PREVALENCE AND RISKS/CHALLENGES OF GRAND MULTIPARITY TO WOMEN'S` HEALTH IN OYO STATE NIGERIA

Kafayat. O. OSHODI and K. K. SALAMI
Department of Sociology
Faculty of the Social Sciences
University of Ibadan.

ABSTRACT

Grand multiparity (GMP) means women undergoing between five and nine viable pregnancies and deliveries. Scholarly attention has been given to preventing GMP through reduction in fertility. However the prevalence of GMP, couple with dearth of information of its threat women`s health especially in Oyo-state, Nigeria has not been adequately addressed. Health belief model (HBM) formed the frame work for this study. A total of 422 structured questionnaire were administered in a survey to GMP women using snow-balling method. Qualitative method was used in selecting and interviewing twelve key-informants with four healthcare practitioners each from western, traditional, and faith-based patterns of healthcare utilisation. GMP women and men were equally engaged in six sessions of focus group discussions. Quantitative data were analysed using Chi-square and Cross-tabulation at p≤0.05. Qualitative data were content analysed. Mean respondents' age was 43.3years ±1.2. About 41.0% and 19.0% acquired secondary and tertiary education respectively. About 18.7% affirmed the prevalence and threat of GMP. 30.0% indicated negative response to the prevalence of GMP, while 50.6% were neutral in their responses. Result showed that 71.5% of respondents indicated positive response to universality of illness during GMP. GMP was significantly associated with respondents' level of education ($\chi 2=365.85$). Maternal age ($\beta =0.04$) and higher parity ($\beta =0.08$) were significantly related to preterm delivery. The study concluded that GMP and its health-risks still exist in the rural areas of Akinyele Local Government Area and socio-cultural factors are major drivers of GMP.

Keywords: Prevalence, Akinyele LGA, Grand multiparous women, women's health Oyo State.

INTRODUCTION

Pregnancy is an inevitable burden, unique but essential for continuation of life and lineage. This stage in woman`s life is simultaneously one of the embodied of human experiences and one of the most discursively regulated (Tidenberg, and Baym, 2017). The first pregnancy marks the crucial transition in status from woman to mother. Subsequent pregnancies enhance that status, molding the mother into a mature and responsible member of society. These necessitate the continuation of the lineage which is associated with child bearing and children as important members of any society (Kyomuhendo, 2003, Magashi, 2015). In order words, woman's ability to conceive, go through pregnancy and child birth is known to have the quality of virtue. Hence, child birth is a universally experienced natural event that is uniquely and globally valued and perhaps is a culturally relatable life experience (Essays, 2018). These experiences mark a woman's high social status in the African society. This is evidenced in mothers being referred to by their children's name in most African societies.

In essence, culture familiarized women with pregnancy and child birth, gives value to their experiences, and stigmatise the childless. This explains why the average family size per woman is usually high ranging from MP, GMP and GgMP due to socio-cultural value ascribed to children specifically among the Yoruba of South-west, Nigeria unlike advanced countries such as Great Britain and United State of America. This arguments corroborate the Yoruba parlance; ``egbe olomo lawa ose o`` (that is, we are members of mothers club), ``Abiyamo`` meaning (a woman with a child/ children, e.g. PP or MP), ``Alabiyamo`` meaning (a woman with many children e.g. GMP) and ``O se abiyamo gan`` meaning (a woman with many children, e.g. GMP or GgMP).Grand multiparous women (GMP) connote pregnant women or mothers involved in delivering of the fifth to ninth (5st–9th) viable pregnancies and deliveries going beyond the twenty-eight weeks of gestation while Multiparous women (MP) implies women who

are undergoing between two to four viable pregnancies and deliveries. Meanwhile, women who are undergoing their tenth (or more) viable pregnancies and delivery are classified as great grand multiparous or huge grand multiparous (GgMP) (Opara and Zaidi, 2007; Shahida, Islam, Begun, Hossain and Azam, 2011; Islamaldin 2013 and Idoko, Nkeng and Anyanwu 2016). The subsequent number of births and deliveries of the aforesaid phenomena is referred to as parity in medical parlance. To assert the existence of this practice, Yoruba established local concept ascribe to different cohort group for example; ``onikunle ikeji si ikerin``, (MP),``onikunle karun si ikesan`s`, (GMP), and ``onikunle ikewa losi oke`` (GgMP). Prevalence of GMP is high in Nigerian due to high fertility rate and low contraceptive prevalence rate of 15.0 percent (Nigeria Demographic and Health Survey, 2013), others include; socio-cultural factors, religion, illiteracy and early marriage which expose women to a longer period of reproduction (Akwuruoha, Kamanu, Onwere, Chigbu, Aluka, Umezuruike, 2011; Nigeria national population commission & Inner City Fund International (ICF), 2014/National Demographic and Health Survey (NDHS), 2013; and Lamina, 2015). Furthermore, most Nigerian women spend majority of their years, usually between 15 and 50 years, conceiving, carrying, delivering and nursing babies (Isiugo – Abanihe, 2012:118). These have considerable implications for their health.

Culturally, Yoruba of the south-western Nigeria cherish and harbor many children. A vivid example is the popular parlance stated above ``egbe olomo lawa ose o`` (that is, we are members of mothers club). This also coincide with Yoruba argument on the relative value of children against wealth ``Omolola, Omoboriowo and Omojola`` (that is, there is no wealth where there are no children). Awoniyi, 2015 equally buttressed this his argument on African cultural values. Similarly, instances have shown that a woman has many children due to the following factors; prove her fecundity, socio-cultural/religious belief and enhancement of socio-status. This thereby necessitates prevalence of the practice. Owunmi (2002) also acknowledge this claim when he opined that Africa culture puts premium value on the existence of children in the family and this premium also supported by Holy Books (Bible and Quran). Again, this also confirmed Yoruba assertion on value of children through the name they bear such as, ``Omoboriowo`` (offspring/progeny precedes wealth). Equally, the low contraceptive prevalence rate of 15.0 % claimed by NDHS, 2013; Nigeria National Population Commission & I C F International, 2014/NDHS, 2013 was another instance. Again, empirically, the fertility rate in Nigeria ranges between 4.3 and 6.7 %, while fertility rate in South-western Nigeria was 4.6 percent. The percentage of women aged 15-49; currently pregnant in the South-west is higher than other Southern zones (South-South and South-East) in Nigeria (NDHS, 2013). Hence, women in these societies may face risks with each pregnancy. Again, the early age range of pregnancy and marriage can result in significant physical psychosocial problems (in both mothers and foetus) and poverty. Thus, mothers associated with teenage pregnancy can be associated with an adverse impact on educational achievement, social isolation, poverty, physical and mental health (Cantlay, 2015).

Hitherto, preference for fertility and GMP preference also manifested in some Yoruba proverbs or saying such as: ``Omo niyi omo nide Omo lasehinde to ba da le``, (children are; honourable, they are as precious, as diamond, and they are the one that remain with us in the old age), `Omo se Pataki Omo se koko`, (children are very important and necessary), ``Omo eni, ni ojo ola eni`` (ones children are ones tomorrow/future); ``egbe olomo lawa ose`` (we belong to mothers club); and ``Olomo lo la ye`` (mothers owns/ possess the world). Similarly, religion is not left out, for instance, Holy Quran is used to buttress this; `` (Q2:233) `` command women on natural family planning in which breast feeding is stipulated for two years for all mothers``. This explains why in some Muslim homes family planning methods and practices is not acceptable. The Holy Bible too, equally have positive notion on high birth rate in which it is stated: “And God blessed them, and God said unto them, be fruitful, and multiply, and replenish the earth, and

subdue it: and have dominion over the fish of the sea, and over the fowl of the air, and over every living thing that moveth upon the earth" (Genesis 1:28-29). Thus, religion served as mesmeric mode towards GMP practices. Consequently, the aforementioned factors influenced the prevalence of GMP practices in Nigeria and the implication is that child`s preference is not only due to monetary value rather, most people beget them due to premium value derived from them which corroborated Owunmi, (2002) stated above.

Yet, sustaining women`s health is imperative because they are central to global health issues. Relatively, the National Population Commission (NPC) records in Akinyele Local Government divulged that the study area had prevalence of GMP practices as at 2015, and this signifies that the incidence of GMP still exists in the area despite the risks and threats to maternal health. It is against this background that the article was, therefore, designed to examine the prevalence and threat of grand multiparity to women's health in the study area.

Risks and Challenges in GMP Practices

Most literatures agree that GMP mothers do not take cognizance of: threats, challenges/risks maternal health and safety of the practice. Although, most western medical practitioners usually discouraged GMP practices because they viewed it as a threat to maternal and infant health. These threats includes various complications such as; preterm-delivery, uterine prolapsed, ante and post-partum hemorrhage and anaemia and so on. Surprisingly, these trends in the past few decades were rarely known in our society (Nigeria) due to our rich socio-cultural heritage specifically, women healers in most African societies were noted for their mystical powers and they excelled and monopolized the use of herbs for healing and traditional midwifery services (that is, Traditional Birth Attendants). Hence, they were given local names such as, "Iya Onisegun" (that is, the mother of medicine), "Iya Abiye" (that is, the woman who delivers babies safely), "Iya Eleweomo" (that is, the woman who knows all herbs for cure of children's diseases) (Sesay and Odebiyi, 1998). Chamberlain, Fergie, Sinclair and Asmar, 2016 also share this view in their study of traditional midwives in South Sudan. This portrays Black and African civilization/belief system. Moreover, most ailments/diseases have their own local concepts, names of identification and description in the areas of maternal health for example, preterm delivery and ante and post natal hemorrhage among others. Thus, one can construe that maternal risks and challenges were given more attention and recognition in the past

Succinctly, risks in pregnancies, deliveries and child bearing practices as at then were collective responsibilities in most homes/communities and so, GMP risk situation was rarely known compared to our modern time. Consequently, these have serious implication to maternal health and safety and so, sustaining maternal health is imperative because they are central to global health issues. According to Schwarz, Davidson, Seaton and Tebbit, 1992, risk connotes; hazard, danger, chance of loss or injury, possibility of losing something of value or degree of probability of loss to a person or thing among others. Similarly, Center for General Studies University of Ibadan, 2012, corroborated that risk is usually expressed in unhealthy or harmful behaviors which places the lives of the person involved in danger. Again, it is equally observed that sometimes the concept may be tangible or intangible object, visible (example, GMP women and their illnesses) or invisible object (example, financial loss and internal injury).

Specifically, as implied by this article, risk is the likelihood of injury in GMP women who experience negative health or health damage due to advanced age or high number of children (high parity) been born during the period of pregnancies and deliveries. Usually, the issue of higher risks among GMP women as against primi-parous and multiparous women is extensively raised by scholars among them were; Luke and Brown, 2007; Borton, 2009; Martin, Hamilton,

Ventura and Mathews, 2013; and Mohammed and Salah, 2015. Additionally, GMP has been claimed to be the major contributing factors to increasing maternal mortality. Abro, Shaikh, Shaikh, and Baloch, 2009 attest to this in their studies. Similarly, increased abnormalities of placenta implantations in GMP women were also highlighted by Agrawal, Agarwal, and Das, 2011 to be constituting factors leading to retained placenta because uterine muscles get replaced by fibrous tissue with repeated pregnancies, with a resultant reduction in the contractile power of the uterus, which may lead to uterine atony and finally, placenta retention (Beazley, 1995; Begun, 1993). Therefore, GMP women continued to be regarded as high-risk factor and challenge for obstetric practice in the developing world (Rayamajhi, Thapa and Pande, 2006). Besides, GMP is considered a public health issue due to the associated risks such as; preterm delivery, diabetes mellitus, pre-term labour, hypertension, placenta implantation and retention, uterine prolapsed, and intra-uterine foetal death (Khan, and Khan, 2010; Powdthavee, 2010; Omole-Ohonsi, 2011; Flenady Koopmans, Middleton, Froen, Smith and Gibbons, 2011; Mgaya , Massawe, Kidanto, Mgaya ,2013; Ozkhan, 2013; and Li Tsui, 2016; Roth, 2016;).Therefore, these categories of women require adequate perinatal care due to high parity, inadequate birth spacing and advance age the following scholars equally attest to this claim (Asaf, 1997; Ezra, Schmuel, Marwan and Schenker, 2001; Rayamajhi et al., 2006; Barnes, 2012; Casas and Herera, 2012; Gunnar, 2017).

Although, some scholars also opine that woman's previous obstetric history and personal health are more relevant despite that she has a large family. This explains why in developed countries, satisfactory healthcare conditions are emphasised. As a result, GMP women are not considered as dangerous/risky (Bugg, Atwal and Maresh, 2002; Paliwal, Dikhit and Singh, 2009). Thus, invariably in such societies it is expected to find lower susceptibility to risks/illnesses among GMP women and vice-versa in countries where healthcare is unsatisfactory due to inaccessibility/inequality of healthcare service and delivery system (example, Nigeria). Hence, GMP women in the latter society will continue to be regarded as a high risk situation. However, scholars have also observed that these cohort pregnant women experience higher maternal health risk factor than PP and MP pregnant women owing to their higher parity and advanced age, regardless of availability of healthcare services. The Yoruba adage also attest to this view when they emphasize that ``ile obinrin kin pe su`` meaning (the pace of menopause is rapid among womenfolk), the meaning attached to this concept is that, pregnancy and delivery or childbearing practices is better observed at younger age because of risk/danger it involves. In fact, scholars have opined that GMP women are usually advanced in age and higher in parity. Thus, they need special and adequate healthcare during these periods. Still, decision to comply or not to comply with healthcare service depends on the level or severity of illnesses and this is one of the basic principles of health belief model. This assertion buttressed Al-Farsi, et al, 2011, argument when they observed that low birth weight syndrome which leads to pre-term delivery is common among mothers of grand-multiparous who under use healthcare service in most developing countries. That is, the inadequate utilisation of healthcare service of GMP pregnant women makes them to be more susceptible to syndromes such as, low birth weight and pre-term delivery. Other scholars who affirmed that GMP pregnancies lead to pre-term delivery are: Bergum, 2005 and Strand, Tumba, Niekowal and Bergstrom, 2010.

Consequently, the issue of risk and challenges cannot be ignored among GMP women in most societies. Yet, despite the foregoing challenges faced by these women (GMP) most especially in African societies (such as, Nigeria), adequate attention has not been paid to these cohort women thus, this article work will thus demonstrate the nexus between; risks and advanced age and high parity originated by GMP practices. Furthermore, focusing on this issue will expose the

plight of these cohort women on factors influencing the practice and its threats. Coupled with its effect on the health conditions of the respondents and vis-a- vis risks associated with GMP pregnancies and deliveries in communities concerned.

The Health Belief Model (HBM) postulated by Hochbaum (1958) provided a framework for this study in view of its arguments which were grounded on; motivation, decision and six factors necessary for healthcare utilization services among individuals namely; patient`s perception of susceptibility, patient`s perception of the severity of condition, perceived value of the treatment benefits, perceived barriers to treatment, cost of treatment in physical and emotional terms and cues that stimulate action towards treatment of illness. Hence, prevalence and risks/challenges in GMP practices may likely be influenced by above postulations. More so, most of the emphases of HBM dwelt on perceptions of patients towards illnesses and this concurs with the argument of this article.

METHODOLOGY

The research employed a multistage sampling technique specifically purposive sampling in its selection. The first stage included local government area which was more rural in Ibadan-land. Thus, Akinyele Local Government area (A.L.G.A.) was chosen due to higher prevalence of GMP practices. A.L.G.A. is located in the northern area of Ibadan city. The area shares boundaries with Afijio L.G.A. in the north; in the south by Ibadan north L.G.A.; in the west by Ido L.G.A.; and in the east by Lagelu L.G.A. and Osun state. The local government is divided into 12 political wards namely; Ikereku (ward 1), Labode/Oboda/ Olanla (ward 2), Arunlogun (ward 3), Onidundun/Amosun (ward 7), Ojoo/ Ajibode/ Orogun/ Owe/Kankon (ward 8), Ijaye (ward 9), Alabata (ward 10), Okegbemi/Mele (ward 11) and Iroko (ward 12). According to National Population Commission (2006), the total population of A.L.G.A. was estimated at two-hundred and eleven thousand three hundred and fifty-nine (211,359). This implies that there are more females than males in the area but with narrow variance of four hundred and thirty five (435) in their figures. Also, the community is predominantly Yoruba entity with over 95% of the total population. Although, there are other visible ethnic groups namely: Hausa-Fulani (usually in SaSa), Nupe, Igbo, Tivs, Edo and Efik, among others.

Occupationally, agriculture is the norm due to favorable climate and soil condition in the area. Similarly, other professions equally abound such as; trading, civil/service, and so on. In terms of market, most farmers market their surplus products periodically, whereas, majority of women in the area sell the family farm produce by themselves though they assist men in cultivation of land which is typical of Yoruba communities (Ajadi, Olaniran, Alabi and Adejumobi, 2013). For example, evidence of this manifest in the Yoruba socio-economic life through their interaction/communication in the description of market schedule, meaning ojo oja/anole oja some are; alternate days (ojo-meta-meta), every five-five days (ojo marun-marun), weekly (ose..ose), every nine- nine days (ojo mesan-mesan), and monthly (oso..suu..), and so on. Thus, this may likely influence GMP practices since women will have time in taking care of their children without barriers. Furthermore, the case study area was chosen for following reasons: (a) the area has higher prevalence of GMP practices/high fertility; (b) studies have shown that averagely, women in that area have low utilization of family planning methods/practices due to husbands disapproval; (c) prevalence of early marriage; (d) lower education of women specifically, primary school holders; (d) low income categories (e) prevalence of cultural and religious practices; (f) a patriarchal society, and so these conditions paved way for the prevalence of GMP practices in the area, besides Oshodi, 2017; Oshodi and Salami, 2017; Ajadi, Olaniran, Alabi,and Adejumobi, 2013; and Alonge and Ajala, 2013 attested to these claims in their various studies. It is also noteworthy, to state that research revealed majority of mothers in A.L.G.A. register for Antenatal care (ANC) lately which contradicts the purpose of

ANC which emphasize early registration as this is synonymous to early detection of pregnancy risks/challenges. Thus, this may likely influence risks/challenges in pregnancy among women in the area this is evidenced in works of Ezeama and Ezeama, (2015).

The second stage also involved the purposive selection of rural wards in A.L.G.A. (according to the documentation from Akinyele classification of semi-urban and rural dichotomies). This is because, studies have shown that GMP practices/high fertility or large households' size is synonymous with the poor and rural dwellers, Ajadi, Olaniran, Alabi and Adejumobi, 2013. The third stage employed snowballing in the selection of GMP women. Specific communities where data collection was obtained in the study included: Ikereku (ward 1), Olanla (ward 2), Arulogun (ward 3), Onidundu (ward 4), Moniyi (ward 5), Akinyele (ward 6), Iwokoto (ward 7), Ojoo (ward 8), Ijaiye (ward 9), Alabata (ward 10), Mele (ward 11) and Iroko (ward 12). The cross-sectional survey research design was employed. Methods were based on quantitative and qualitative methods. The quantitative method of survey including questionnaires methods was applied. A pretested 422 copies of questionnaire were administered on GMP women using Conchran`s, size formula, (1977). The procedure included retrieval of questionnaire copies, cleaned, coded, processed and presented with aid of Statistical Package for Social Sciences (SPSS, version 23). Analysis was at univariate, bivariate and multivariate levels. The findings were presented in frequency, percentages and through inferential statistics.

The qualitative involved the use of six sessions of Focused group discussion (FGDs) with a group of GMP men and women discretely from the six selected wards purposely to draw information on prevalence and risks/challenges of GMP practices among GMP women. Each session entailed 8 to 12 participants. Likewise, Key-informant-interviews were conducted with GMP women and a healthcare practitioner each in faith-based (Islam and Christian healing homes), traditional and orthodox healthcare centers. Data analysis for qualitative involved the following; recording, transcribing, cleaning, content analyses and through ethnographic summaries. The essence of the latter was to enhance interpretation through direct quotations of vital responses usually originated during interviews. Furthermore, most of the interviews involved narratives specifically, in local language (Yoruba) later translated to English language. Succinctly, all the aforementioned steps were in line with the objectives of the study.

Ethical considerations were adhered to throughout the period of data collection; the confidentiality of the study participants was assured. Engagement of respondents was on the basis of voluntary and informed consent. Also, the principle of no harm to subject was applied. Preceding the commencement of the interviews and discussions, the participants were informed of the essence and importance of the research to GMP women, men and their children. Again, rights to withdraw from the study at any time they felt so, was accentuated.

RESULT, FINDINGS AND DISCUSSION

Socio-Demographic Characteristics of Respondents in the Prevalence of GMP practices

As indicated in table 1, the highest age categories of respondents according to the table are age 40 – 49 years (57.6%) while the lowest age range are > 50 years. The religious distribution of the respondents indicated that majority are Christians; next to this are Islam adherents, whereas, traditional adherents occupy the least (9.2%). The ethnicity distribution reveals that Yoruba was highest (51.7%) and Hausa-Fulani lowest (9.28%). Similarly, in terms of GMP practices, family size 5-7 children are in the highest range and lowest are family size > 10 children. Also, the habitation categories revealed that GMP women who live with their husbands are in highest rank (51.7%) meanwhile, those that live with their mothers-law are in the least

category (9.2%). Likewise, house ownership shows husband ownership in majority (37.2%) and renting in minute entity (14.5%).

Furthermore, educational attainment of GMP women indicated that complete secondary school holders as been highest in category (32.2%) and incomplete primary in the least category (10.4%). Hitherto, spouse education divulged that complete secondary are in majority (32.2%) while the least category are complete primary (10.4%). Equally, in terms of occupational distribution those in the private firm/ sector are in majority (39.6%) whereas, house-wives are the least represented (4.7%) which implies that most of the respondents have daily source income. Additionally, spouse occupations (that is, GMP men) expose that highest per cent are in private firm/sector (54.3%) and the least occupation is trading (4.7%). Monthly income of GMP women reveal that those in the income range N20,001-N30,000 are highest (46.8%) and the least income earners are in income range N20,001-N30,000 (6.7%). Hitherto, spouse`s monthly income indicated earners in income categories > N50,000 are in majority (49.2 %) whereas, income earners N40,001-N50,000 are in minority (17.2%).

Table 1.0 Percentage distribution of respondents by socio-demographic characteristics

Variables	Responses	Frequency	Total (%)
Age	20-29 years	48	11.4
	30-39 years	116	27.5
	40-49 years	243	57.6
	> 50 years	15	3.6
Mean = 43.3; SD = 1.20; Minimum = 20; Maximum = 52			
Religion	Islam	160	37.9
	Christianity	223	52.8
	Traditional	39	9.2
Ethnicity	Yoruba	218	51.7
	Igbo	165	39.1
	Hausa/Fulani	39	9.2
Number of children	5 -7 children	257	60.9
	8 – 10 children	126	29.9
	>10 children	39	9.2
Mean = 6.32; 1.57; Minimum = 5; Maximum = 11			
Type of house	Two room apartment	20	4.7
	Self- contain apartment	81	19.2
	Two bedroom apartment	258	61.1
	Three bedroom apartment	63	14.9
Habitation	Live with husband	218	51.7
	Live with in-laws/extended family	165	39.1
	Live with mother-in-law	39	9.2
House owner	Husband	157	37.2
	Joint	80	19.0
	Family house	124	29.4
	Rent	61	14.5
Educational Attainment	Incomplete primary	44	10.4
	Complete primary	121	28.7
	Incomplete secondary	39	9.2
	Complete secondary	136	32.2
	Tertiary	82	19.4
Spouse's education	Incomplete primary	124	29.4
	Complete primary	80	19.0
	Complete secondary	136	32.2
	Tertiary	82	19.4
Occupation	House wife	20	4.7

	Trading	40	9.5
	Public/civil servant	120	28.4
	Employee in private firm	167	39.6
	Self-employed	75	17.8
Spouse's occupation	Trading	20	4.7
	Farming	59	14.0
	Employee in the public sector	39	9.2
	Employee in the private sector	229	54.3
	Self employed	75	17.8
Monthly income	N10,001-N20,000	20	6.7
	N20,001-N30,000	139	46.8
	N30,001-N40,000	75	25.3
	N40,001-N50,000	63	21.2
Spouse's monthly income	N30,001-N40,000	80	33.6
	N40,001-N50,000	41	17.2
	> N50,000	117	49.2

Source: Field survey, 2016

Table 1 above revealed information on socio-demographic characteristics of GMP women and men. From the table, 49 years is the highest and this testifies the postulation that most GMP women are of the advanced age probably due to early marriage or premium value of children among the Yoruba in which A.L.G.A. is not an exception. The foregoing issue corroborate the Yoruba parlance on their view that; ''Omo bibi kin se arun'' (meaning begetting many children is not a disease/illness), among others. Hence, it will influence their decision making towards compliance to GMP practices irrespective of advanced age and this view corroborates the argument of HBM. Among scholars who affirmed the issue of advanced age are Barnes, 2012; Yasir, Perveen, Ali, Perveen and Tayyab, 2010; and Omole-Ohonsi, 2011. Similarly, table 1 also revealed Christian faith to be highest among the respondents which implies that they will equally be high in the GMP practices. This testifies to the biblical notion (Genesis, 1:28-29; Genesis, 1:24; and Psalm, 127:3). Thus, religion served as hypnotic mode to GMP practices. It also confirmed the Yoruba (irrespective of religious affiliation) parlance of ``Olohun ni ki ama bi si, ka si ma resi, ka si ma gbadun yun lori ile`` meaning GOD enjoins us to be fruitful and multiply on earth and ``Ebun/Ore oluwa ni omo`` meaning children are gift/blessing from GOD. Scholars who agreed to this notion are Mberu and Reed, (2014), to them, Nigeria is characterized by ethnic, regional and religious identities. Likewise, HBM also concur with this notion in its emphasis on cues that stimulate action to treatment (e.g. cues that stimulate action towards GMP practices).

On ethnicity, the above table shows Yoruba ethnic group to be highest in category more so, the case study area is in the south-west (Yoruba). Again, with reference to the first premise of HBM which bases its argument on the person`s perception of the susceptibility to illness. This view can influence perception of mothers to GMP practices if the individual concerned believes that such practices are insignificant to susceptibility of illnesses during and after pregnancy periods. Furthermore, this scenario substantiate the Yoruba parlance on the conviction of ''ifanu'' meaning, giving birth to many children are normal in other to prevent susceptibility to sickness/illnesses in old age which also corroborate the emphasis of HBM. Mberu and Reed, (2014), also stressed this in their studies.

The highest family size in the table is family size five-seven and this indicate that there is prevalence of GMP practices in the area. This may likely be due to low utilization of family planning methods moreover, studies have also shown that most households in the rural communities their household size are usually large, and this coincide with Alonge and Ajala, 2013; Ajadi, Olaniran, Alabi and Adejumobi, 2013 in their various studies,. On the other hand, Yoruba of the south-west, Nigeria also acknowledge household size in their socio-cultural life, by categorizing pregnant women in terms of parity bases, `` Adelebo``, meaning mother of one

or more than one ``Abiya mo``, meaning mother of more than one ``Alabiyamo``, meaning mother of more than two or more children and ``Iya- Opere`` meaning mother of many children and general description of mother of many children meaning ``Iya awon majesin``. Again, Yoruba people and Gynecologist have descriptive identifications for number of deliveries/births, for example, `` Onikule kan``, meaning`` Primiparous women`` ``Onikunle keji- ikerin``, meaning `` Multiparous women``, `` Onikunle ikarun-ikesan``, meaning`` Grand Multiparous women``, ``Onikunle ikewa losoke`` meaning ``Huge/Great grand Multiparous women``.

Consequently, the aforementioned discourse explains the prevalence of GMP in African society or else, there will not be name/identification signifying such phenomenon or phrase. Additionally, is the issue of habitation and house-ownership and there effect on the prevalence of GMP practices according to the findings, the GMP women who lives/co-habits with their husbands (that is, GMP men) occupies the highest rank. This may likely be attributed to prevalence of GMP practices and which is synonymous to husband support and power of the patriarchy. This view is akin to the premise of HBM which stress that socio-cultural factor is tantamount to motivation and decision-making in healthcare utilization (and GMP practices) and cues that stimulate action towards GMP practices.

Educationally, complete secondary school holders are highest among GMP men and women. This finding buttressed the insinuation of the effect of level of education on fertility/GMP practices between sexes. For instance, the higher the educational attainment of couples the lower the fertility prevalence and vice-visa. Thus, it corroborates the notion of Emechebe, Njoku, Eyong, Madueke and Ukaga, (2016). To them, high fertility is characterized by lower education and lower class status most especially among women. Occupationally, employees in the private firms occupy the highest rank both among the GMP men and women in the findings. This is possible since A.L.G.A. is captured by many private firms, (such as, poultries, industries, research institutes, community/commercial bank, private hospitals and so on). Expectedly, one will assumed that because the area is noted as favorably for agriculture due to its good soil and climatic condition and so, farming business will also thrive. This may likely be true to some extent, but the findings reveals most GMP men and women respondents are complete secondary school holders hence, they feel that white/blue collar job is more ideal and more comfortable than farming.

On the issue of income the highest grade among GMP women respondents are N20, 001-N30, 000 (46.8%) whereas, that of GMP men are> N50,000. This findings confirmed scholars who opined that GMP women are characterized by low-income earners, usually poor, malnourished, and low level of education, among others. This condition can cause feminization of poverty in most cases, Ali, Rayis, Mamoun and Adam, 2011; Afolabi and Adeyemi, 2013 and so on, substantiated this in their various writings. For instance, about 54% of the Nigeria population live below the poverty line (United Nations Children`s Fund, 2013) and besides, the poor in Nigeria have no form of financial risk protection, that is, a yardstick for universal health coverage (World Health Organisation, 2016) and with the recent economic downturn facing the country (recession) among others, these instances are vivid realities in Nigeria society. Besides, this assertion confirmed one of the KII interviewee when she stated that:

> Where both men and women are busy in their respective occupation, you would hardly see them having more than four children (KII/Female/Islamic health worker/2016).

Subsequently, the implication of the aforementioned view is that sometimes irrespective of parity of a woman financial sustainability is vital even to achieve good and quality healthcare utilization and this corroborate HBM on its emphasis on barriers to healthcare utilization. Even, Yoruba adage equally emphasizes riches/possessions in their socio-cultural life, a case in point is the name ascribed to newly born babies ``Owolabi`` meaning (child bearing practices is

money venture practices). Other instance is the premonition and necessity of money in socio activities/ engagements, pregnancy, deliveries, child rearing and nurturing nowadays irrespective of gender and level of parity are easily recognize among peoples. Example of this abound in name/alias such as, ``Owonikoko`` meaning money is vital not only in child bearing but in human endeavor/social life. Therefore, roles of money/income play a significant role both in healthcare utilization and prevalence of GMP practices.

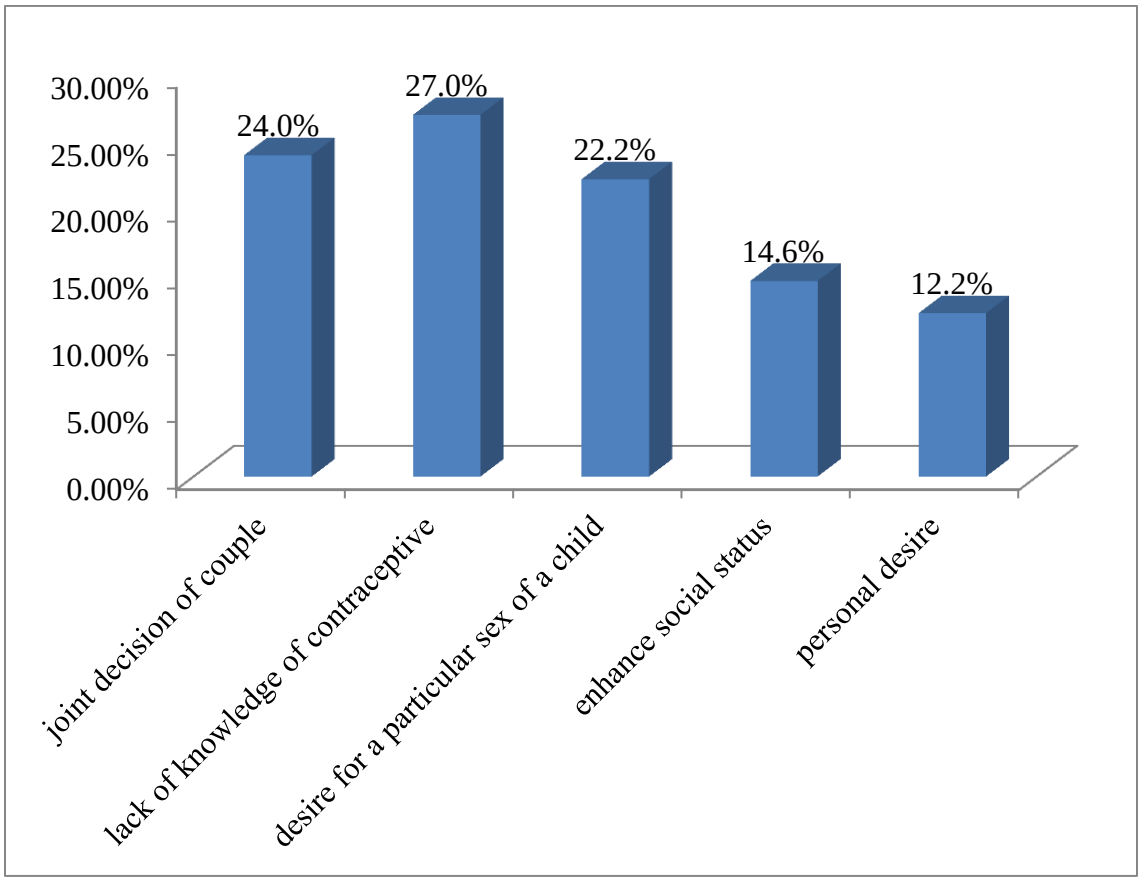

Figure 1.0 Bar chart showing respondents reasons for the involvement of women in GMP

Factors influencing GMP practices

According to figure 1 above, women are involved in GMP practices based on different reasons. For instance, lack of knowledge of contraceptive was the highest factor in the reason for the prevalence of GMP practices. This implies that prevalence rate of contraceptive usage was low probably because of the following; low level of awareness, low level of literacy, husband`s preference, and so on. A case in point is the argument of one the KII interviewee who also corroborated this view by stating that:

> Tell me, the woman that relies heavily on her husband for survival will not have any control over her sexual life. Such a woman will continue to have children as long as it pleases the husband and this also arises because the level of education in villages is still very poor (KII/Female/Islamic health worker/2016).

Therefore, in such communities, people may not know the value and role of contraceptive practices in the prevention of unwanted pregnancies, child spacing, and maternal health and safety instead high fertility rate will prevail. The following scholars equally validated this claim in their studies of A.L.G.A. Alonge and Ajala, 2013; Ajadi, Olaniran, Alabi and Adejumobi, 2013 in their various studies. Corroborating this, Wusu, 2009, equally observed that high fertility prevalence is a peculiar force in Africa society (such as, Nigeria) judging by total fertility rate (TFR) of 5.7 (Population Reference Bureau, 2014) in the influence of GMP practices in Nigeria. In addition, Isiugo- Abanihe, (2010) also expatiated this in his reviewed work.

Culturally, Yoruba morphology and proverbs also acknowledge the essence of GMP practices and ultimately support for contraceptive/family planning usage is affected. For instance such parlance include; ``Omo o laayole, eni omo sin lobimo``, (that is, children are unreliable so, it is those children that survive you that is your legacy), `` Iye omo ti eniyan bi ni o nwo nu iyara eni`` (that is, the value/importance of many offspring are reaped in the old age) while the biblical value equally emphasizes this in psalm 127:3-4. Likewise, the Holy Quran 2:233 attested to the importance of children in the family and society, among others. Succinctly, these factors are enough to influence the prevalence and involvement of GMP practices in the area. Hence, low prevalence of family planning may occur in these circumstances due to religious and socio-cultural value of children.

Again, the qualitative findings also corroborated the above claim. For example, the (FGD) revealed that majority of GMP men did not support family planning practices because they believed it would make women more promiscuous and there would be lack of trust and so GMP men may have negative attitude towards contraceptive practices. This assertion is equally affirmed by Ankomah, Anyanti, Adebayo and Giwa (2013). Besides, the relevance of husband cannot be ignored in marital issues most especially in patriarchal society like ours (Nigeria) Jegede, 2010 and Isiugo - Abanihe, 2012 also attest to this claim in their various works. Moreover, Yoruba belief also emphasise this in their family life whenever they eulogize their husbands examples; ``Oko ni olowo ori aya and Baale mi`` meaning (husband who paid the dowry of his wife is the lord; and the head of the house). Thus, power of masculinity is also a vital force Badder, Gillerman and Lerner, 2012 also authenticated this in their writings. On the other hand, environmental factor also influence level of acceptability and non - acceptability of family planning practices. That is, family planning practices is synonymous with socio-environment vis-à-vis involvement of women in GMP practices. This claim was equally buttressed by an Islamic health worker who stated that:

> You cannot rule out the role of environment in why people have many children. Okay, why is it that those who live in cities have lesser children than those in villages in the cities where there is better awareness about family planning and when you look critically, you would see that those that have more than four children are mostly the poor in the cities. So, I believe that the environment matters a lot (KII/Female/Islamic health worker/2016).

In effect, people viewed urban dwellers as modern and civilized than rural dwellers. This analogy affirm the Yoruba claim of ``ara oko`` and `` ara igboro` ` that is, rural dwellers and urban dwellers. Hence, one can infer that family planning practices vis a-vis socio-environment contributed to the prevalence of GMP practices. Therefore, the social milieus of GMP men and women have enormous impact on the fertility behavior of such individuals.

Table 2.0: Effect of GMP practices on the health conditions of the respondents

Variable	Response	Frequency	Percentage
Sickness during GMP pregnancy	Yes	61	18.7
	No	100	30.7
	Sometimes	165	50.6
	Total	326	100.0
Universality of illness during GMP pregnancies	No	40	9.5
	Yes	302	71.5
	Sometimes	80	19.0
	Total	422	100.0

Source: Field Survey, 2016.

Similarly, findings in table 2 revealed effect of GMP practices on the health conditions of the respondents. 18.7% of the respondents indicated that there is sickness during GMP pregnancies whereas, majority (50.6%) affirmed that sickness during GMP pregnancy is sometimes. Likewise, the question of universality of illnesses during GMP pregnancy revealed minority view of 9.5%, while huge majority disclosed that generally there are illnesses during GMP pregnancies (71.5% yes).

The above table vividly exposed the necessity and importance of maternal health among GMP women. Maternal health is essential because the good state of maternal health is one of the key indicators of a society`s level of development, as well as of the performance of healthcare delivery system (NDHS, 2003; SDGs 5; WHO, 2015; UNICEF, 2015; and WHO, 2016;). For example, in 2015 303,000 women died of maternal causes. Specifically, this can be prevented through high quality antenatal care and gynecology/obstetrical care and proper healthcare utilization for both mothers and foetus irrespective of parity (Nikiema, Kameli, Capon, Sondo, and Prevel, 2010). Therefore, women are central to world health issues, maintaining their health become highly essential (Centers for disease control and prevention, 2008; Holtz, 2010; Africa progress panel policy brief, 2015 and WHO, 2015). According to table (2), respondents' perception of illnesses during pregnancies varies according to their belief and perception of GMP illnesses and pregnancies as mentioned above. Consequently, one can insinuate that GMP practices are a nexus of numerous pregnancies and complications. Succinctly, GMP women are more susceptible to numerous health risks/challenges, most especially in rural areas where the practice is abundant and coupled with inaccessibility/inequality and under-utilization of healthcare services. This argument coincides with KII male interviewee in the health sector who stressed that:

> We often have pregnancy complications and emergencies among GMP women than those with less than five children. Some of these women are not aware that their high parity may adversely affect their pregnancies and even some of these women find it difficult to deliver their babies smoothly. (KII/Male/Western healthcare admistrator/2016).

Similarly, an Islamic female health worker also buttressed that:

> Look, GMP practice is very dangerous and for me there is no need for it. Sometimes, people don't know that some of the things we see and do in our culture are actually detrimental to our wellbeing. Even come to think of it, a woman having 8, 9 or even 10 children is only inviting illness or death upon herself. (KII/Female/Islamic health worker/2016).

Therefore, based on the aforementioned factors stated earlier, it implies that GMP pregnancies in most cases prompted series of illnesses and health complications due to; cultural perception of GMP practices and socio-environment people inhabit (such as, rural area) also, universality

of this is real. However, these challenges can be curbed if people involve are ready to change their orientation and cultural perception of GMP practices. Besides, this view substantiate the Yoruba morphology of ''Omo bibi kin se arun '' (meaning begetting many children is not a disease/syndrome), and likewise controversy surrounding ``ifanu`` concept (that is, the perception that giving birth to many children are normal in other to prevent sicknesses/illnesses in old age) which testify to the assertion of Yoruba socio-cultural belief and practices, so it will be very difficult to stop this practice based on peoples conviction. Consequently, people's orientation matters most in the suppression of susceptibilities of sicknesses/illnesses in GMP pregnancies.

Succinctly, maternal health and safety are decisive in global health issues more so, healthcare disparities especially in developing countries can result in; inaccessibility to appropriate healthcare services, variations in health status, and poor health of women irrespective of parity. Subsequently it may likely contribute to feminization of poverty (Holtz, 2010 and Centers for disease control and prevention, 2008). Although, sensitization on the dangers surrounding GMP practices and its illnesses should be stressed so as to curtail some of these risks/challenges this position is also upheld by one of the KII interviewers when he noted that:

> There is need for sensitization on the danger of having many children. Some of them fall sick frequently and some even lost their lives in the process (KII/Male/Western healthcare administrator/2016).

Contrary to the above claim, this situation was unlikely to take place in the past for the reason that women were the main health providers within the informal system in their capacities as mothers, female relatives and neighbors because they were more accessible Pearce (1995). However, with social and cultural changes which have permeated into every sector in the society, it has relegated some of these values and believes. In the light of the above argument, it is clear that women are crucial and stake holders in socio-economic and political development of any nation thus, grand multiparity practices and its prevalence need to be controlled because it is usually accompany with health challenges and large family size. Additionally, it may likely affect family income and family size, a case in point is the Yoruba analogy of ``Amokun eru e wo, oke lenwo, ewo isale``, (that is, misconduct among children/youths emanated from early age and uncurbed child bearing practices).

Table 3.0: Risks associated with GMP pregnancies and deliveries

Complications	Independent variables	Coefficient (B)	P value
Diabetes mellitus	Age	0.090	0.003
	High parity	0.204	0.001
	Educational status	-0.295	0.000
Pre-term labour	Age	0.043	0.031
	High parity	0.084	0.009
	Educational status	0.021	0.627
Hypertension	Age	0.092	0.003
	High parity	0.293	0.000
	Educational status	-0.204	0.001
Placenta implantation and retention	Age	0.365	0.000
	High parity	0.077	0.005
	Educational status	-0.241	0.002
Uterine prolapsed	Age	0.273	0.004
	High parity	0.315	0.000
	Educational status	-0.077	0.005
Intrauterine foetal death	Age	-0.079	0.004
	High parity	-0.375	0.000
	Educational status	-0.062	0.066

Source: Field Survey, 2016

Table 3 above demonstrated risks associated with GMP pregnancies and deliveries. According to the table, advanced age and higher parity of GMP women have positive/significant value and relationship in; diabetes mellitus, hypertension, placenta implantation and Uterine prolapsed among GMP women in pregnancies and deliveries and vice-versa for educational status. Similarly, advanced maternal age, higher parity and educational status of GMP women have positive/significant value and relationship in pre-term labor. Contrary to foregoing claims, advanced age, higher parity and educational status of GMP women have negative/insignificant value and relationship in intrauterine foetal death.

Specifically, table (3) above indicated diabetes mellitus having a significant/positive relationship with maternal age (β=0.090, p= 0.003) and high parity (β = 0.204, p= 0.001) whereas, the higher, the educational status (β= - 0.295, p= 0.000), the lower the risk of susceptibility to diabetes mellitus among GMP women. Consequently, advanced maternal age, high parity and lower educational status of women have significant/positive susceptibility to diabetes mellitus and vice-versa for GMP women with higher educational status. This assertion confirmed the views of; Cigolle, Lee, Langa , Lee, Tian, and Blaum, 2011; and Agrawal, Agarwal and Das, 2011, that diabetic mellitus is synonymous with GMP women. It also, supports the views of KII female interviewer who said that:

> *Well, I feel illiteracy is one of the factors responsible for some of these illnesses/risks. This is because you won't see much of these risks among those women who are educated and who know about contraceptives or family planning* (KII/Female/Islamic health worker/2016).

Similarly, pre-term labour is significantly and susceptible related to advanced maternal age (β = 0.043, p = 0.031) and high parity (β = 0.084, p = 0.009) irrespective of educational status (β = 0.021, p = 0.627). Thus, education is not significantly related to the risk of pre-term labour however, women with advanced maternal age and higher parity (GMP women) were more prone to this risk. These findings corroborated the arguments of Yasir, Perveen, Ali, Perveen and Tayyab, 2010; Al-Farsi, Yahya, Brooks, Werler, Cabral, AL-Shafel and Wallenburg, (2011), Pasupathy, Wood, Pell, Fleming and Smith, 2011 ; Mohammed and Salah, 2015; and Roth, (2016).

Furthermore, there are significant relationships and high susceptibility among women of; advanced age (β =0.092, p = 0.003), high parity (β = 0.293, p = 0.000) and hypertension complication/risk and conversely among women with higher educational status (β = - 0.204, p = 0.001). Therefore, one can insinuate that hypertension is more prone among GMP women due to the above factors and vice-versa among women with higher educational status. This view affirmed the claims of Powdthavee, 2010 and Agrawal, Agarwal and Das, 2011.
Likewise, the analogy of placenta implantation and retention the findings revealed that, advanced maternal age (β = 0.365, p = 0.000) and high parity (β = 0.077, p = 0.005) were more identifiable among GMP women, while higher educational status (β = - 0.241, p = 0.002) have less significant relationship with placenta implantation and retention among these cohort women. This implies that, the higher, the educational status, the lower, the risk of susceptibility to placenta implantation and retention among these cohort women. Therefore, advanced maternal age and higher parity have stronger correlation with this complication than higher educational status. This notion is upheld by, Yasir, Perveen, Ali, Perveen and Tayyab, (2010), to them advanced maternal age has been found to be an independent risk factor for a number of antenatal medical disorders. Similarly, claims of high parity and risks have equally been stressed by Hoque and Kader, (2008) and Omole-Ohonsi, (2011).

However, maternal age (β = - 0.079, p = -0. 004), parity (- 0.375, p = 0.000) and educational status (β = - 0.062, p = 0.066) of women are negatively/insignificantly related to intra uterine foetal death that is, irrespective of; maternal age and level parity and educational status of GMP woman concerned. The opinions of the following scholars concurred with this claim Roman, Robillard, Verspyck, Hulsey, Marpeau, and Barau, (2004). In fact, the foregoing arguments buttressed the MGDs 5 and SDGs 5 on reproductive health status of women.
The result above have revealed that there are lots of risks associated with GMP pregnancies and deliveries such as; diabetes mellitus, Pre-term labor, hypertension, Placenta implantation and retention, Uterine prolapsed and Intrauterine foetal death among others. All these validated the medical views of threats/challenges among GMP practices. Evidence of these abounds in Yoruba philosophy of ``Ewu`` (danger) which is viewed from eight perspectives, namely; biological, psychological, economic, political, geographical, religion, sociological and cultural. These categories demonstrated pathological traits in them for example; ``ewu``(danger list) that is, psychological/biological. ``Ewu`` (between life and death) that is, medical/biological/religious viewpoint. ``Ewu`` (risky venture/exercise) that is, economic angle. ``Ewu`` (natural disasters such as, water and fire) that is, geographical perspective. ``Ewu`` (aisan/arun) that is biological/medical view point. ``Ewu`` (serious problem) that is, socio-political angle. And moreover ``ewu`` in terms of delivery of new born baby into the world, Yoruba assumed this scenario is between life and death among pregnant women and this manifest in Yoruba forms of greeting newly delivery mothers and their babies ``eku ewu omo `` (happy safe delivery/new born baby) that is, socio-cultural point of view . Similarly, risks of GMP practices is not strange to Yoruba of the south-west and that is why they are given different names, descriptions and identifications for example; ``ewu``(aisan/arun) that is, diseases/sicknesses, Examples of these are; ``ewu ibadi ati ile omo toman dera sile debi pe koni le gbe ile omo duro `` (uterine prolapsed). Others are; ``ewu ti o romo bibi omo laito ojo`` (preterm delivery) and ``ewu eje yiya ninu oyun ati lehin oyun`` (ante and post natal hemorrhage). Therefore, these explanations correspond with Jegede, (2017) category of four types of illnesses/sicknesses. In essence, the above examples demonstrated the reality and existence of risks (``ewu``) in human life (such as, in Yoruba ethnic group).
The foregoing discourse demonstrates reality of risks and threats of pregnant women even among the Yoruba of south-west, Nigeria. Moreover, these risks and threats can be curtailed if only we incorporate our socio-cultural belief of traditional healing practices into the obstetric

practice of maternal health. For example, then people patronized these traditional healers because they used to be accommodating, patience and demonstrated positive attitudes to their clients. The latter argument attested to Yoruba sayings ``Ma ro ro, nitori oku roro kin ko yon jo, maroro``, meaning (don't be malevolent because such people do not accommodate/gather people instead, it scares people from you). The foregoing argument validate the emphasis of HBM and its relevance to this study which state that cost of treatment in physical and emotional terms is indispensable in healthcare utilization.

Unfortunately, social change in the family institution caused by; westernization, modernization, civilization and globalization experienced globally also penetrates to Nigeria society (including the location area). Thus, the following trends manifest in the society; more female remarry, low formalization of marriage between sexes, and high divorce rates unlike in the past (olden days). Thus, overtime women may bear children to different fathers invariably GMP practices sets in as a result of high-birth rates. Moreover, risks of child bearing practices becomes higher due to inadequate care from spouses, extended families and other socio-support groups in the community unlike in the past whereby, some of these were rarely experienced. This is so because, at that time women in most African societies were noted for their mystical powers. For instance, among the Yoruba, women healers were admired and respected because as they excelled and monopolized this profession, they were given such local names as "Iya Onisegun" (the mother of medicine), "Iya Abiye" (the woman who delivers babies safely), "Iya Eleweomo" (the woman who knows all herbs for cure of children's diseases) (Sesay and Odebiyi, 1998). Consequently, these women healers were highly recognized because of their accessibility and acceptability of midwifery services. These functions explain the magnitude and obligation of women in the provision of traditional midwifery services such as Traditional Birth Attendants (TBAs) (Ekanem, 1975; Adedokun, 1997; Odebiyi, 1990; Pearce, 1995).

On the other hand, research have proven that with proper healthcare utilisation some of these risks can be curbed and so our value of treatment benefit should be incorporated towards quality healthcare which is one of the arguments of HBM which also buttressed the Yoruba adage that; `` Itoju ara se Pataki, ose koko papa fun awon alaboyun nitorina odara ti alaboyun banlo si ile -iwosan ti o danto`` meaning quality and proper healthcare is essential most especially to pregnant women to be utilised, and likewise Yoruba concept of ile-iwosan ti o danto, tio peye meaning standard and qualitative healthcare service respectively. Furthermore, this argument is even logical to the culture of the people concerned (Yoruba), because generally, Yoruba cherish good health evidence of this is reflected in their attitude to health and illnesses which is viewed from four perspectives, namely; biological, psychological, sociological and cultural. These categories demonstrated pathological traits in them for example, ``aisun``, meaning (sleeplessness),`` aiwo``, meaning (restlessness),`` aije`` meaning (inability to eat), ``aimu``, meaning (inability to drink), ``aito`` meaning (inability to urinate) and aisu meaning (inability to defecate), (Jegede, 2017). The implication of the aforementioned factors is that threats to GMP may exist if the GMP woman concerned is insensitive to her health challenges or unable to utilise proper and quality healthcare service to her advantage

Implication of the study to public health

The study discovered that prevalence of GMP and its risks/challenges abounds in the area of study. According to the findings, socio-cultural, religion, low utilization of family planning/methods, illiteracy, among others, contributes to prevalence of this phenomenon. Additionally, illiteracy, poverty, cost of healthcare, lack of information/knowledge of GMP risks/illnesses, and the like contributes to some of these risks/challenges. Therefore, campaign about risks/challenges needs to be intensified by different stake holders such as, government, religious leaders etc. Hence, information is vibrant on issues relating to risks, illnesses, healthcare utilization and antenatal care (ANC). Even, Yoruba of the southwest; Nigeria

demonstrated this in their social life. For instance, most rural dwellers have high regard for information, though the electricity coverage may be lower compared to city, but they listen to radio to be aware of; what is happenings, reports/information, entertainment/ events, latest gossip in town, politics, and current affairs and so on. Typical examples are; ``irohin``, meaning (news), ``oro ton lo`` meaning (current affairs), ``ki lon sele?`` meaning (what is happening), ``nje eti gbo?`` meaning (have you heard?) among others. All these are favorite programs listened to by the local audience in Oyo-state, and it also stress the significant of HBM in this study.

Furthermore, government should establish more hospitals/ maternity centers most especially in the rural areas where the presence of low income earners is easily manifest, coupled with high cost of transport and distance in this area. Thus, sometimes non-utilization of healthcare services may likely be rampant. Alternatively, satisfactory traditional pattern of healthcare utilization should be encouraged since it is familiar with our culture and predates western medicine. In addition, there is need to re-orientate people on harmful effect of GMP practices as a result of recent change in the family institution globally. Precisely, it has affected our system of maternal health and healing practices traditionally. For instance, the benefit derived from social support system/significant others such as; extended family, neighbors, friends, peer groups and so on during pregnancies and deliveries is either out of fashion or no longer guarantee. Hitherto, coupled with unemployment and recession currently experienced in Nigeria society this may likely contribute to some of these threats. Accordingly, it requires commitment from all the stakeholders to realize that prevalence of this trend need to be curtailed by controlling family size per woman at households' level vis-à-vis state/national level in other to check population growth. This is crucial more so, report have shown that unemployment rate among females (16.3%) is higher than males (12.3%), likewise, underemployment rate among females (24.2%) than males (17.9%) 2016-2017, (National Bureau of Statistics, 2017). In the long run, the above steps will; truncate feminization of poverty, maternal risks/challenges, infant, and maternal mortality in the country. Instead, maternal safety will be enhanced.

CONCLUSION AND RECOMMENDATION

This study has confirmed that GMP is prevalence in our society and in most cases linked with various risks/ challenges among GMP women. This perception is common among the medical practitioners and GMP women for the reason of advanced maternal age and higher parity most especially in the rural areas due to premium value and recognition of socio-cultural factors. These threats can be prevented or overcome through proper and satisfactory healthcare utilisation among women of these categories. The findings of this study require the following recommendations: There is need to give health education precisely to these cohort women for the reason of their advanced maternal age and higher parity so as to reduce their susceptibility to illnesses/sickness during pregnancy. Also proper healthcare utilization, proper ante natal and post natal care are necessary so as to reduce risks/challenges and promote maternal safety. More so, harmful socio-cultural practices should be discouraged while beneficial ones should be encouraged in order to promote our cultural heritage. Besides, religious leaders should be involved in counseling and campaign on benefit of maternal safety and dangers /risks involved in GMP practices as a result of inadequate care of mothers and foetus during pregnancies and deliveries periods. Religious leaders can serve as intermediary between the government and the GMP women/men because if the support of GMP men is achieved then it will be easier to address some of these challenges faced by GMP women, because Nigeria is a patriarchal society and decision of men is indispensable in family matters.

Furthermore, government should establish more hospitals/ maternity centers most especially in the rural areas and among low income earners since cost of transport and distance are sometimes factors influencing non-utilisation of healthcare services. Alternatively, satisfactory

traditional pattern of healthcare utilisation should be encouraged since it is familiar and predates western medicine in our society more so, our culture allows it. Additionally, publicity of the challenges /risks experienced by this cohort group of women should be exposed to media and general public in order to create awareness among people.

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