Socio-Cultural Implications of Exclusive Bio-Paternity System on the Health of Women of Owukpa Community in Benue State, Nigeria

Takim Asu Ojua[1], Chiemezie Atama[2], Jeoma Igwe[2], D. S. Obekezie[2] & Chidi Ugwu[2]

ARTICLE INFO

Available Online July 2014

Key words:
Bio Paternity;
Socio-cultural;
Implications;
Exclusive Health;
Women

ABSTRACT

There is generally poor maternal health and high maternal mortality rate in developing countries, thus influencing the examination of the practice of bio-paternity pattern as one of the often over-looked socio-cultural factors contributing to poor health of women in Nigerian rural communities. The study was based on a survey conducted at Owukpa community in Ogbadigbo LGA of Benue State. The study made use of 268 respondents for the study. The questionnaires and interviews constituted the major instruments for data collection. The result showed that bio paternity is the prevalent cultural or traditional pattern of paternity in the community, and it has certain grievous implications for maternal health. Thus, it was found that this pattern of paternity facilitates multiple partnerships, which is the major cause of the spread of different sexually transmitted diseases like HIV/AIDS in the community. Bio-paternity pattern was also found to have effects on the fertility rate in the community. The paper highlighted some of the effects of this bio-paternity and recommends that more advocacy services be outlined for children, women and entire community about the effects of some of these negative practices. More health and educational policies need to be established to engage and enlighten the women specifically about the dangers of this bio-paternity.

1. Introduction

This paper examines the socio-cultural practices of exclusive bio paternity system and its implications for maternal health in Nigeria. This is important in view of the poor health that is characteristic of women in most developing countries including Nigeria which has resulted to high rate of maternal mortality. Thus, it is critical to look into some of these cultural practices considering that achieving the fifth Millennium Development Goal (MDG) which is to improve maternal health, reduce maternal mortality ratio and ensure universal access to reproductive health by 2015 remains the greatest development challenge. It is clear from different ethnographic data that one's relationship in a family whether extended or nuclear in Africa or across the globe makes meaning through socio-cultural or/and biological tracing which makes our work in this paper most valuable and necessary as it relates to the child.

Kuntala and Gopa (2002) observed that statistically women make up half of the population of many of the developing nations, more so, majority of these women live in rural areas where they are faced with a number of challenges. Though WHO (2009) reports that life expectancy was higher for women than men in most countries, a number of health situations and socio- cultural factors combine to create lower quality of life for women in developing countries. Abejide, Makanjuola and Okonofua (1992) have observed that poor maternal health leading to high rate of maternal mortality in Africa and other developing nations is currently a major source of concern to policy makers throughout the world. It is now increasingly observed that while issues undermining women's health could be closely tied to availability and accessibility of adequate health care services, the cultural aspect of customs and traditions relating to women's health cannot be ignored.

Fertility behaviour has been observed as one of the factors that predispose women to poor health in most developing countries especially in Africa (Nwakeze, 2003). World Bank (1994) noted that in high fertility countries, a woman is at risk of pregnancy related mortality many times during her reproductive time. This has resulted to over half a million preventable maternal death every year in developing countries. It has been

[1] Sociology Department, University of Calabar, Cross River State, Nigeria, taojua2007@yahoo.com
[2] Sociology and Anthropology Department, University of Nigeria, Nsukka, Nigeria

argued that reducing maternal mortality and improving maternal health in Africa and Nigeria in particular requires lowering fertility rates which tends to put women at risk.

Despite this recognition however, achieving this has been difficult because high fertility reflects cultural and social norms of the people. Davies and Blake (1956), Kuntala and Gopa, (2002). Onyeneho, (2003), have differently noted that a striking feature of underdeveloped areas is that virtually all exhibit a much higher fertility than do urban – industrial societies. This according to them is as a result of marked differences in the social structure and social organization of the two societies which appear to bring about variations in fertility. However Struensee (2004) observed that in many African countries, social structure and organization are result of patriarchal system which perpetuates certain cultural practices and traditions mostly in favour of men.

Arthur (2006) maintained that the key origin of patriarchy probably lies in the biological need for people to invest in their own children rather than someone else's. He argued that why women always know that the children they bear are their own blood, men can never know for sure. According to him in ancient societies the obvious and most practical way for men to ensure that they invest only on their own children was to dictate and restrict women 's sexual behaviour. In other words, throughout patriarchal history, society has guaranteed men's paternity by controlling women's reproductive capacity through so many means including; arranging marriages, treating women as properties of men , imposing premarital virginity and use of trado-medical herbs,. Thus, paternity is a feature of human reproduction that has shaped the mating institution of many. In most human societies, men want to know which children are theirs, however, how this is determined vary from culture to culture and from one society to the other.

In some societies, paternity involves the act of parenting which is the process of promoting and supporting the physical, emotional, social, and intellectual development of a child from infancy to adulthood. It involves raising a child rather than biological relationship with a child, whereas in other societies paternity involves exclusively having a biological relationship with a child (Anne, 1995). These categories led (Ezeh, 2004) to identify two types of paternity in Nigeria. Using anthropological terms, he referred to *genitor* as somebody's biological father and *pater* as socially created father. In this study, our focus is on exclusive bio-paternity (genitor) which is one of the structural arrangements of the society which stipulates that the only criteria for establishing paternity or fatherhood is having a biological relationship with a child. In other words, the legitimacy of a child lies only on recognizing the man who is biologically responsible for the birth of the child whether the man was married to the child's mother or not. Thus, exclusive bio-paternity system facilitates multiple-partner fertility which is a major cause of the spread of sexually transmitted infections like HIV/AIDS, and it encourages high fertility rate which has potentially negative consequences for men, women and children (Logan, Manlove, Ikramullah and Cottingham, 2006).

Given the imperative of maternal health for the well-being of families and societies, and for sustainable development, this study examines exclusive bio-paternity pattern as one of the socio- cultural factors affecting maternal health in most rural communities in Nigeria. The need to undertake this is the importance of social and cultural norms, values and practices placed by Africans in establishing familial relationships with others thereby creating a valuable and sustaining (healthy) society.

2. Study Methodology

A cross sectional survey research design was adopted for this study as it was considered the most appropriate to generate the needed data and meet the study objectives. The study was conducted in Owukpa community, Ogbadigbo LGA of Benue state an Idoma speaking area of the middle belt of Nigeria between June and July 2011. Accordingly, three villages were purposively selected for the study; these were Aiodu, Itabono and Nkwo. The target population for the study was mothers aged 15 – 49 years who had at least one child whether married or unmarried. The study was based on an estimated population of 5523 of women of childbearing age in the community according to Benue State Planning Commission, (2010), out of which a sample of 280 respondents was randomly selected. In addition, six persons were purposively chosen from the community for in-depth interviews and a total of two persons each from the three villages were selected. The major instrument for the study was the questionnaire; however, other complementary instrument like in-depth interviews was also used to collect qualitative data. This was considered necessary to give some contextual meaning to the quantitative findings in the study, as well as provide some vital information, which the questionnaire was weak in collecting. Women who had at least secondary school education and adequate

cultural knowledge of the community were purposively selected for the in-depth interview. People of the Owukpa Community are predominantly poor, rural and subsistent farmers and these features gives impetus to the strong and increasing practice of early marital relationship that often times results to unwanted pregnancies.

3. Socio-Demographic Information

The ages of the respondents ranged from 15-49 years. The average age of the distribution in the community was 26 years as shown in table below. This shows that women bear children early in the community. The early childbearing in Owukpa could be attributed to the exclusive biological paternity being practiced in the community which initiates them into early childbearing since they must not wait to be married before they start giving birth.

Most of the respondents in the community were married, 47.8% (128). However, the marriage pattern was not defined. Most often women who bear children out of wed lock in the community also consider themselves married because of the practice of exclusive bio paternity which makes it possible for the children to identify their father no matter the cultural arrangement and conditions of marriage or cohabitation. Those who indicated that they are single mothers constituted 20.1% (54). While separated, divorced, and widowed women constituted 20.9% (56), 4.5% (12), and 18 (6.7%) respectively. Our respondents therefore were dominated by married women, hence, justified the contextual placement that bio-paternity practice as a cultural behaviour encourages early marriage.

Majority of the respondents in Owukpa could be categorized as uneducated as 67.2% (180) had FLSC and no formal education. Those with NCE/OND are 69 (25.7%) as second largest and BSc/HND are lesser with 4.5% (12) in number. The number of respondents with MSc/PhD were 7 (2.6%) and the least number of respondents. This has implications for women as education has been held as an important predictor of other variables. Also, this gives an insight into understanding why many engage in early marriages, child bearing/delivery etc. with or without a formal consummation of marital rites.

The distribution on the next page shows that the modal occupation for respondents in Owupka community was business/trading respectively 87(32.1%). Other occupational groupings constituted varying proportions of the sample. Among them are farmers 28.7% (77) and 19.6% (53), apprentice 17.5% (47) and 3.3% (9) respectively. While artisans constituted 6.3% (17), unemployed, and students had equal respondents of 3.0% (8), and other which included the house wives constituted the least of the sample population with 1.6% (5). This confirms the assertion on section 4.1.3 that education is a predictor of other variables.

The distribution of the respondents by religious affiliation showed that despite efforts to get respondents from different socio-cultural background in the two communities, the data seems to be in favour of the Christians of various denominations. Thus, the table above indicated that majority of the respondents in the community were Christians with 96.9% (259). On the other hand, only 3.4% (9) and 4.1% (11) of the respondents in Owupka professed other religion like Muslim and African Traditional Religion.

	Frequency	Percentage
Age group		
15 -19	52	19.4
20 -24	98	36.6
25 -29	44	16.4
30 - 34	36	13.4
35 - 39	21	7.8
40 – 44	11	4.1
45 - 49	6	2.2
Total	**268**	**100**
Mean	25.8	
Standard deviation	7.48	
Marital Status		
Married	128	47.8
Single	54	20.1
Divorced	12	4.5
Separated	56	20.9
Widowed	18	6.7
Total	**268**	
Educational attainment		
No Formal Education		
FSLC	78	29.1
WASCE/SSCE/GCE	102	38.1
NCE/OND	69	25.7
B.Sc/HND	12	4.5
M.Sc\PhD	7	2.6
Total	**268**	**100**
Occupation		
Unemployed	8	3
Student	8	3
Apprentice	47	17.5
Farming	77	28.7
Civil Servant	5	1.9
Business/Trading	101	37.7
Artisan	17	6.3
Other	5	1.9
total	**268**	**100**
Religious Affiliation		
Christians	259	96.9
African Traditional Religion	9	3.4
Muslim	-	
Atheist	-	
Total	**268**	**100**

	Frequency	Percentage
Age group		
15 -19	52	19.4
20 -24	98	36.6
25 -29	44	16.4
30 - 34	36	13.4
35 - 39	21	7.8
40 – 44	11	4.1
45 - 49	6	2.2
Total	**268**	**100**
Mean	25.8	
Standard deviation	7.48	
Marital Status		
Married	128	47.8
Single	54	20.1
Divorced	12	4.5
Separated	56	20.9
Widowed	18	6.7
Total	**268**	
Educational attainment		
No Formal Education		
FSLC	78	29.1
WASCE/SSCE/GCE	102	38.1
NCE/OND	69	25.7
B.Sc/HND	12	4.5
M.Sc\PhD	7	2.6
Total	**268**	**100**
Occupation		
Unemployed	8	3
Student	8	3
Apprentice	47	17.5
Farming	77	28.7
Civil Servant	5	1.9
Business/Trading	101	37.7
Artisan	17	6.3
Other	5	1.9
total	**268**	**100**
Religious Affiliation		

4. The Situation of Maternal Health in Owupka Community

The respondents were asked how they would describe the situation of women's health in their community. The responses are presented on table II.

Table II: Percentage Distribution of Respondents Opinion on the Situation of Maternal Health in the Community.

Opinion	Owupka	
	f	(%)
Very Good	-	-
Good	-	
Fair	17	(6.3)
Poor	122	(45.5)
Very Poor	129	(48.1)
Total	268	(100.0)

Source: Field Survey, 2011.

The above table shows that majority of the respondents 93.6% (251) in Owupka indicated that the situation of Women's health in the community was poor/very poor, while only 6.3% (17) said that it was fair. Thus, this poor health condition in the community could be attributed to high illiteracy level as indicated on table I, which also has association with the type of occupation and above all the way they appreciate this very aspect of their culture (exclusive bio-paternity system) regardless of the harm it is causing their health. This is because more girls and women are engaged in sexuality behaviour without core cultural restrictions towards control, hence, often results to more cohabitation syndrome in place of marriage, keeping of multiple partners, free behaviour to unwanted pregnancy, etc. All these places the lives of women of child bearing age in health risky behaviour and condition generally. It is pertinent to further investigate how this practice specifically affects this category of respondents or people of Owuikpa community.

Table III: Percentage Distribution of Respondents' by the Effect of Exclusive Biological Paternity on the Health of Women

Exclusive biological Paternity Encourages	Owupka					
	Agree		Disagree		Total	
	f	(%)	f	(%)	f	(%)
High sexual activities	202	(75.4)	66	(24.6)	268	(100.0)
Exposes women to sexually transmitted infections (STIs)	268	(100.0)	-	-	268	(100.0)
Giving birth to many children	191	(71.3)	77	(28.7)	268	(100.0)
Women remarrying more often	262	(97.8)	6	(2.2)	269	(100.0)

Source: Field Survey, 2011.

From table III, we find that a large proportion of the respondents in the community indicated that exclusive bio-paternity encourages high level of sexual activities (promiscuity) with 75.4% (202) in the community as against 24.6% (66) who disagree to this fact. In addition, all the respondents unanimously maintained that exclusive paternity exposes women to sexually transmitted diseases (STD). On the other hand, while another large proportion of the respondents 71.3% (191) and 97.8% (262) in the community agree that exclusive bio-paternity encourages giving birth to many children and women moving from one man to another, there was little disagreement with 28.7% (77) and 2.2% (6) respectively.

5. Discussion and Conclusion

During the interview sessions, some important information was gathered on this aspect of culture, in Owukpa community, some key informants revealed that it is an abomination for a man to deny fatherhood of a child whom he is responsible for or to claim fatherhood of a child whom he do not have biological relationship with. In fact it was found that such claim or denial is usually punished by "Alekwu" the god responsible for the punishment and blessing of the people. Though, they indicated that exclusive paternity encourages promiscuity which according to them is not good for the health of women, one of them revealed that

"*it is usually a thing of joy to bear children into a royal or rich family whether married or not, especially when the child is a baby boy".*

This statement is in line with earlier findings that a male child is of great social value in Nigeria (Obikeze, 1988, Onyeneho, 2003). Two of the women leaders interviewed in Owupka revealed that, though , the two types of paternity have health implications on women, some people in that community are beginning to appreciate social paternity which allows men ownership of children whether they are biologically fit or not. The study also reveals that the bio-paternity practice exposes women to more unhealthy health behaviour which are risky to the women especially people of child bearing age (Anne, 1995). Some of these effects as earlier mentioned are vulnerability to diseases and infections, unwanted pregnancy, moral decadence increasing behaviour, poor child upbringing among others. These consequences have other chain negative effects on the society and individuals in different levels and stages of growth for the child, and ranges from psychological, social emotional to physical challenges.

The study also reveals the African structural discriminatory pattern against women. Women are put under control of sexual behaviour and restrictions to partners while men can get as many women or "wives" as he wishes, hence, causing more socio-cultural problems in society. This trend encourages more gender issues and discrimination as well as men's liberty to polygamy, as also asserted by Aurthor (2006).

The result of our study has shown that exclusive bio- paternity practice has certain health implications for women in the community. These implications ranges from multiple fertility which result to sexually transmitted infections and high fertility rate which is a risk factor for the women of childbearing age. Despite these, women are helpless as a result of the patriarchal nature of our society which tends to protect most of these practices in favour of the men, as earlier highlighted, thereby increasing the population with poor care for these children due to multiple partners.

The study recommends that there should be a rigorous level of advocacy to the area about the need to checkmate this practice and streamline issues of this nature. This advocacy must be all involving and a collective efforts to correct some of the misgivings. For example, social workers, health personnel, anthropologist and sociologists must play a group and team roles with the elders and community leaders (both male and female) to correct this trend.

Government agencies and parastatals should be able to bring out policies to control some of these negative socio-cultural practices. Women be reconscientized and educated about the dangers of this practice to their health and the future of the children and society at large. Finally, it is necessary to recommend that more medical or health care facilities and services should be established to render more proactive services rather than curative thereby reducing the socio-cultural effects of the problem amongst this people.

References

Abejide, A., Makanjuola, R. & Okonofua, F. (1992). "Maternal mortality in Ile-Ife, Nigeria": A study of risk factor. *Studies in Family Planning, 23* (5), 319-324.

Anne, E.C., (1995). Re evaluating the value of children in sub-Saharan Africa. The impact of changing forms of marital unions. Paper presented for the annual meeting of Population Association of America held in San Francisco.

Aurthur, J. (2006). Paternity, patriarchy and reproductive rights. Retrieved on 28/06/13, from mypage.direct.ca/w/writer/paternity-patriachy-reproductive-right.html.

Benue state planning commission (2010). Benue state official gazette, 27 (4).

Davis, K., & Blake, J. (1956). Social structure and fertility: an analytical frame work. In Economic Development and cultural change *4* (3) 211-235.

Ezeh, P.J. (2004). *Signs and society: A short introduction to symbolic anthropology.* Delta, Nigeria: Central

Books Ltd.

Kuntala, L.D. & Gopa, S. (2002). State initiatives for the empowerment of women of rural communities: Experiences from eastern India. *Community Development Journal; An international Forum 37* (2) 138-142.

Logan, C., Manlove., J., Ikramulla, E., & Cottingham, S. (2006). Men who father children with more than one woman: A contemporary portrait of multiple-partner fertility. Child Trend-2006_11_1_RB_MultiplePartner.pdf. Retrieved September 11th 2012.

Obikeze , D.S., (1988). Son preference among Nigerian mothers: its demographic and psycho-social implications. International Journal of Contemporary Sociology, *25* (1-2) 55-63.

Onyeneho, N. J. O., (2003). Son preference and fertility in Mbaise households, Imo state, Nigeria. *Journal of the Population Association of Nigeria 3 (1) 68-78.*

Prevention of Maternal mortality Network (1992). Barriers to treatment of obstetric emergences in rural communities of West Africa. *Studies in Family Planning, 23* (5), 279-281

Stuensee, V., & Vanessa, M. G. (2004). Widows, AIDS, health, and human right in Africa. Retrieved on 12/06/13, from SSRN:http://ssrn.com/abstract-569665 orhttp://dx.doi.org/10.2139/ssrn.569665.

WHO (2009) Women and health: Today's evidence tomorrow's agenda. Retrieved 3rd March,2010. From *http://www.who.int/gender/women_health.*

World Bank (1994). *Development in practice: Better health in Africa, experience and lessons learned*. Washington, D.C: World Bank