize the house chores, besides taking care of the baby. This results in some routine changes, as well as changes in the dynamics of families, and everyone must adapt to the new condition. Help with house chores can strengthen family bonds; if adolescents would take on theses chores themselves before, they now have the help of the closest people to them. This sharing of house chores was also observed in another study, which found that people are supporting each other and strengthening the bonds when they share these chores.

Financial support was provided by the partner, mother and stepfather. They also had the support of other people from their community, who donated clothes and some materials for daily care, in addition to help in commuting to the health service, when necessary (Teixeira *et al,* 2015). The financial condition of adolescent mothers of this study was poor. This is confirmed by these statements, which showed the participation and generosity of the social network, beyond the core family. The provision of material for baby care was appreciated by mothers, since those are products, they could not afford, and the growth of the family structure requires adaptation and financial reorganization. Support provided by the adolescents' families had a positive effect on the postpartum period.

These findings were also found in another study by Braga, Oliveira, Spanó, Nunes and Silva (2014), which indicated that instrumental support was given by means of the provision of financial and material resources necessary to daily care. Some mothers also had the support of the baby's godmother, who welcomed them in their houses, thus giving them peace of mind. The adolescent's mother took the older granddaughter home to make sure she could rest while the baby was sleeping. One of them had the empathy of her co-workers, who took over the heavier work and her maternity leave was extended to five months.

Some adolescent mothers of this study lived in a troubled environment, sometimes stressful, either because of an alcoholic brother or the presence of older brothers who required care, resulting in a psychological or work overload, since they did not have the help from their husbands. In this context, a quiet place could offer well-being to adolescent mothers and their children.

In Berlin, Germany, a study by Elsenbruch *et al* (2007), reported that the association between social support, psychological stress and pregnancy outcome is undoubtedly complex. It has been proposed that effective psychosocial resources, particularly social stability and social participation providing emotional and instrumental support, are protective by buffering the impact of life stress on the emotional well-being of the mother. In addition, social support may be one determinant of lifestyle habits and relevant health behaviours, including substance use such as alcohol and tobacco, as well as dietary habits which can by themselves adversely affect pregnancy outcomes. The study revealed that women with low social support lack effective psychosocial resources, particularly social stability and social participation and therefore receive insufficient emotional and instrumental support from the partner, family and/or friends. During early pregnancy, a time of significant life change requiring major psychological adjustments, the perception and expectation of insufficient support clearly have a detrimental impact on maternal psychological well-being.

Also, the data support the notion that lack of social support represents an important risk factor during pregnancy, and its consequences may be markedly exacerbated by additional risk factors such as smoking. Strong support networks, on the contrary, appear be protective, particularly in the presence of additional risk factors such as smoking and chronic distress, which is illustrated by our findings of fewer pregnancy complications and comparable birth weights between smokers.

According to a study by Rodrigues, Torquato, Davim, Oliveira and Alves (2016), Brazilian public health policies, for example, ensure pregnant women get the right to health during pregnancy. Among these rights are quality prenatal, childbirth and postnatal care, labour and social rights which regulate the employment relationship and ensure job retention, and also rights related to health protection and students' rights. The group of pregnant women was mentioned as an articulator of exchange of experience and information. When pregnant women share their doubts and feelings, they relate to each other and learn with the reports of different experiences. With regard to emotional support, it was given by mothers, partners, sisters, cousins, aunts, co-workers, friends and health professionals. Mothers encouraged their adolescent daughters to remain confident and to believe they would be good mothers. They also followed and gave advice regarding baby care.

Similarly, a study by Primo, Dutra, Lima, Alvarenga and Leite (2015), revealed that partners gave love and affection, and said comforting words to improve the adolescents' self-esteem. Sisters showed happiness with their nephews' arrival. People from work, colleagues and friends, and health professionals volunteered to help and give confidence to the adolescent mothers, reaffirming they were good mothers. The reports showed a wide and strong social network that promotes health. This network aroused positive feelings and involved people from family and work, friends, and institutions. In this process of autonomy building, it is important to feel supported, and this may have an effect on self-confidence and on the relationship with the child. To confirm this, social network support is also important to maintain mental health and to deal with stressful situations, such as the transition period after baby's birth.

In a study in Turkey, it was reported that in the period after discharge, women who do not receive sufficient professional care and support may experience a number of complications. Lack of access to postpartum care may prompt new mothers to turn to traditional practises to deal with health problems. New mothers and their infants can face various problems (infection, developmental delay, psychological problems, etc.) as a result of following traditional beliefs and practises during the postpartum period. In the postpartum period, a mother must be able to return to her prepregnancy state in both physiological and psychological terms, and all members of the family must adapt to their new roles. During the postpartum period, the mother is expected to care for her infant, provide the child with a safe environment,

communicate with the child, learn about her new role as a mother and help the rest of the family to adjust to the infant and its needs (Gulbahtiyar, Gamz, Birnur & Adem, 2018).

Traditionally, support after childbirth in Tanzania is provided by family members. However, young populations in urban areas are less likely to receive family support and more likely to experience divergent views from different ethnic groups they encounter, as they attempt to adapt to their new urban settings (Mbekenga, Pembe, Elisabeth, Kyllike & Pia, 2013).

In Nigeria, many cultures have a support process for the early postpartum period often involving immediate female family members and, in some instances, elderly community women. The parturient woman receives support (especially with domestic chores) from friends and family during the postpartum period. The woman receives physical and emotional support, and some nurturing advice from older adults (especially first-time mothers). For example, in the Eastern part of Nigeria, the '*Omugwo'* practise is common. During *Omugwo,* the parturient woman's mother takes over her care to facilitate the healing process towards the pre-pregnancy state. In the Southern part of Nigeria, either the parturient woman's mother or mother in-law takes up the care responsibility (Awolayo, 2019).

In Benue state, social support, usually in the form of family members caring for the new mother and her infant for a specified period of time, is also provided in the early postpartum period by the mother, mother-in-law, other female relatives, or husband. Respected older female community members, traditional birth attendants or young women from the community may also be involved in providing care for the mother. The support often includes practical assistance (e.g., household chores or cooking), as well as information for the mother regarding how to care for herself and the infant. These practices have implications on fertility levels.

According to National Demographic and Health Survey (NDHS), in 2018, Benue State had a Total Fertility Rtae (TFR)of 4.5, the second least state with TFR after Federal Capital Territory (FCT) with 4.3, followed by Plateau State with 4.7 (National Population Commission (NPC), 2019). This shows a sharp decline in TFR from 5.9 in 2008 to 5.2 in 2013 and 4.5 in 2018. According to the Survey, the number of people using any method of family planning was 17.1%, breastfeeding was 0.7%, and any traditional method was 1.6%, while withdrawal accounted for 0.6% and those who were not using any method of contraceptives were 82.9%. Within this time, the percentage of mothers who were utilizing contraceptives for spacing was 9.5%, those for birth limiting were 7.2%. The sharp decline in TFR in the state is associated with diverse factors. The formulation of population policies by the government has not been effective in regulating fertility rate as the country still have a TFR above the one (4 children) in the policy

Researchers have examined social support in other parts of the world but there is currently inadequacy of comprehensive scientific researches with focus on the effects of social support and fertility levels in Benue State. There is the need to unearth the effects of social support on such decline. As a result of this intellectual gap, this study examined the influence of postpartum practices on fertility levels in Benue State, Nigeria. Therefore, the objective of the study is to:

1. Examine how financial, tangible, emotional and informational support affect fertility levels in Benue State, Nigeria?

Research hypothesis

H0: Financial, tangible, emotional and informationalhas no significant effect on fertility levels in Benue State, Nigeria.

Conceptual clarifications

Social support

There has been relatively little agreement among authors as to the precise theoretical and operational definition of the concept of social support. However, Barrera, Sandler and Ramsay (1981), provided an early definition of social support, specifying that it refers to the 'various forms of aid and assistance supplied by family members, friends, neighbours, and others', which broadly encompass a multitude of social interactions. Malecki, Demaray and Elliott (2000), state that social support is an

individual perception of care from people in their social network, which increases their functioning and may safeguard them from negative outcomes. Wills (1991), cited by Taylor and Sherman (2004), defined social support as the perception or experience that one is loved and cared for by others, esteemed and valued, and part of a social network of mutual assistance and obligations.

Other scholars refer to social support as one's reception of information, guidance, comfort and help from his own community group or informal members of social networks. Moreover, Hafen, Karren, Frandsen and Smilth (1996) illustrate that social support is the degree to which a person's basic social needs are met through interaction with other people. It is the resource in both tangible and intangible forms that other people provide. Uchino (2004) postulates that social support is usually defined to include both the structure of an individual's social life (for example, group memberships or existence of familial ties) and the more explicit functions they may serve (for example, provision of useful advice or emotional support). In a nutshell, Sarason, Sarason and Pierce (1994) define social support as physical and psychological comfort provided by other people to others in need.

Contextually, social support means help or assistance given to parents such as family members, friends, and other social network groups to meet their desirable needs. This comes in form of informational support, tangible/instrumental and emotional support. Informational support involves the provision of information, education, or guidance for use in managing personal and health-related problems. Instrumental support (also referred to as tangible support) involves the provision of tangible assistance, in the form of financial aid, material goods, labour, time, or any direct help. Emotional support involves the provision of empathy, affection, love, trust, encouragement, listening, and care from members of an individual's social network.

Social support may come in multiple functional types, including emotional, informational, appraisal/and tangible support as well as positive social interaction (Sherbourne & Stewart, 1991). Emotional support includes nurturing, love, trust, and caring, whereas informational support includes giving of advice. Appraisal support includes helping the individual understand information and assisting the individual with coping strategies and resources. Tangible support is the provision of actual goods and services, or actual helping behaviours. Research suggests that tangible or informational types of social support can be detrimental when the support is viewed as nagging about behaviours.

Social support is, therefore, the care or help provided by an individual or group of persons (families, friends, co-workers, etc,) to meet another person's need(s) which has been deprived by a particular situation or event such as ill-health (Onyishi, Okongwu & Ugwu, 2012). This comfort can be in the form of resources provided by others to assist the patient. Social support can be instrumental, tangible, informational and emotional.

Fertility levels

Fertility is "the actual reproductive performance of an individual, a couple, a group or a population" (Ode, 2006). Fertility behaviour means all human actions related to the actual reproductive performance of an individual, a couple, a group or a population (Kwaghga, 2018b). Fertility transition refers to the downward or upward trend or change in the level of birth rate. It is a change in fertility from higher to lower levels and vice versa (Kwaghga, Shimakaa & Chinta, 2018). It is generally defined as having started in a country when there is at least 10% decline in fertility which begins an irreversible trend downwards. Also, it is said to be "completed" when replacement fertility levels are achieved. Fertility transition began in most industrialized countries in the late 19th century and completed by early/mid-20th century. It started in most of Asia and Latin America after World War II and completed, or is nearing completing in some (e.g., Brazil, Thailand, and China). It has also begun in most sub-Saharan African countries (Caldwell, 1997). During fertility transition, the proportion of decline in fertility may not be the same across age groups. With delay in age at marriage over time, with no concomitant increase in premarital fertility, the fertility in age group 15-19 will decline over time as observed in East Asia, especially in Japan.

Fertility trends in most of the developed world in the late 1990s showed a substantial decline to two children or fewer from the traditional six children per woman. Despite the declining fertility rate, the total fertility rate (TFR) is still high in sub-Saharan Africa. In sub-Saharan Africa, the TFR is five children per woman on the average, whereas countries like Chad, Mali, Niger and Nigeria record over six to seven children per woman. Among sub-Saharan African countries, Nigeria is generally known as the most populous country in Africa with a population of over 174 million in 2013, which is approximately one-sixth of the total African population (Alaba, Olubusoye & Olaomi, 2017). The population increased to over 206 million in 2020.

Sub-Saharan Africa is an important region to study, partly because its fertility has been and remains extremely high. If the region is to prosper, it would appear that fertility must eventually fall. Hence, the question of whether economic development will lead to a fertility transition is important. Another reason for studying sub-Saharan Africa concerns the high rates of HIV/AIDS for many countries in the region. HIV/AIDS threatens to dramatically alter the course of population growth in the region. It is an open question, as we shall see, whether this epidemic will hasten or retard the fertility transition (Isiogu, 2003).

In 1962, virtually all countries in sub-Saharan Africa had a reported total fertility rate above 6.0, with an average of 6.54. The most notable exception was Gabon at 4.06. Eleven countries had total fertility rates above or equal to 7.0, with Kenya reporting a total fertility rate of 8.12, which is one of the highest total fertility rates ever reported for a country. Fertility has fallen but remains high with an average total fertility rate of 5.02. This decline opens up the possibility that fertility in sub-Saharan Africa is responding to economic change (Isiogu, 2003).

In Nigeria, there has been some arguments on the state of fertility transition; but with the current TFR of 5.3 (NPC 2019), it is obvious that the expected level of fertility transition has not been achieved. In Nigeria, fertility levels have remained relatively stable (average TFR of 5.5) till date. Millions of couples and other categories of people who hitherto had no chances of birth have been granted opportunity to have children. An analysis of fertility estimates of Nigeria shows that; the country had a crude birth rate (CBR) of 50 births per a thousand (50/1000) between 1965 and 1966 with a TFR of 6.60. The TFR was 6.50 in 1970. It rose to 7.30 between 1971 and 1973, and declined to 7.00 in 1975. It further declined to 6.43 between 1978 and 1982 and then rose to 7.40 between 1983 and 1986. Also, the TFR stood at 6.20 between 1987 and 1990, 5.40 in the years 1992 and 1994, 5.20 between 1995 and 1999 (Kwaghga, Shimakaa & Chinta 2018, Otieno, Agwanda & Khasakhala 2019).

The National Demographic and Health Surveys of 2003, 2008, 2013 and 2018 show that the country had a TFR of 5.7, 5.7 and 5.5, 5.3 respectively. The TFR of 5.3 is 0.2 children per woman less than that reported in the 2013 NDHS (5.5 each) (NPC, 2019). These differ significantly from the UN and NPC projections of 5.16 and 5.18 between year 2000 to 2005, 4.76 and 4.91 between 2005 to 2010, and 4.37 and 4.63 between 2010 to 2015 (Kwaghga & Dewua, 2020). Statistically, the TFRs in Nigeria have remained relatively unchanged. The projections have not been obtainable; birth rate has remained high, thus hindering the onset of fertility transition. There are more incidences of multiple births (Ikechebelu, et al 2016), causing a geometric progression in birth rate.

In Nigeria, there appears to be high fertility among many families. A high fertility rate, which is defined as a TFR of 5.0 or higher, is characterized, among others, by health risks for children and their mothers, food insecurity, high unemployment rate, slow economic growth and environmental threats

Theory of Reasoned Action (TRA)

The theory was propounded by Ajzen and Fishbein. Ajzen and Fishbein (1970) and (1980) proposed this framework initially in the 1970s and further furnished it in 1980. According to TRA individuals' intentions are crucial to developing certain attitudes that trigger whether the expected behaviour would take place or not. Attitudes can be positive or negative based on the beliefs people have about the outcomes of specific actions. Subjective norms are associated with belief holder's expectations about other important people who influence their behaviour or actions. Perceived behavioural control determines the value

attached to the positive or negative outcome of the actions. If a person thinks he or she can have control over some actions to do certain tasks or engage in behaviour it will decide whether that particular action will be performed or not.

The theory of reasoned action suggests that a person's behaviour is determined by his/her intention to perform the behaviour and that this intention is, in turn, a function of his/her attitude toward the behaviour and his/her subjective norm. The best predictor of behaviour is intention and it is the cognitive representation of a person's readiness to perform a given behaviour. It is considered the immediate antecedent of behaviour. Three things determine this intention: their attitude toward the specific behaviour, their subjective norms, and their perceived behavioural control. This theory details the factors and inputs that result in any particular behaviour.

According to Ajzen and Fishbein (1980), a person's attitude toward a behaviour consists of a belief that such a behaviour leads to a certain outcome and an evaluation of the outcome of that behaviour. Exclusive breastfeeding for six months from birth is of well-known importance for infants' nutrition. Breastfeeding delays the return of fertility in the mother, thus contributing to longer birth intervals. Birth-spacing allows continuation of breastfeeding for the child's benefit and has other advantages to the mother and the child. Better nutrition promotes infant and child survival, which, in turn, tends to increase birth intervals. In addition, all these processes benefit the health and well-being of the mother. If the outcome seems beneficial to the individual, lactating mothers may then intend to or actually participate in this particular behaviour of using exclusive breastfeeding as a contraceptive.

In the use of isolation, polygyny, sexual abstinence, period of rest, social support, family planning and exclusive breastfeeding, partners, relations, significant others and health officers have a lot of roles to play by emphasizing the advantages of these practices on child spacing and maternal health. For example, exclusive breastfeeding is not only a good nutrition, but also has contraceptive effects, which is very cheap, effective and has no side effects on the woman and on the child. The practice of social support has evolved overtime due do rational actions of the people to solve their everyday problems. Even then and now, it is individual choices and the influence of people around them that determine their course of action towards the practices. **The practice of social support arises from intentions and attitudes held by people in the society because attitudes and behaviours do not emanate on their own but from intentions and beliefs. The subjective norm held in communities and by individuals about use social support practices may emanate from societal norms and how they are viewed by others in the society. The use or non-use of social support practices can, therefore, be deliberate and planned.**The reasoned action theory, thus, explains the attitude, intention and behaviour of people towards social support practices at varying levels.

Methodology

Study setting: The area of this study is Benue State, Nigeria. Benue State has diverse cultural practices that are favourable to high fertility. These include the existing traditional religion, the stigma attached to being an *ikyom kwase* (a barren woman), children as social security in old age, patriarchal and existing lineage system, polygyny, preference for sons, age at marriage, extended family system, male dominance in decision making, existing agricultural system, preference for large family size, etc. The existing fertility regulation policies in the state are seen to have recorded little or no success in achieving desired fertility outcomes. These prevailing cultural practices which determine the behaviour may likely be associated with the levels of fertility transition in the state. Benue State is largely a rural area with a TFR of 4.5 (NPC, 2019). The fertility level in the state is the second lowest in the North Central after the FCT with 4.3 followed by Plateau State with 4.7 (NPC, 2019). It has also witnessed a relatively sharp decline in TFR from 5.9 in 2008 to 4.5 in 2018 (NPC, 2019), while Nigeria as a whole has recorded a negligible decline from 5.7 to 5.3 within the same period.

Study design: This study adopted cross sectional survey research design. The design helped the study to explore the effects between the variables examined.

Population of the study: The population of the study was all adult females who have birthed a child in Benue State.

Sample size determination; the sample size determination formula by Cochran was used to determine the minimum sample size of the study. Cochran's formula ($N = Z^2 P (1 – P)/d^2$) of sample size determination for unknown population using a prevalence of 50% for involvement in postpartum practices and 50% for non-involvement. The choice of 50:50 was due to non-availability of researches on prevalence of postpartum practices in Benue State, Nigeria. The calculated sample size was 1067. To handle attrition rate, ten percent (107) was added to the computed sample size to give 1067+ 107 = 1174. Therefore, the sample size used in this study was 1,174 respondents.

Sampling techniques: A multistage sampling technique was used in the study. A cluster sampling technique was used to divide the study area into clusters using the existing internal structure within the state. Using this structure, thirteen (13) clusters were selected for the study. This was done to ensure a fair coverage of cultural diversities and differences that may exist within the state. These included Katsina Ala, Ukum, Kwande, Konshisha, Buruku, Gboko, Gwer East, Makurdi, Otukpo, Okpokwu, Apa, Oju and Agatu LGAs. In the second stage, proportional sampling technique was used to determine the representative sample size per cluster. It was done using the formula Y=N/n×SS/1. In all these clusters, the Primary Health Care Household (PHCH) listing within the council wards was used to get households where respondents were selected. The number of households selected was determined using the formula X=SS/NCW. The selection of the respondents was done using simple random sampling technique

Instruments of data collection: The instruments used in this study were questionnaire and Key Informant Interview (KII) guide. A questionnaire with close-ended questions with a scoring system (from 1-5) was used to elicit data from one thousand, one hundred and seventy-four (1,174) respondents. KII was used to conduct interviews with key informants to gain deeper understanding of the subject under study. These included women who have birthed many children as well as those who have born fewer children. These were conducted in their residence. It was conducted with thirty-nine (39) key informants who were selected to provide deeper information in the study

Validation of instruments: The study utilized face and content validity of the instruments. The first test of validity was done by ensuring that the instruments captured the objectives of the study. Secondly, the questionnaire and key informant interview guide were presented to experts in the field of sociology for validation. One of the experts was a demographer. The questionnaire and key informant interview guide were presented to the experts for scrutiny with respect to their scope, coverage, content relevance and clarity. The necessary corrections were done to ensure that items measured the purpose for which they were designed.

Reliability of instruments: *This study utilised a test-retest type of reliability. Test-retest reliability indicates the repeatability of test scores with the passage of time. Test-retest reliability measures the consistency of results when one repeats the same test on the same sample at a different point in time. Three local government areas not sampled for the study were used.*The researcher visited Tarka, Konshisha and Ogbadibo Local Government Areas and administered the instrument to the respondents under close supervision. All the copies administered were collected and analysed using Cronbach Alpha coefficient method of estimating reliability. The result indicated a reliability coefficient of 0.88, which indicates that the instrument is reliable.

Techniques of data analysis: The data collected in this study were qualitative and quantitative and thus analysed with descriptive and inferential statistical tools as well as manual content analysis. Statistical Packages for Social Sciences (SPSS) was used to collate the data. The analysis was done at the following levels:

The univariate analysis was done using frequency distribution tables, mean and standard deviation. A statement with a mean above 2.50 was accepted. The responses were reported in counts and percentages,

especially socio-demographic data and other quantitative variables. The univariate analysis involved the use of descriptive statistics to examine the background characteristics of the respondents. The bivariate analysis was done using Pearson's R. The multivariate analysis was used to explain the association between postpartum practices and fertility levels. The multivariate analysis was done using binary logistic regression model to test relationship among variables. The dependent variable was recoded into a binary (low fertility-1-4 children and high fertility-5 children and above) to achieve this purpose. A mixed method (triangulation) approach was employed in analysing the data. The qualitative data was analysed using manual content analysis.

Ethical considerations: Respondents were informed that they had the right to decline participation or to withdraw from the study at any time they wished. Respondents were also informed there were no penalties or loss of benefits for refusal to participate in the study, or for withdrawal from it. Participation in the study was therefore voluntary. Consent of respondents were sought before administration of questionnaires and confidentiality of information were assured as copies of the questionnaire were anonymously filled. Efforts were made to avoid harm or risk to respondents as a result of their participation in the study. The analysis was done without any form of bias.

Results

Out of one thousand, one hundred and seventy-four (1174) copies of questionnaire administered, a total of one thousand, one hundred and twenty-five copies (1125) were returned. The analysis was based on the copies of questionnaire returned, representing 95.8 percent and considered adequate for analysis and the 39 KIIs conducted. Thus, the number of respondents who participated in the study was 1,164 (1,125 from questionnaire and 39 from KII). This is higher than the minimum sample size required for the study (1,067).

Socio-demographic characteristics of respondents.

The findings of the study revealed an average age of 31.9 years. This implied the youthful nature of women who gave birth in the study area. Majority of the respondents had secondary education followed by those who attained tertiary education. This portrayed the extent of formal education among women in Benue State. Also, most of the respondents were Christians. Benue State is generally dominated by Christians of different denominations with numerous churches. This result confirmed the true religious life of the women. In terms of sources of livelihood, farming constituted the main source of living of the respondents, followed by employment in private establishments. Interestingly, a larger proportion of women in Benue state are farmers who eke a living from agriculture. The inability of governments over the years to employ citizens in the formal sector of the economy and the low level of education have pushed many into the informal sector where employment opportunities exist.

The estimated income of the respondents per annum showed a majority earned less than N200, 000 per annum. This showed the low financial status of women in the state. Many of the respondents had between one to four children. This relates with the findings of 2018 National Demographic and Health Survey, (NPC, 2019) which also implied the probability of decline in the next NDHS. With regards to the population in households, most of the households had populations of seven people and above, followed by those with four to six persons. This implied the extended nature of families and large households prevalent in the area. In terms of marriage type, a higher percent of the respondents was in monogamous marriages. This was due to the influence of Christianity, the level of socio-economic development and education in the state. Findings on the place of residence of respondents showed most of them lived in rural areas. Benue State is largely rural, with relatively fewer persons dwelling in urban areas. Findings on ethnicity revealed the Tiv tribe was higher followed by Idoma. The state is majorly populated by these two ethnic groups. The data is summarized in table 2.

Table 2: Socio demographic variables of respondents

Variable	Categories	Frequency (N=1125)	Percent

Age	31.9 (Mean)		
	15-19	33	2.9
	20-24	130	11.6
	25-29	323	28.7
	30-34	256	22.8
	35-39	196	17.4
	40-44	111	9.9
	45+	76	6.8
Educational attainment	No formal education	113	10.0
	Primary Education	99	8.8
	Secondary education	492	43.7
	Tertiary education	421	37.4
Religious affiliation	Christianity	1087	96.6
	Islam	28	2.5
	Traditional	9	0.8
	Others	1	0.1
Source of livelihood	Farming	570	50.7
	Government work	130	11.6
	work in private establishment	265	23.6
	self employed	160	14.2
Estimated annual income	less than N200,000	631	56.1
	N201,001-N400,000	297	26.4
	N401,001-N600,000	130	11.6
	N601,001 and above	67	6
Number of children	One to four children	934	83
	Five to six children	149	13.2
	Seven and above	42	3.7
People in households	One to four people	217	19.3
	Five to six children	348	30.9
	Seven and above	560	49.8
Family type	Nuclear family	588	52.3
	Extended family	523	46.5
	Others	14	1.2
Marriage type	Monogamy	909	80.8
	Polygyny	174	15.5
	Single	42	3.7
Place of residence	Rural	651	57.9
	Urban	474	42.1
Tribe	Tiv	765	68.0
	Idoma	265	23.6
	Igede	54	4.8
	Agatu	22	2.0
	Etulo	6	0.5
	Other tribes	13	1.2

Source: Field Survey, 2025

The data in Table 2 showed the relevant socio-demographic characteristics of respondents covered in the study. This was necessary in understanding the nature of respondents and their relevance in providing useful information necessary in addressing the study objectives. It also had implications on the findings and its generalisations. Analysis of these characteristics showed the suitability of the respondents and validity of findings.

Social support among respondents

An assessment of social support among the respondents showed many have received it. Such social support was in different forms. These included assistance in domestic chores, material gifts, taking care of the children, as well as emotional, informational and financial assistance. Social support came from health personnel, unknown persons, religious members, colleagues, friends, family members and husbands.

Data on the various ways social support postpartum influenced fertility levels included, ensured child survival, encouraged child birth, helped in planning for next pregnancy. Others included reduced stress in child rearing, reduced workload and burden on parents, and improved child health. The list also included enhanced birth spacing and limiting, encouraged child birth, encouraged early onset of sexual intercourse and increased rate of child birth. The findings are presented in table 3.

Table 3: Ratings of responses on social support among respondents

Sn	Social support and fertility levels	Strongly Agree	Agree	Undecided	Disagree	Strongly disagree	Mean	Std
1	The information I get from people after child birth ensure his survival	361	479	135	115	35	3.90	1.059
2	The material assistance I get after child birth encourages me to born more children	171	338	159	331	126	3.09	1.282
3	The emotional assistance I receive after child birth helped to plan for the next pregnancy	228	481	182	176	58	3.57	1.128
4	It makes child rearing less stressful	308	499	150	133	35	3.81	1.061
5	It reduces the overall burden on the parents	285	518	129	135	58	3.74	1.117
6.	It improves the health status of my child	285	555	150	115	20	3.86	0.968
7	It enhances birth spacing	168	345	179	310	123	3.11	1.267
8	It encourages child birth	206	439	187	216	77	3.43	1.186
9	It gives room for early onset of sexual intercourse	155	338	242	292	98	3.14	1,200
10	It increases the rate of child birth	181	310	224	299	111	3.13	1.250

Source: Field Survey, 2025. (N=1125). Key: Std -standard deviation

The findings in table 3 showed the different ways the respondents rated social support in the study area. All the means were above the accepted point of 2.50, showing the acceptability of the postpartum practices. The values of standard deviation were between 0.9 and 1.2 which show how close the values are to the mean.

Social support and fertility levels

The hypothesis used in the study was “social support has no significant effect on fertility levels in Benue State, Nigeria”. Social support as a postpartum practice was explored across places of residence of the respondents. Findings on the correlation of social support postpartum and fertility levels in Benue State,

Nigeria revealed a nexus among the variables. By implication, social support influenced fertility levels at 0.05 and 0.01 level (1 tailed). The findings are presented in Table.

Table 4: Pearson correlation between social support and fertility levels in Benue State

	1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*
1. *Number of children born*	1										
2. *It ensures child's survival*	0.061*	1									
3. *It encourages childbirth*	0.027	0.299**	1								
4. *It helps to plan for pregnancy*	-0.026	0.367**	0.420**	1							
5. *It makes child rearing less stressful*	0.047	0.433**	0.379**	0.444**	1						
6. *It reduces burden of child care*	0.041	0.348**	0.348**	0.343**	0.635**	1					
7. *It improves children's health*	0.118**	0.389**	0.184**	0.332**	0.487**	0.535**	1				
8. *It enhances birth spacing*	0.016	0.159**	0.162**	0.207**	0.177**	0.242**	0.353**	1			
9. *It encourages child birth*	0.002	0.275**	0.324**	0.366**	0.263**	0.329**	0.401**	390**	1		
10. *Leads to early sexual intercourse*	0.068*	0.138**	0.371**	0.329**	0.240**	0.336**	0.296**	.220**	40**	1	
11. *It increases the rate of child birth*	-0.001	0.250**	0.501**	0.355**	0.252**	0.307**	0.252**	.269**	55**	05**	1

Correlation is significant at the 0.05 level (1-tailed).

Correlation is significant at the 0.01 level (1-tailed).

As shown in the table above, most of the aspects of social support examined correlated with fertility levels significantly at 0.01 and 0.05 levels. By implication, the null hypothesis "social support has no significant effect on fertility levels in Benue State, Nigeria" was rejected and the alternate hypothesis accepted.

The practise of social support was probed with the key informants. The findings revealed the existence and persistence of tangible material support, financial support, emotional support, informational and appraisal assistance. The findings on the source of social support from KII corroborated those from quantitative data. In the words of a 30-year-old Idoma mother with three (3) children;

> At the time I gave birth to my first child, I received many gifts from friends, relatives, church members, my husband and many others. The gifts included pampers, cloths, food, counsel, shoes and prayers. Others assisted in domestic chores which afforded me the opportunity to rest and regain my strength. The birth of the other children did not bring as many gifts as the first. This assistance greatly helped my well-being and that of the child.

These views were also expressed by many other key informants. A 25-year-old mother with five children also noted that;

> I had little or no knowledge of child care when I had my first child. The information I needed was provided by members and others significant others. I was assisted in numerous ways instrumental to my child's survival and improvement in my health status. My child was always neat and well fed. The stress in childrearing was minimal. This helped me to be stronger and better prepared for the next pregnancy.

Similarly, a 50-year-old mother with five children from Idoma asserted that;

> I received help whenever I put to birth. This does not in any way influence my desired fertility level. I had always wanted four children with my husband. We are only determined to achieve this goal. I cannot continue having children because of assistance from others. I usually plan for all my children before delivery.

Again, a 43-year-old mother with three children from Tiv remarked;

> After childbirth, I got information from friends especially on family planning and child care. I was able to detect the worries and needs of my child and also use appropriate family planning methods to prevent unplanned pregnancy. Most of my domestic chores were performed by friends and family members for a period that ranged from one to four months. I had enough rest and time for my child within this period.

Also, a 40-year-old mother of six children in Adoka, Otukpo LGA, noted that:

> The assistance I have received from family, friends, health personnel and others have ensured the success of my pregnancies. It has also enhanced the survival of my children and improved my health. Often, I have received assistance in form of information, finances, materials and child care. As a result, I have not lost any of my children. This has helped me to achieve my desired number of children.

Recounting how assistance from significant others ensured the survival of her children, a 45-year-old mother of eight children stated that:

> I remember how my first child almost died due to poor care if not for the support of other members of my family and friends. She was taken to the hospital and the bills were paid by others. On return, I was adequately counselled and that never happened again. I was also guided on pregnancy care and child nutrition. The finances I got from family and friends enabled me to meet some of the basic needs of my children.

In a nutshell, findings from KII revealed the influence of social support on fertility levels through child care, survival, encouraged childbirth, reduced stress in child care, improved maternal and child health status and encouraged early onset of sexual intercourse.

Discussion of findings

Social support and fertility levels

The practise of providing social support postpartum was firmly established. Most of the respondents received different forms of social support. The various forms of social support included tangible/material, financial, informational and appraisal. These were provided by family members, friends, religious groups, colleagues and unknown persons/ strangers. Previous research revealed that social support is almost universally provided in the early postpartum period by the mother, mother-in-law, other female relatives, husband, elder female community members, traditional birth attendants or young women from the community (Dennis et al., 2007). The support often includes practical assistance as well as information for maternal and infant care. These practices have implications on fertility levels

This is similar to a study carried out by Cremonese et al (2017) in South America which revealed that the social support received by the postpartum adolescents had the predominance of instrumental support, followed by information and emotional support, which were provided mainly by family members. These supports enhanced child survival, encouraged more births, ensured better preparation for subsequent

pregnancies, reduced stress of child rearing, improved maternal health, enhanced birth spacing and limiting, encouraged early onset of sexual intercourse and thus increased childbirth.

Similarly, a study conducted in Germany found that lack of social support constitutes an important risk factor for maternal well-being during pregnancy and has adverse effects on pregnancy outcomes (Eberhard, et al, 2010, Elsenbruch, et al., 2007). By implication, social support influenced significantly fertility levels in Benue State, Nigeria.

Conclusion/recommendations

The practise of providing social support postpartum was firmly established. The various forms of social support included tangible/material, financial informational and appraisal. These were provided by family members, friends, religious groups, colleagues and unknown person/ strangers. Social support has significant effect on fertility levels in the study area.

The practise of giving social support and period of rest to women after birth should be encouraged. This will help to adequately care for their infants with the assurance of survival and thus avoid the birth of too many children, with the hope of having surviving ones despite mortality. To ensure the realization of the long-awaited reduction in fertility levels, the trend must be checked gradually until it reverses itself. This involves a conscious reawakening of the minds of the people regarding the future effects of high fertility by traditional leaders, youth organizations and women societies. Benue State as a whole lacks the needed institutions (social welfare, pension services, and people-oriented civil services, effective fertility regulation mechanisms) to externally, legally and forcefully enforce fertility laws that will help to achieve the desired fertility transition in the country.

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