Socio-demographic Factors Influencing Health Programme Usage by Pregnant Mothers in Nigeria: Implications for Policy Action

By

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Abstract

Despite several interventions towards mitigating maternal mortality especially in developing countries including Nigeria, such as Safe Motherhood Initiative, 1987, Millennium Summit, 2000, etc., maternal mortality is still soaring, as more than half a million women die from pregnancy and related causes every year. Majority of these deaths incidentally, occur in sub-Saharan Africa. Maternal mortality in Nigeria is very high and maternal deaths are strongly linked to deliveries which took place at home, without proper assistance from trained skilled birth attendants. Presently, access and utilisation of health care are constrained by socio-economic factors, making it a commodity for the rich in a country with over 56 per cent of population living below the poverty line. Given the pervasive poverty, illiteracy and lack of quality health care services, maternal mortality situation can hardly get better in the near future except utilisation level is accelerated. This paper examines the factors which influence health care intervention utilisation among women during pregnancy and child delivery. This study is empirical and used face-to-face structured interview technique in eliciting the data. Correlates were found and recommendations put forward for effective utilisation of interventions in order to stem the unacceptable level of maternal mortality in Nigeria.

Keywords: maternal mortality, utilisation services, pregnancy, antenatal care, health centres.

Introduction

Maternal health means ensuring that all women receive the care they need to be safe and healthy throughout pregnancy and childbirth. Women's health is a critical area, which reflects national health standards and basic to women's advancement. The health of the mothers and children has improved dramatically during the last two decades globally as a result of the increase in imported medical advancement, availability of low-cost and high impact public health measures such as Oral Rehydration Therapy (ORT) and vaccine for mothers/children, improved nutritional practices, improved maternal and child health care. In spite of the above development, more than half a million women (many of them living in developing countries) die during pregnancy or childbirth or within a few weeks of delivery.(WHO, UNICEF and UNFPA, 2003).

A recent study reveals that a ratio of 1:15 African women die from complications of pregnancy, delivery or puerperium. In Asia, the ratio is 1:105, Europe is 1:1895 and North America is 1:3750 (Abdoulaye, 2006). Despite the global effort to improve maternal health and safer delivery through the International Safe Motherhood Initiative, 1987 in Kenya, World Summit for Children, 1990, International Conference on Population and Development (ICPD), 1994, Beijing-Fourth world Conference on Women, 1995, ICPD + 5 & + 10, Beijing + 5 & +10, Sri Lanka, 1997, United Nations MDGs 2000, and its local equivalent in Nigeria such as National Safe Motherhood Conference, Abuja 1990, Integrated Maternal Newborn and Child Health Strategy, etc, there is still high maternal deaths in the country. In fact, four years into the lifeline for achieving MDGs, there is no clear evidence that Nigeria has yet achieved any remarkable achievements.

Many studies have attributed this challenge to the state of health of pregnant women, poor delivery process, and poor antenatal and postnatal care utilisation of available health care services (NPC, 2004, NPC, 2000). Given the low maternal reduction in Nigeria during the past ten years and the country's need to achieve the millennium development goals by 2015, little is known about the current magnitude of use and factors determining the utilisation of these services in Nigeria . Hence, this study becomes imperative to uncover the state of health care utilisation among mothers during pregnancy and child delivery using community-based empirical data in order to effect sound policy intervention measures.

Maternal mortality can be reduced through appropriate utilization of health care intervention measures such as increasing accessibility to health services and improving the status of women which put this vulnerable group at a higher risk of death. Access to and utilisation of health care is also constrained by a range of factors which could be responsible for increasing maternal health risks in Nigeria. Nigeria ranked second globally as the country with the highest estimated number of maternal deaths with 37,000 cases of maternal deaths annually. India occupied the

first place with 136,000 maternal deaths and Pakistan was in the third place with 26,000 deaths.

It is interesting to note that health care utilisation is poor in Nigeria. The 1999 multiple indicator cluster Surveys (MICS) revealed that in the five years prior to the survey, about 12-13.9 per cent of women with births received antenatal care from a doctor or took place in a health facility and 34-36% of all births were delivered by skilled personnel (FOS/UNICEF,1999; NPC, 2004: FMOH, 2003).

Maternal mortality and morbidity are critical priority problems that demand recognition and acceptance by the policy makers and health administrators. When women are in a state of pregnancy, their health status is far more complicated. It is no gainsaying that inappropriate, incorrect treatment or even lack of appropriate and timely interventions underlies most maternal deaths in developing countries and Nigeria in particular.

But among the numerous factors militating against the use of health services by mothers, socio-demographic factors have been the least focused in terms of research. Health needs of women in relation to maternity cannot be addressed in isolation but rather a holistic and inter-sectoral approach.

The Objectives of this Paper are

1. To examine major factors challenging maternal access to health care services during pregnancy and childbirth.
2. To proffer intervention strategies from the results of the study, for improving the current low utilisation of health care facilities by pregnant mothers by policy makers.

Rationale of the study: High rates of maternal mortality and morbidity are related to knowledge about health services, the access to and utilisation of services subject to availability. Examining and addressing the social-demographic dimensions of the problem is therefore as vital as dealing with the medical dimensions. The existing interventions intended to benefit the target group is yet to be met. This means that there are other factors causing restraint to accessing health care services by pregnant women in addition to medical factors. No doubt some studies have been carried out in this area but they concentrated on intervention measures to boost maternal health services; no study has dealt exclusively with the reasons for the retardation or poor utilisation of the services. Therefore, in order for maternal health programmes to remain focussed, and to make a quantitative evaluation of programmes'

results, maternal mortality statistics must be available at local and national levels to prioritise the health services.

The hypothesis considered here to plausibly reinforce or answer the research question raised is that socio-demographic characteristics of respondents (pregnant mothers) such as age, education and working status are significant determinants of facility utilisation.

Review of Related Literature

Based on UNICEF (2005) data, the average lifetime risk of a woman in least developed country dying from complications related to pregnancy or childbirth is more than 300 times greater than for a woman living in an industrialized country. Millions of women who survive childbirth suffer from pregnancy related injuries, infections, diseases and disabilities, often with lifelong consequences. It further asserted from research that approximately 80 per cent of maternal deaths could be averted if women had access to essential maternity and basic health-care services which are far better in developed than in developing countries. Literature search reveals that modern use of health facility is low in developing countries, including Nigeria. The poor usage of health care services can be influenced by several factors ranging from social, economic, cultural, availability and accessibility. According to Federal Ministry of Health Nigeria (FMOH) (2005),these factors work through the pervading high level of poverty in the country, low status of women and high prevalence of harmful traditional practices, all add up to pose great obstacles, to women's access to much needed reproductive health information and services. Maternal education has been found to relate positively with the utilisation of maternal care services (Addai, 2000; Celik and Hotchkiss, 2000). Education serves as a proxy for information, cognitive skills, and values; education exerts effect on health-seeking behaviour through a number of pathways .These pathways include higher level of health awareness and greater knowledge of available health services among educated women, improved ability of educated women to afford the cost of medical health care, and their enhanced level of autonomy that results in improved ability and freedom to make health-related decisions, including choice of maternal services to use. Educated mothers are more likely to take advantage of public health care services than other women. Education may also impart feelings of self-worth and confidence as well as reduce the power differential between service providers and clients, thereby reducing the reluctance to seek care. (Elo, 1992; Caldwell, 1979).

Cultural factors also affect the utilisation of maternity care services in Africa (Leslie and Gupta, 1989). In consonance with the above assertion, WHO (1998) corroborates that in many parts of Africa, women's decision making power is extremely limited, particularly in matters of

reproduction and sexuality. The low status of women and husband's domination, all worsen the ugly and poor utilisation of health care services.

The tragedy of maternal mortality and the poor health status of women in Nigeria are deplorable. Over 1000 women die from causes related to pregnancy and child birth and almost equivalent proportion suffer unnoticed. The Federal Ministry of Health (FMOH) (2007) reveals that maternal mortality ratio in Nigeria is estimated to be 800 per 100,000 live births. Women's health is a critical area, which reflects national health standards and basic to women's advancement. Also, the Federal Ministry of Health (2006) observes that Nigeria contributes about 10% of the world's global burden of maternal mortality.

To date, very few population-based studies of maternal mortality have been carried out in developing countries. The estimated number of maternal deaths worldwide in 2000 was 529,001. These deaths were almost equally divided between Africa (251,000) and Asia (253,000), with about 4% (22,000) occurring in Latin America and the Caribbean and less than 1% (2,500) in the more developed regions of the world. In terms of the maternal mortality ratio (MMR), the world figure is estimated to be 400 per 100,000 live births. By regions, the MMR was highest in Africa (830), followed by Asia (330), Oceania (240), Latin America and the Caribbean (190), and the developed countries (World Bank, 2004; Cohen 1987; World Bank, WHO and UNFPA, 1987, WHO, UNICEF and UNFPA, 2001; Jamison, 2006).

The effort to lower this maternal death rate has become a high government priority. This informed the launching of the National Programme for the Prevention of Maternal Mortality (NPPMM). The aim of this programme is to expand and strengthen advocacy projects for safe motherhood, ignoring the lack of both baseline estimate of sources and methods for tracking the incidence of deaths among pregnant women. These include reducing maternal mortality and morbidity by 50%, neonatal morbidity by 30%, unwanted pregnancies by 50%, and sexually transmitted infections by 50%. Setting targets for maternal reduction without evidence based data is likely to end in non-achievement of goals. This is because evidence-base decision making clearly requires data which are readily available. The tragedy of maternal mortality and morbidity has been the recipient of a step motherly treatment at the hands of health policy makers and health administrators in the developing countries during the last 3-4 decades. Perhaps, it's due to the paucity of data on maternal mortality and that too, at micro/community level.

Recent surveys and studies on this problem of maternal deaths have established that thousands of women in the reproductive age die during pregnancy or child-birth, either at home or in the hospital. Globally speaking, nearly half a million maternal deaths occur every year and ninety per cent of the deaths occurring in the developing world are preventable, to a great extent. While there are only 2-9 maternal deaths per 100,000 live births in the developed world, it is

alarming to observe that it ranges from 300-1000 per 100,000 live births in the developing world (World Bank, 2004; Cohen, 2009; World Bank, WHO and UNFPA, 1987). It is interesting to note that maternal mortality ratio in Nigeria is currently estimated at 800 to 1000 maternal deaths per 100,000 live births in 2000 (FMOH, 2006). And similarly, only 61 per cent of pregnant women received antenatal care from trained provider, only 32.6 per cent delivered in health facilities (NPC, 2004).

In a study conducted by the Federal Ministry of Health and the United Nations Population Fund (FMOH & UNFPA, 2003) on the quality of care, only 18.5% of the 4,500 facilities surveyed had the capacity to provide emergency obstetric care. Even where the skilled attendants were available, poor inter-personal relations had been reported to impact negatively on the utilisation of services by women.

A social audit of every maternal death that takes place in the developing world should be undertaken so that the underlying medical and non-medical problems are better understood and measures initiated for preventing its recurrence.

Methodology-

The study covers five (5) rural wards of Ado-Odo/Ota Local Government Area in Ogun State, Nigeria. The study used face-to-face structured interview and focus group discussion (FGD) with a two-level analytical approach in data analysis. In-depth interviews were held with specific stakeholders in the community, some officials of the five primary health care units in the wards selected and staff of the only general hospital residing in the Local Government of the study area. A stratified sampling technique was adopted in selecting the respondents who were ever married women in child bearing age (15-49) years who had at least one live-birth in the last two years preceding the survey. On the whole, 260 female respondents were randomly selected from five wards out of the sixteen wards in the local government area. They were interviewed through a face-to-face approach and focus group discussion with a two-level analytical approach capturing both the qualitative data and information from the discussion segment. The survey data were analysed statistically using statistical package for social sciences (SPSS) while information from the focus group discussions were transcribed and analysed using content analysis. A combination of univariate and bivariate analyses were conducted to ascertain maternal and infant mortality awareness and attitude of women towards those facilities available in the area. Pearson product moment correlation coefficient (r) coupled with the coefficient of determination (R^2) were incorporated to ascertain relationships, direction and the strength of the association between the variables of interest.

Results and Discussions

The results of the analysis are based on a few selected variables, to examine the reasons why pregnant mothers do not patronise health facilities especially in rural areas. The result (Appendix-1 Tables 1 and 2) show that the educational attainment of the respondents is very poor with slightly above half of the population having only secondary education (55.5%). Respondents with no schooling, those having primary level account for 22.7 and 18.2 per cent respectively. Nevertheless, a negligible number of the respondents had attained above secondary level education (3.6 %). This is serious in view of the importance of education as a vital force in shaping the whole gamut of an individual's life particularly mother's empowerment.

Distance to the health facility is also a major retarding factor in accessing health services among the five wards in the study area. While 68% of the respondents have health facility within two kilometres distance from their homes, a reasonable proportion (32%) of these respondents has to walk beyond three kilometres distance to access health services. This is a problem, especially as the road network is poor or virtually not in existence and lack of transportation. A pregnant mother will prefer to visit the next door traditional birth attendant rather than to walk for kilometres to the health centre where she has no confidence in the service.

The low status of women is manifested on who decides where the household including pregnant mother should go for treatment as well as the payment of the treatment costs. These are exclusively the domain of the husband especially in African countries where culturally, male dominance and women subjugation are normal ways of life. In the study area, 73 per cent of the respondents stated that it is their husbands who decide when and where to go for treatment and equally pay for the treatment costs. The implication of this is that a woman has no reproductive right whether pregnant or not. She is grossly incapacitated to take care of herself as permission is needed for any visit to health clinic .A number of socio-cultural beliefs and practices in Nigeria limit the ability of women to take independent decisions about their own lives, including the decision to seek appropriate health care. The decision-making power often lies with the husband or their male relatives.

The awareness of place of antenatal care (ANC) is fascinating as overwhelming proportion of the respondents admitted knowledge of place of ANC treatment (93%). However, the common reasons hindering attendance or registration for antenatal care is high cost of ANC service. Only one-tenth (10.5%) of the respondents agreed that what they spend at health centres is convenient (cheap) for them. However, 51.8 per cent and 37.7 per cent stated moderate and expensive charges respectively. Cost may reduce women's use of maternal health services from having hospital –based deliveries or seeking care even when complications arise. Information

gathered through in-depth interview revealed that even when formal fees are low, other informal costs such as buying complete delivery items, drugs, food, etc pose barrier to utilisation of available health services.

The assistants during pregnancy and child birth were identified to be nurses/midwives (56.8%), doctors (20%); and traditional birth attendants (17.7%) and relatives (5.5%). The worrisome aspect of this is the high proportion of mothers patronising home delivery at the hands of these non-medical personnel in Nigeria and other developing countries. The occupational status indicates that larger proportion of the respondents is into trading (37.7%). This is followed by unskilled/labourers (23.2%), farming (15.5%) and artisans (14.5%). On the other hand, mothers who are fulltime housewives account for the least (9.1%). Similarly, the husband's occupational status indicates that larger proportion of the respondent's husbands is into unskilled jobs (30%). This is followed by trading (27.7%), artisans (18.8%) and farming (12.7%). Nevertheless, 10 per cent of husbands are unemployed.

Other motivating forces are the availability of ambulance services and referral facility. Respondents will patronise health centres with the above facilities as the journey of pregnancy and child birth is not a smooth one in this part of the globe. However respondents' assertion on the provision of or existence of ambulance and referral arrangement registered 29% and 60% respectively. Feeling is an internal mechanism that drives one to his or her directional behaviour. When the feeling is not right, the propensity to patronise will be lacking. The general feeling of respondents about the services the health centre provides is considered in this study. While respondents who feel satisfied with the services account for 61.4 per cent, those who feel otherwise account for bothersome proportion (38.6%). The question on the age of the respondents at the time of survey shows that 15-19 years registered 15%, followed by 20-29 with 55%, 30-34 category accounts for 20% and the last category 35 years and above accounts for the least proportion (10%). It is observed that low age at marriage exist in the study population, as large proportion of them (70%) married in their 20s.It is equally interesting to note that while over half of the respondents (55%) petronise non-modern facility, slightly three-fifths of them stated that their husbands do not perceive pregnancy as risky journey. This relates to the causal treatment given to pregnant women in the study area.

Regression Analysis Results

To buttress the above findings, regression analysis was carried out (Appendix 2 Table 3). Regression analysis shows that husband's occupational status, perception of service; treatment decision and distance to health facility are negatively related to health programme usage by pregnant mothers in the study area. Educational attainments, payment of treatment bills,

respondent's age, husband's perception about pregnancy and perception of ANC cost are positively associated to ANC use. This implies that the higher the level of mothers' education, the more likely it is that they will use health facility or attend ANC counseling. However, except, religion and type of family all other variables are significantly related to the preferred health facility. This result implies that variables relating to husband such as occupation, perception about cost of service, treatment decision and payment of treatment cost weigh more on the use of modern health care services. This could be true because in this region male dominance is culturally supported. Thus whoever is in charge of both fund and decision is in control. Also higher social status by way of better husband's occupation implies more income that can encourage the wife to seek for modern medical services.

Furthermore, since the F- statistics calculated is greater than the F- tabulated the hypothesis that the socio-demographic characteristics of the respondents are significantly related to the health programme usage by pregnant mothers is upheld.

Policy Implications and Recommendations

Maternal health utilisation research is essential in actualising MDGs of reducing maternal mortality by half by the year 2015**.** Hence, the following recommendations may go a long way in the quest for a lasting solution in the campaign to stem maternal mortality and accelerate the utilisation of health facilities in Nigeria and other regions:

1. Costs alleviation for women seeking antenatal care and delivery services should be put in place to encourage women to patronise health services.

2. Restoration of the dignity of women, through education and empowerment for the prospective mothers. Generally, the use of maternal health care services increases positively with education. Both education and good occupation will bring women on board the decision-making realm including health care. In addition, education may increase and usher in late marriage which will reduce early pregnancy among women in the study area.

3. Effort should be made to train the traditional birth attendants to refine their operations and lessen the havoc caused by them. As we know that the use of modern health services is often influenced by individual perception or feelings of the efficacy of the services.

4. Orientation should be conducted for health workers on how to uphold the ethics of the profession and on rudimentary principles of human relations to make better friendly services.

5. Government should revitalise rural health operations and establish mid-way service delivery points (MSDPs) to reduce the problem of distance and further bring grass roots health care services closer to the rural population.

Conclusion

Maternal mortality in developing countries continues to be a serious public health problem and contributes to the low life expectancy in Nigeria. The study has identified several factors that have important influence on utilisation of maternal health services in the study area. Among these include the predictor variables such as education and occupation of mothers, distance to the health facility, and cost of antenatal care among others which are examined against the dependent variable-preferred health facilityf. Success in the scaling up the utilisation of health care services requires adequate and friendly services to boost confidence of the masses on health care services.

In addition, culturally appropriate health education especially on harmful traditional practices and benefits of safe motherhood should be employed as a short term measure. Socio-economic transformation and 'cultural revolution' should be effected for better healthcare utilisation among pregnant women. However, a more nationally representative sample survey study including urban and rural areas is needed to help examine extensively the socio-demographic and cultural factors limiting maternal utilisation of health services in Nigeria for wider application of findings.

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Appendix

Table 1 Socio-demographic characteristics of respondents

Variables	Number	Per cent
Educational Attainment		
None	59	22.7
Primary level	47	18.2
Secondary level	144	55.5
Tertiary level	10	3.6
Occupational status		
Farming	40	15.5
Full time housewife	24	9.1
Labourer/unskilled	60	23.2
Artisans	38	14.5
Trading	98	37.7
Occupational status of husband		
Farming	33	12.7
Labourer/unskilled	78	30
Artisans	49	18.8
Trading	72	27.7
unemployed	28	10.8
Religion		

Christianity	158	60.8
Islam	76	29.2
Traditional	26	10.0
Type of Family		
Nuclear	172	66.2
Extended	88	33.8
Age		
15-19 years	46	17.7
20-29 years	145	55.8
30-34 years	45	17.3
35 years	24	9.2

Source: Field Survey 2011

Table 2 Health utilization characteristics of respondents

Variables	Number	Per cent
Distance to health facility		
< 1 km	122	46.8
1-2 km	54	20.9
3-4 km	24	9.1
5 km and above	60	23.2
Treatment decision		

Husband	189	72.7
Wife	43	16.4
Relatives/Neighbors	28	10.9
Knowledge of p lace of ANC treatment		
Yes	241	92.7
No	19	7.3
Perception of ANC cost		
Very expensive	5	1.8
Expensive	93	35.9
Moderate	135	51.8
Cheap	27	10.5
Assistance during delivery		
Doctors	52	20.0
Nurses/Midwives	148	56.8
TBAs	46	17.7
Relatives	14	5.5
Availability of ambulance at health facility		
Yes	74	28.6
No	186	71.4

Awareness of referral facility at the health center		
Yes	156	60.0
No	104	40.0
Feeling about services		
Satisfactory	160	61.4
Unsatisfactory	100	38.6
Preferred health facility		
Hospital/PHC	117	45
Traditional Healer	81	31
Faith clinic	39	15
Indifference	23	9
Husband's perception about pregnancy		
Risky	101	39
Non-risky	138	53
Indifference	21	8

Source: Field Survey 2011

Appendix-2

Table 3: Regression Analysis

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.991[a]	.982	.980	.10761

a. Predictors: (Constant), Respondent's education, Religion, Respondent's age, Distance to Health facility, Husband's occupation, Decision on where to go for treatment, Who pays the treatment bills, Feeling of services, Husband's perception about pregnancy, Type of family, Perception of ANC cost.

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	60.840	11	5.531	477.614	.000[a]
	Residual	1.123	97	.012		
	Total	61.963	108			

a. Predictors: (Constant), Respondent's education, Religion, Respondent's age, Distance to Health facility, Husband's occupation, Decision on where to go for treatment, who pays the treatment bills, Feeling of services, Husband's perception about pregnancy, Type of family, Perception of ANC cost.

b. Dependent Variable: Preferred health facility

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	3.018	.219		13.805	.000
	Religion	.004	.024	.003	.173	.863
	Type of family	-.009	.012	-.012	-.755	.452
	Husband's occupation	-.034	.013	-.045	-2.644	.010
	Educational attainment	.046	.012	.076	3.863	.000
	Husband's perception about pregnancy	.063	.021	.058	3.053	.003
	Perception of service	-1.243	.057	-.736	-21.839	.000
	Perception about ANC cost	.567	.040	.321	14.304	.000
	Treatment decision	-.138	.029	-.101	-4.767	.000
	Distance to health facility	-.106	.024	-.101	-4.367	.000
	Who pays the treatment bills	.547	.032	.362	16.938	.000
	Respondent's age	.107	.028	.066	3.817	.000

a. Dependent Variable: Preferred health facility