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**Migration Status, Reproductive Behaviour and Fertility in the City of Port
Harcourt, Rivers State, Nigeria**

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Abstract

This paper examined migration status and reproductive behaviour and fertility of women in Port-Harcourt, Rivers State, Nigeria. The study contends that fertility behaviour of urban women is better understood when examined within the contexts of system and voluntary social action analysis. The study reveals that migrants have lower fertility than non-migrants. This is in the expected direction even though the relationship is not statistically significant. Among the reasons, migrants are generally more progressive and tend to exhibit higher levels of motivation with respect to family and lifestyle matters, being better educated and with higher levels of aspiration. The major childbearing behaviours, such as age at first marriage, ideal birth interval, ideal length of breastfeeding and knowledge, attitudes and contraceptive use, were found to be relatively higher among migrants than non-migrant women. Again, these differences are hardly significant, partly due to the small sample size analysed here. The result of this study could warrant a possible future fertility decline among migrants, but also not excluding the non-migrants, if the current level of use of contraceptives continues to improve. The effects of these factors may translate into low urban fertility desires and the adoption of small family size norms in the nearest future.

Keywords: Migration status, reproductive behaviour, fertility, contraceptives, Port-Harcourt

Background to the study

Nigeria, like other sub-Sahara African countries, has experienced declining but still high fertility levels in the last three decades (NPC, 1991, Feyisetan & Bankole, 2009; Isiugo-Abanihe, 2010; Casterline, 2017; Adebowale 2019; NPC and ICF, 2019). According to the 2018 Nigeria Demographic and Health Survey (NDHS) report, Nigeria's crude birth rate stands at 38 (down from 46.3 in 1960); and total fertility rate is 5.3, down from 6.0 in 1990 (NPC and ICF, 2019). The observed high fertility rate and its momentum in the country can be

attributed to the high fertility norms which are largely a response to past unfavourable demographic, economic and political situations (Obono, 2003; Feyisetan & Bankole, 2009; Adebowale, 2019) that are aggravated by insipid developmental policies.

The biological and behavioural determinants of fertility have remain largely unchanged in Nigeria; age at marriage (median of 19.1 years) and contraceptive prevalence (17%) are quite low, while exposure to sexual intercourse at early age is high as the percentage of women who have had sexual intercourse by age 18 increased from 54% in 2013 to 57% in 2018 (PRB, 2007; UNFPA, 2005; NPC, 2004; NPC and ICF, 2019). In addition, there is an inverse relationship between contraceptive knowledge and use in a nation where desired fertility is higher than current fertility (NPC and ICF, 2019). The proximate determinants of fertility, interacting with the cultural values of childbearing, continue to sustain high fertility, especially in urban Nigeria (Ibisomi, 2008; Casterline, 2017). Perhaps, the contradiction noted by Bongaarts and Lesthaeghe (1984), Caldwell and Caldwell (1987), about the influence of modernization accompanied by education and urbanization on fertility behaviours in urban centres of sub-Sahara Africa remains significantly pronounced; fertility-inhibiting effects are continually offset by fertility-enhancing effects, leading to sustained high fertility among women in urban areas in different sub-region including the Niger Delta (Isiugo-Abanihe, 1999; Isiugo-Abanihe & Iloh, 1999).

In recent times, the rate of internal migration in Nigeria – particularly the rural-urban and urban-urban types - is far higher than it was at the pre- and early post-independence period (Isiugo-Abanihe & IOM, 2016). Clearly, the importance of migration to the survival and wellbeing of any society is well established (Filani, 2005; Marshall, 2018). However, impromptu out-migration of people to urban centres of the Niger Delta “readily manifests in distorted social equilibrium,” which sometimes has “short-lived, long-lasting or even permanent effects” (Nwokocha, 2007: 3). One of such effects is the high urban fertility levels, resulting partly from in-migration, and the ‘crossover effect’ of cultural values regulating fertility and childbearing behaviours of migrants (Rele & Kanitkar, 1974; Makinwa-Adebusoye, 1981; Nwokocha 2013).

The foregoing raises some pertinent questions: what is the implication of migration status for fertility behaviours of women in urban Niger Delta? Does fertility differ by migration status? What is the effect of background factors (education, occupation and income) on the fertility and differentials in relation to migration status? And what are the implications of current contraceptive practices for fertility level of women? Consequently, this study seeks to understand the fertility behaviour of women resident in Port Harcourt, Rivers State. The city is in a region described by Ikporukpo (2002) as one of the least developed in Nigeria due to vivid political and economic marginalization, environmental degradation and ensuing poverty conditions. However, its economic viability and endowment as the oil capital of the Nigeria constitute a

major pull factor for migrants from surrounding rural communities, towns, and cities with the attendant demographic consequences.

Conceptual Framework

The conceptual framework adopted in this study highlights the effects of background variables, and the role of human voluntary actions on the fertility behaviours and level of women – non-migrants and migrants - in a social and physical environment (Fig 1). Studies of fertility behaviour have focused on the indirect role of background variables, whether socio-economic, cultural and medical on fertility behaviour, but the role of voluntary action in the cascading influence of these factors on fertility behaviours cannot be ignored. Consequently, the element of voluntary action is incorporated into the framework.

In any human society, and depending on its peculiar characteristics – whether rural or urban - the social and physical environment determines the individual background socio-economic variables as well as cultural factors operating through the fertility behaviours of non-migrant and migrant women - to determine fertility level and family size (Bongaarts, Frank & Lesthaeghe, 1984; Wusu & Amoo, 2016; Klimek, 2017; Osazuwa & Ugal, 2018). On the other hand, the capacity for human agency is also predicated on the same social and physical space, and is exercised via the background socio-economic and cultural variables. As a result, the effects of these background variables on fertility behaviour of women are reproduced, reinforced, mediated and altered by voluntary individual actions (Giddens, 1984). While the society (through these background variables) influences the end sought by an actor and the means to attain them, the availability of alternative means, the capacity to make conscious choice, and the subjective meaning attached to the actions to achieve desired goals, make human agency inevitable and an intricate part of the role of background factors on fertility behaviour and outcomes.

Individual fertility behaviour occurs within complex and multiple sociocultural realities (Isiugo-Abanihe, 1999; Nwokocha, 2015; Odimegwu & Adedini, 2017; Osazuwa & Ugal, 2018) to determine demand in fertility and the sufficiency of fertility supply. But correspondingly, the assimilation of urban values and acquisition of urban attributes equip women with the propensity to make conscious choices in the face of these realities. As a result, there are differentials in fertility behaviour and fertility outcomes among people. Education and occupation are two important socio-economic variables that enhance the status of women (Wusu & Isiugo-Abanihe, 2017), thereby affect fertility behaviours and promote more egalitarian relationship in the home. In urban areas where access to education and occupation by women is becoming increasingly unrestricted, due to changing gender ideology and value systems that support and accommodate gender equity, women are gaining more control of their fertility behaviours reinforced by improved educational attainment and occupational status (Wusu & Isiugo-Abanihe, 2017).

Fig 1: A framework of migration status and fertility outcomes

Educational attainment and occupational status confer on women differential partnership and stakeholder status that define their role on decisions involving age at marriage, length of breastfeeding, postpartum abstinence, fertility level, family size, birth interval and contraceptive use. So, they act sometimes independent of established norms whether patriarchal or otherwise. As a result, with regard to fertility regulation, they make use of preferred choice of contraceptives or become covert users of contraceptives independent of their spouses. Even those without education or with low educational attainment and

occupational status are aware of the possible dangers to reproductive health and behaviour solely regulated by patriarchy and its attendant factors (religion, customs, policy and political institutions). They are encouraged (by health practitioners during antenatal and postnatal) to exercise conscious control over their fertility behaviour jointly with their spouse and individually when necessary. The factors outlined above play an inalienable part in determining fertility outcomes of women.

Data and Method

The location of the study was Port Harcourt, the capital city of Rivers State, in Nigeria. It is a major industrial centre with large number of multinational firms and other industrial concerns particularly related to the petroleum industry. The city is the crude oil capital of Nigeria (*Encyclopedia Britannica*, 2007), and therefore exerts a huge pull factor to internal migrants from different parts of Nigeria because of the prospects of “good life” in the booming economy based on the petroleum industry.

This study was exploratory and cross-sectional and carried out within the framework of a survey research design. The city was stratified into three residential patterns; the Government Reservation Areas (GRA), middle and low class residences (typified by blocks of rented single, double and three bedroom apartments and single-unit rooms housing units) and private estates (PEs). Two districts were selected via simple random technique from each of the stratified clusters of residential locations respectively. These include Lagos and the Borokiri district (GRA), Mile One and Mile Three residential district (a middle and lower class residential location) and Garrison and Ogbunabali residential areas (PEs). Streets and households were randomly and systematically selected respectively; the simple random method (balloting when necessary) was used for the selection of final respondents and the administration of questionnaires. Individuals who had insight on the study theme and objectives were purposively selected for in-depth interview, while the traditional birth attendants (TBA) were selected via the snowball method.

A total of 433 questionnaires were administered to a cross-section of women age 15-49. The instrument was designed in close and open-ended formats. Eleven in-depth interviews were conducted; the interviewees included six women, two orthodox health practitioner (a male and female), two TBA practitioners, and a non-migrant male respectively. The quantitative data were analyzed with the Statistical Package for Social Sciences (SPSS); descriptive analyses of means and distribution of variables; cross-tabulations and T-test were conducted to explain relationships and differences in fertility level of groups. Logistic regression was used to explain fertility differences between migrant and non-migrants when the given set of socio-demographic variables is controlled for. Qualitative data were analyzed using manual content analysis technique and relevant responses that elucidate the study objectives were isolated and employed verbatim for descriptive purposes.

Results and Discussion

Fertility Differentials by Migration Status

The modal age group was 25-29 years but more migrant women fall within age group 25-34 years. The majority of women have attained some tertiary education, particularly the non-migrants. The cosmopolitan nature of the Port-Harcourt appears to influence both migrant and non-migrant women who tend to exhibit peculiar and sometimes similar reproductive behaviours. Table 1 shows the mean values of selected fertility and related variables of these women by migration status.

Table 1: Mean Value of Fertility and Related Variables by Migration Status

Variables	Migration status		All women (Median)
	Non-migrants (Means)	Migrants (Means)	
Age at first marriage	25.15	25.67	25
Ideal Age at First Marriage	22.62	23.11	23
Length of marriage	4.87	6.66	3
Children ever born	2.45	2.58	2.54
Birth interval	26.57	25.80	24
Ideal birth interval	25.79	26.39	24
Length of breastfeeding	15.15	14.32	12
Ideal length of Breastfeeding	16.41	18.39	18mth
Desired children	2.52	2.45	2.00
Desired no of sons	1.59	1.63	2.00
Desired no of daughters	1.54	1.31	1.00
Family size	4.70	4.33	4.00

A 2-year difference exists between actual age at marriage and ideal age at first marriage, indicating possible future decrease in marriage ages. On the average, migrants have spent more years in marriage (6.66 years), have shorter birth interval (25.8 months) as well as shorter length of breastfeeding (14.32 months), conditions favouring conception and actual fertility. Expectedly, they have a slightly higher mean number of children ever born (2.58). This supports Isiugo-Abanihe (1999) who averred that the longer the period of union or cohabitation, the higher the risk of child-bearing, hence fertility. Even so, it is noteworthy that migrants' ideal length of birth interval and breastfeeding is longer than non-migrants'; this may not be unconnected with the 'crossover effect' of their childbearing values, norms and practices of their places of origin (Rele & Kanitkar, 1974). Also, it indicates a lack of consistency between attitude which is mostly latent and behaviour which is more manifest.

It is noteworthy that the desired number of children among migrant and non-migrants is low (about 2.5), and coincides with the number of children ever born (MCEB), an indication, perhaps, of declining urban fertility,

although many of the respondents were yet to completed their family size given their current age. A slight preference for male children is evident in the data.

Table 2: Distribution of Mean Children Ever Born and Migration Status

Age group	Migration Status		All women
	Non-migrants	Migrants	
Below 25	1.14	1.29	1.21
25-29	1.85	1.63	1.72
30-34	2.18	2.27	2.25
35-39	4.08	3.45	3.69
40 and above	3.40	3.70	3.66
Total	2.45	2.59	2.54

Overall, mean live birth increases with age of the women, with slight distortion at age 40 years and above among non-migrants. The monotonic increase in the mean number of children among migrant women is the expected pattern which is also related to the age at first marriage. Mean number of children of women age 40 and above approximates completed fertility, which in this case is lower than 4 children per woman. Again, this is an indication of declining fertility in the city of Port Harcourt. However, the result of t-test of MCEB of migrants and non-migrants shows no significant difference, an indication of similarity in behaviour, and perhaps attitude, among women in the city. This is suggested by a number of respondents in the in-depth interviews.

A woman IDI respondent provides this insight, which was re-stated in different words by other interviewees.

Because of the economy, people (women) are not really giving birth to too many children. I don't think indigenes are giving birth to more children than non-indigenes; things are difficult in Port Harcourt, so many people are cautious about the number of children they give birth to. The government schools are not good and everybody wants their children to go to private school which is very expensive. So women have fewer children whether they are migrants or non-migrants. (*Female, from Kalabari, Age 26*)

The absence of significant fertility differential between migrant and non-migrants seems to point to the cascading effect of economic constraints and/or possibly convergence of family size norms. As a result, women have to make conscious choice(s) about desired fertility level(s). This perhaps will lead to change in family size norm from large to small family sizes.

The Effects of Migration Status on Fertility Behaviour of Women

It is established in the literature that migration status has effect on fertility behaviours of women, with a corresponding effect on actual fertility

performance. Consequently, its effect on fertility behaviours, such as age at first marriage, length of marriage, length of breastfeeding, and postpartum abstinence were examined. The results are presented in Tables 3, 4, 5, 6 and 7.

Table 3: Percent Distribution of Respondents' Age at First Marriage and Migration Status

Age at First Marriage	Migration Status		All women
	Non-migrants	Migrants	
19 and Below	5.4 (6)	6.1 (12)	5.9 (18)
20-24	34.8 (39)	32.0 (62)	33.0 (101)
25-29	44.6 (50)	48.5 (94)	47.1 (144)
30-34	10.7 (12)	12.4 (24)	11.8 (36)
35 and Above	4.5 (5)	1.0 (2)	2.3 (7)
Mean	25.15	25.67	25.48

Considering age at first marriage, Table 3 indicates that 47 percent of the women, and irrespective of their migration status, marry between 25 and 29 years. More non-migrants were married at age 20-24, but more migrants were married at age 25-29 and 30-34. However, the difference between them is hardly significant. The mean age at marriage in the city of Port Harcourt (25.5) is high (25.15 for non-migrants and 25.67 for migrants), clearly an indicative of the cosmopolitan character of the city.

Table 4: Percent Distribution by Age at First Marriage, Education and Migration Status

Age at first marriage	Migration status					
	Educational Attainment					
	Non-migrants			Migrants		
	Primary	Secondary	Tertiary	Primary	Secondary	Tertiary
19 and below	100.0 (1)	14.8 (4)	1.2 (1)	100.0 (2)	13.8 (9)	0.8 (1)
20-24	-	37.0 (10)	34.6 (28)	-	36.9 (24)	30.3 (36)
25-29	-	33.3 (9)	48.1 (39)	-	41.5 (27)	52.1 (62)
30 and above	-	14.8 (4)	16.0 (13)	-	7.7 (5)	16.8 (20)

Table 4 shows that age at first marriage tends to increase with level of education, especially among migrants. This is in line with the finding of Makinwa-Adebusoye (1981), Appleton (1995) and NPC (2004). More non-

migrants with tertiary and secondary education married for the first time at age group 20-24 years and 30 years above respectively, while more migrant women with secondary and tertiary education married for the first time at the age of 25-29 years. The majority of the women irrespective of migration status married for the first time between age 20-29 years, migrant women are more likely to have a higher age at first marriage with respect to educational attainment. The number of years spent in marital union has also been noted to a large extent to determine the possibility of fertility as well as its level as captured in the table below.

Table 5: Distribution by Length of Marital Union and Migration Status

Marital Union	Migration Status		Total
	Non-migrants	Migrants	
Below 1 year	12.0 (13)	9.1 (17)	10.2 (30)
1-2years	34.3 (37)	27.8 (52)	30.2 (89)
3-5years	27.8 (30)	22.5 (42)	24.4 (72)
6-9years	13.9 (15)	15.0 (28)	14.6 (43)
10-15years	6.5 (7)	13.4 (25)	10.8 (32)
Above 15years	5.6 (6)	12.3 (23)	9.8 (29)
Mean	4.87	6.66	6.00

It is obvious from Table 5 that migrants have been in marriage for a longer duration than non-migrants. Only 26 per cent of migrants have been in marriage for upward of 6 years relative to 40.7 percent among migrant women. The mean length of marriage differential of 1year 8months in favour of migrants could explain why migrant women have slightly higher fertility than non-migrants. This is because length of marriage determines exposure to sexual intercourse, pregnancy (NPC, 2004; Isiugo-Abanihe, 1999), and of course fertility. The length of breastfeeding practiced by women has been reported to be largely influenced by cultural ethos of childbearing and childcare. Also, it has been reported that breastfeeding period is declining particularly among educated women in urban areas. The result in Table 6 seems to support this assertion.

Table 6: Distribution by Length of breastfeeding and Migration Status

Breastfeeding in Months	Migration Status		
	Non-migrants	Migrants	Total
6mths and below	6.3 (4)	3.8 (5)	4.6 (9)
7-12months	40.6 (26)	49.6 (66)	46.7 (92)
13-18months	29.7 (19)	31.6 (42)	31.0 (61)
18months and above	23.4 (15)	15.0 (20)	17.8 (35)
Mean	15.15	14.32	17.58

A considerable proportion of women breastfeed their children for a long period of time (Isiugo-Abanihe and Iloh, 1999); the same pattern is observed irrespective of migration status. It is noteworthy that a significant majority (70 to 80%) of women in both categories breastfeed for between 7 to 18 months and even longer, among some women. Although the mean difference (0.83) is hardly significant, it indicates that non-migrants breastfeed for longer periods, a situation that may account for the slight difference in fertility level in favour of migrants.

The three childbearing behaviours examined so far individually or collectively have direct implications for current fertility. But future fertility levels are consequent upon desired family size. The common practice among African women not minding residential location is to have as many children as their husbands' desire, which is usually more than four. It is becoming common practice, however, among families in urban areas, including Port-Harcourt, to desire at least three children.

Table 7: Distribution by Desired Fertility and Migration Status

Desired Fertility	Migration Status		
	Non-migrants	Migrants	Total
1	25.8 (16)	21.6 (21)	23.3 (27)
2	32.3 (20)	33.0 (32)	32.7 (52)
3	12.9 (8)	26.8 (26)	21.4 (34)
4	21.0 (13)	14.4 (14)	17.0 (27)
5	8.1 (5)	4.1 (4)	5.7 (9)
Mean	2.52	2.45	2.47

A glance at Table 7 shows that women who desire two children are more (33 percent), while about a fifth desires either one, three, and four children. The

variation between the two groups of women is more significant among women who desire three (13.9%) or four (6.6%) children. Differentials by migration status indicate that migrant women who desire three children are double the non-migrants; conversely, more non-migrants desire four children or more. Irrespective of migration status, most women desire between two and three children, which is indicative of the new norm of urban fertility decline.

The responses of two interviewees to a question on desired family size are insightful. The first interviewee opines:

Unlike before, women do not want to have many children. Besides, hospitals and clinics teach child-spacing methods to nursing mothers especially in the languages the mothers understand. This is regardless of formal education. Women do not have children anyhow anymore, they plan their family and everybody is the same whether non-migrants or migrants. (*Community health nurse, Age 32*)

The second interviewee corroborates the above response:

Most (women) desire four; two boys and two girls. There is no difference in the number of children non-indigenes and indigenes give birth to because they live in the same environment. They do not want to have many children because of the high cost of raising them. (*TBA (faith healer), Age 62*)

Since behaviour is closely linked to perception, and more often than not, guided by it, the perceived time to resume sexual intercourse after birth can provide an indication on the length of postpartum abstinence in the city. It has been reported in the literature that the length of postpartum abstinence is declining in urban Africa. As shown in the following table, ideal length of postpartum abstinence among sampled women in Port-Harcourt is indicative of the reports in the literature.

Table 8: Distribution by Postpartum Abstinence and Migration Status

Postpartum Abstinence	Migration Status		Total
	Non-migrants	Migrants	
It Depends	2.9 (3)	5.3 (9)	4.5 (12)
8weeks	26.5 (27)	32.7 (56)	30.1 (81)
12weeks	25.5 (26)	30.4 (52)	29.0 (78)
16weeks	18.6 (19)	17.5 (30)	17.5 (47)
20weeks	7.8 (8)	4.7 (8)	5.9 (16)
24weeks	14.7 (15)	7.6 (13)	10.4 (28)
Above 24weeks	3.9 (4)	1.8 (3)	0.4 (1)
Mean	3.90	3.33	3.54

From Table 8, most women (59 percent) and irrespective of migration status perceived a period of 8 to 12 weeks as the ideal for postpartum abstinence. Migrants, more than non-migrants, perceived this period as most ideal. However, non-migrants are more likely to practice longer postpartum period because two-fifth felt 16 weeks or above are ideal for postpartum abstinence, which reduces the likelihood of conception and high fertility. Bongaarts, Frank & Lestheage (1984) had reported that postpartum abstinence is shorter in urban sub-Saharan Africa. This perhaps may not be unconnected to some factors such as the lack of supervisory eye of in-laws and relatives in an increasingly individualistic environment and the fear of encouraging extra marital affair among husbands or partners (Lee, 1992), declining belief among educated women for the need to abstain from sexual intercourse for health of mother and child (Makinwa-Adebusoye, 1981; Lee, 1992) and standard medical prescriptions which is widely encourage during ante and post-natal sessions that barring any medical problem, after natural birth delivery, a woman can resume sexual intercourse after six weeks of delivery.

With regard to birth spacing, three quarters of migrants and non-migrants responded affirmatively that they practice consistent birth interval. Considering that these women are from diverse social and ethnic backgrounds with dichotomized migration status, one would expect varied differentials in their ideal birth interval. However, Table 9 indicates no significant differential between non-migrant and migrant on ideal child spacing practice.

Table 9: Distribution by Ideal Birth Interval and Migration Status

Ideal Interval	Migration Status		Total
	Non-migrants	Migrants	
12mths and Below	2.4 (3)	3.5 (7)	3.1 (10)
13-24mths	77.8 (98)	75.6 (152)	76.5 (250)
25-36mths	19.0 (24)	17.4 (35)	18.0 (59)
37mths and Above	0.8 (1)	3.5 (7)	2.4 (8)
Mean	25.79	26.39	26.16

It is clear that perceived birth interval only represents an insignificant difference in quantifiable terms (25.79 months among non-migrants and 26.39 months among migrant women). The preferred ideal birth interval is between 13-24 months; three-quarters of non-migrant as well as migrant women consider this interval most ideal for child spacing. The preference for this interval by a significant number of these women is likely connected to the prescribed period for breastfeeding emphasized during ante-natal and post-natal sessions, which should be at least a year including an exclusive practice for six months. Another plausible and related explanation may be found in the reproductive health talk by experts in family planning on the ills of short birth intervals. Still, this interval falls short of the 31 months prescribed by the NPC and ORC (2004). Nevertheless, few women irrespective of migration status considered an interval of 25 months and above ideal. A contemplation of this sought may indicate a possible change in birth interval trend especially in the nearest future.

Migration Status, Knowledge, Attitude and Use of Contraceptives

The average age for the commencement of contraception among sampled women in Port Harcourt is high, 22.75 years; non-migrants commenced contraceptive use earlier (22.25 years) relative to migrants (23.01 years). Considering its city status with relatively high anonymity, and availability of contraceptives and contraceptive sources, it is expected that contraceptive practice would commence earlier than observed. Consequently, knowledge, attitude and use of contraceptives among these women were examined to further understand the dynamics of this fertility behaviour. Table 10 shows that migrants are more knowledgeable of all contraceptive methods than non-migrants.

Table 10: Distribution by Knowledge of Contraceptives and Migration Status

Contraceptives	Migration Status		Total
	Non-migrants	Migrants	
Pill	17.4	31.3	48.6
I.U.D	10.0	21.5	31.5
Norplant	4.4	13.7	18.1
Injection	11.6	24.5	36.1
Condom	17.8	34.0	51.8
Diaphragm	5.3	16.4	21.7
Female sterilization	7.9	16.9	24.8
Male sterilization	-	0.7	0.7
Rhythm & Billings	0.2	5.3	5.5
Withdrawal	9.7	24.1	33.8
Abstinence	10.6	22.2	32.8

The level of awareness of methods to delay or prevent pregnancy in Port-Harcourt was found to be quite high (97 percent). This was corroborated in the IDI sessions; respondents were of the opinion that women's knowledge of contraceptives is high irrespective of migration status. A respondent said:

All the groups have knowledge of methods to delay or prevent pregnancy; the information is everywhere both indigenes and non-indigenes have knowledge of contraceptives. Hardly will you see any adult male or female that will say they have not heard about family planning and the methods. (*Chief Matron from Kalabari, Age 52*)

Table 10 also shows that, generally, the knowledge of artificial methods is comparatively higher than natural methods; also migrants demonstrate a higher level of knowledge on these broad categories. For instance, the proportion of migrants with knowledge about condom, pills and injection is twice that of non-migrants; the same pattern is observed for natural methods. Knowledge is highest for condom and pills irrespective of migration status. This is hardly surprising; both methods are among the most popular (NPC & ICP, 2019), readily available (Konje *et al.*, 1998) and most financially and physically accessible. Knowledge of male sterilization is low, possibly because men do not discuss the possibility of using the method with their wives since it is a permanent method. The low knowledge about Rhythm and Billings methods may be due to the nomenclature used; few women know the method by that name.

Consummate knowledge of contraceptives was also enquired so as to match awareness with method of use of contraceptives. Consummate knowledge (whether they know how each method is used) of contraceptive methods is reflective of the pattern on awareness. Whether generally, or by

migration status, women who know how to use condom more than any other method are comparatively higher. Women who have consummate knowledge of pills, withdrawal and abstinence are also prominent. Table 11 captures this pattern.

Table 11: Distribution by Consummate Knowledge of Contraceptive and Migration Status

Contraceptives	Migration Status		Total
	Non-migrants	Migrants	
Pill	10.4	17.8	28.2
I.U.D	3.9	10.6	14.5
Norplant	1.4	5.9	7.3
Injection	6.0	10.6	16.6
Condom	13.4	23.8	37.2
Diaphragm	2.1	6.5	8.6
Female sterilization	2.6	7.2	9.8
Male sterilization	2.6	6.5	9.1
Rhythm & Billings	2.3	10.6	12.9
Withdrawal	7.9	16.0	23.9
Abstinence	8.3	15.0	23.3

Although, more migrants have consummate knowledge of all contraceptive methods, effective knowledge of individual method of use is generally low. This has a direct implication for the proportion of women who practice contraceptive effectively, whether those who have ever used or are currently using. Generally, Table 12 indicates that only a quarter of the women have ever used condom, 14% of women have ever used pill, withdrawal method and abstinence. Migrants double, and in a few cases triple, the numbers of non-migrants on ever use of contraceptives, supporting the finding that more migrants have consummate knowledge of contraceptives.

Table 12: Distribution by Ever Use of Contraceptives and Migration Status

Contraceptives	Migration Status		Total
	Non-migrants	Migrants	
Pill	5.3	9.3	14.6
I.U.D	1.2	2.6	3.8
Norplant	3.2	10.0	13.2
Injection	0.9	3.0	3.9
Condom	9.0	16.4	25.4
Diaphragm	-	0.7	0.7
Female sterilization	-	0.2	0.2
Male sterilization	-	0.4	0.4
Rhythm & Billings	0.2	5.3	5.5
Withdrawal	4.4	9.7	14.1
Abstinence	5.1	8.8	13.9

Uncharacteristically, the women who have ever used nor plant are fairly high particularly among migrants (10 percent); the use of this method may have been influenced by its covert nature. Figures on ever use of diaphragm, female and, male sterilization methods possibly demonstrate respondents' lack of confidence on these methods, which may stem from their possible side effects, and the irreversibility of the surgically induced methods. Expectedly, ever use of condom is highest especially among migrants; moreover, more migrants have ever used all methods of contraceptives. This finding is in conformity with the report of NPC and ORC (2004) on the pattern of ever use of contraceptives in Nigeria. Overall, the foregoing analysis reveals that ever use of methods is relatively low, and did not reflect the high level of knowledge and consummate knowledge. Table 13 provides information on current use of contraceptives of contraceptives.

Table 13: Distribution by Current Practice of Contraceptive and Migration Status

Current Contraceptive Practice	Migration Status		Total
	Non-migrants	Migrants	
None	14.3	13.5	13.2
Abstinence/Withdrawal	24.4	31.5	25.7
Pills	18.4	7.9	11.8
Rhythm and Billings	4.1	10.1	11.8
Tubal Litigation	-	1.1	0.7
Injectables	-	1.1	0.7
I.U.D	4.1	5.6	4.4
Condom	34.7	29.2	31.6

It is obvious that a considerable proportion of the respondents, irrespective of migration stats, are currently using abstinence/withdrawal; more migrants are using the rhythm method than non-migrants. Non-migrants are currently using the pill (18.4%) and condom (34.7%) relative to migrants (7.9% and 29.2% respectively). The pattern of use may have been influenced by the social environment of the women than do the attributes of specific contraceptives (Kim, Kols & Mechaka, 1998). According to Potter (1999), an entire community may encourage the use of a particular type of contraceptive based on choice of earlier users, rather than individual needs or side effects experienced by some of her members (Entswile *et al.*, 1999). People choose contraceptives methods that are prevalent in their community because they tend to know more about these methods and they believe it is socially acceptable (Rogers & Kancaid, 2004). This is likely true for non-migrants than migrants; the latter's childhood socialization and the 'cross over effect' may have accounted for the relative preference for natural methods.

It is important to know the reasons why some of the women are not currently using contraceptives because these provide platforms for interventions regarding fertility regulation. Table 14 below captures the reasons for not using contraceptive.

Table 14: Reasons for not Currently Using Contraceptives and Migration Status

Reasons for not currently using contraceptives	Migration Status		Total
	Non-migrants	Migrants	
Expecting a Child	15.6	13.2	14
Side Effects	37.5	22.1	27
Desire more children	12.5	19.1	17
Menopause	3.1	7.4	6
Husbands Disapproval	6.3	4.4	5
Prefer Natural Method	25.0	33.8	31

The preference for natural contraceptives (31 percent) was the major reason for not using modern contraceptive among both groups of women; side effects and fertility related factors were other prominent reasons. Preference for natural methods and side effects were the principal reasons for refusing contraceptives (modern method) among migrants, while the fear of side effects and pregnancy were the principal reasons among non-migrants. For both groups, improved use will be dependent significantly on reducing, or allaying the fears of possible side effects of methods.

Logistic Regression of Fertility of Migrants and Non-migrants

The mean number of children ever born (MCEB) is further examined, controlling for some key socio-demographic variables, including current age, education, income and duration of marriage, to ascertain their effects on the fertility of migrants and non-migrants. We designed a logistic regression analysis of children ever born by migration status, controlling for the available socio-demographic variables. Dummy variable analysis was adopted, in which one category of each factor is omitted for comparison. The dependent variable is dichotomous, below the mean of 2.5 MCEB, and above the mean, with the former coded 0 and the latter 1, thus predicting the likelihood of having higher fertility. Two model were estimated, the first for migration status alone, and the second with the inclusion of the independent variables. Table 15 presents the result of logistic regression of children ever born by migration status, controlling for the available socio-demographic variables of age, education, income and length of marriage.

Table 15: Logistic Regression Model (Standardized Coefficients) for Mean Children Ever Born and Migration Status

Variables	Model 1	Model 2
Migration Status:		
Non-migrants	1.275	1.391
Migrants (RC)		-
Current Age:		
Below 25 (RC)	-	-
25 to 29	-	.935
30 to 34	-	5.939
35 to 39	-	3.691
40+		6.612
Education:		
Secondary and below (RC)	-	-
Tertiary		.055***
Income:		
20,000K and below	-	.248
Above 20,000K (RC)		
Length of Marriage:		
5yrs and below	-	.000***
Above 5yrs (RC)		-
Constant	-	-
Adjusted R-Sq	.002	.320
N of cases = 432		
Note = ***P < .001		

RC – Reference category

Model 1 indicates that non-migrants have higher fertility than migrants, although the relationship is not statistically significant. It should be noted that the study suffered from small sample size, which may account for the weak differences observed in many instances. The higher fertility for non-migrants persists in Model 2, but again, not significant. Generally, fertility increases with age, as expected, but the relationship is hardly significant. Education is inversely related to children ever born, with women who had tertiary education having lower fertility. The relationship is significant, an indication of the modernizing influence of higher education with respect to lifestyle and attitudes. There is no significant difference in the fertility of women with high and low levels of income; in other words, income does not have a significant relationship with fertility. Duration of marriage has positive relationship with fertility, a confirmation of the conventional wisdom about the relationship between length of marriage and fertility.

Conclusion

This study examined reproductive behaviour and fertility with respect to migration status of women in Port-Harcourt. The objectives of the study were to determine the extent of fertility differential between migrants and non-migrants, examine differences in fertility behaviour by migration status, as well as the role of socio-economic factors on fertility. The study reveals that migrant women have relatively lower fertility than non-migrants. Although the relationship is not statistically significant, it is in the expected direction. Among the reasons, migrants are generally more progressive and tend to exhibit higher levels of motivation with respect to family and life style matters, being better educated and with higher levels of aspiration.

The major childbearing behaviours, such as age at first marriage, ideal birth interval, ideal length of breastfeeding and knowledge, attitudes and contraceptive use, were found to be relatively higher among migrants than non-migrant women, a product of the combined effects of higher female-migrant education and labour force participation (Wusu & Isiugo-Abanihe, 2017). This could warrant a possible future fertility decline if the current level of use of contraceptives continues to improve. The effects of these factors may translate into low fertility desires and the adoption of small family size norms in the nearest future.

Though fertility behaviours are largely influenced by background societal factors, individual women especially those residing in urban centres possess a degree of autonomy which sometimes enables them to act independently of the cascading effects of the societal factors. Educational attainment, particularly tertiary education, and participation in formal work, equip women with the capacity to control their childbearing behaviours in environments where fertility values favour small family size norms. To a considerable extent, the above scenarios are true of the city in Port-Harcourt.

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