SOCIO-ECONOMIC FACTORS INFLUENCING THE UTILIZATION OF MATERNAL HEALTH CARE SERVICES IN AMUWO-ODOFIN LOCAL GOVERNMENT AREA OF LAGOS STATE, NIGERIA

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ABSTRACT

The use of maternal healthcare services reduces maternal mortality, which is unimaginably high in Nigeria. Therefore, this study investigates the socio-economic factors influencing the utilization of maternal healthcare services in Amuwo-Odofin Local Government Area of Lagos state, Nigeria. Each of the socioeconomic factors of women and their spouses which include: income, occupation, education and culture were examined. Primary data was gathered through administration of questionnaires in the study. A total sample size of 230 respondents was selected. The univariate, bivariate, chi-square test and Analyses of variance (ANOVA) were employed in order to identify the influence of socio-economic variables on the use of maternal health care services in the study. Findings from Chi-square analyses depict that respondents' income (p=0.000), culture (p=0.000) and educational status (p=0.000) have significant influences on the use of maternal healthcare services in the study. Further results from one-way ANOVA reveal that respondents' occupational status (p=0.011) has significant influence on the use of maternal healthcare services in the study. Therefore, this study recommends that the government should channel more of her resources and attention to ensuring a more sustainable growth of women's socio-economic status in Nigerian society.

KEYWORDS: Maternal Healthcare Services, Utilization, Socio-Economic Factors

INTRODUCTION

Background to the Study

Maternal health is a crucial indicator of quality of health care in any country. The health of a woman is tied to the health and wellbeing of her children, her family and community as a whole. Thus, when there is maternal mortality, it reflects one of the shameful failures of human development in a country (freedman et al, 2003). The continued increase in maternal mortality is an issue of concern in the world today.

According to World Health Organization (WHO, 2005), about 80% of maternal mortality worldwide occur due to hemorrhage, sepsis, induced abortion, hypertensive disorder of pregnancy and obstructed labour among others. Of-course, such happenings are unpleasant and can be avoided by key health interventions such as: provision of antenatal care services, medically assisted birth delivery and so on (Adam et al. 2005; MCcaw-Binns et al. 2009). No doubt, the tragedy of not taking steps in preventing these preventable diseases resulted in 536,000 maternal deaths worldwide in the year 2005 (World Health Organization; 2007). Apart from the afore-stated proportion of deaths, about 10 million women suffer from various body weakening illnesses and life-long disabilities across the globe (United Nations, 2007). Unfortunately, 75% of death occurs during delivery and postpartum period. Therefore, increasing attention has been placed on maternal health globally in order to reduce maternal mortality. In 2000, there was an estimate of 529,000 maternal deaths worldwide, and from this figure, Asia and Africa accounted for about 95% (502,550) deaths, where each continent contributing half of

this figure, and about 4% (22,000) occurring in Latin America and the Caribbean and less than 1% (2,500) in developed countries.

By definition, maternal health refers to the health of women during pregnancy, child birth and postpartum periods. Maternal health care service utilization would is very important for the early detection of mothers who are at high risk of illness and eventually die during pregnancy. In effect, the key maternal health care services that should be rendered during pregnancy include antenatal care (ANC) or prenatal care, skilled care during delivery and postnatal or postpartum care (PNC) (Adam et al. 2005; MCcaw-Binns et al.; 2007). Although, the risk of maternal death is extremely high in developing countries, it is often assumed that maternal mortality is not a challenge in wealthier countries. Yet, the United Nations estimates (2010) revealed that the United States ranked 50th in the World for maternal mortality, with its maternal mortality ratio higher than all other European nations and also some countries in Asia and the Middle-East. Although, in some most industrialized nations, this is not the case. For example, China has made a remarkable progress in maternal health nationally, their overall maternal mortality has reduced from 64 per 100,000 in 1996 to 38 per 100,000 in 2008, and total deliveries in the hospital rose to 94.7% also in 2008. All these successes can be attributed to the government's efforts to promote maternal health services. However on a general note, the average number of women that die is between 10 and 15 per 100,000 live births in developed countries. According to United Nations Children's Fund (2008) report, over 500,000 women die annually due to complications from pregnancy and child birth, and unfortunately, 99% of these deaths occur in developing countries. To be specific, about 56% of these deaths occur in sub-Saharan Africa, with another 29% in south Asia, thus, these two regions are responsible for 85% of maternal mortality (World Bank data, 2012).

At this juncture, it is expedient to enumerate the socio-economic factors influencing the use of maternal health care services in Nigeria as follows: Education as a socio economic factor has major influence on the use of maternal health care services. For instance, Orubuloye (1998); women that are educated tend to seek better health treatment for themselves and their children than women that are not educated. However, the higher the educational level of a woman, the higher her knowledge base on the importance of maternal healthcare to her and that of her child. The attainment of higher educational status gives greater and effective decision making power, and also provides a platform for comprehending health information much better. Women with basic education on health issues increase their awareness on the importance of utilising maternal healthcare services for their good and their children. It also ensures that women are aware of the dangerous signs and symptoms associated with pregnancy. According to World Health Organisation, about 88 to 89 per cent of death related to pregnancy causes would have been prevented if women had access to and utilized reproductive healthcare services (Kunst and Houweling, 2001). Income level is one of the main factors that directly or indirectly hinder a woman's access to utilization of maternal health care services in developing countries with 'low incomes'. According to World Health Organisation (2004) estimates, 60% of births in low income countries occur outside a health facility where 47% were assisted by only traditional birth attendants and family members. The impact of fees on health care service often reduce women's use of maternal healthcare services and therefore keep millions of women from taking delivery in hospitals and seeking health care when complications arises, this is a major barrier to women in deciding whether to utilize these services or not. Such costs may include: costs of transport, drugs, feeding, accommodation charges, etc and this has resulted them seeking assistance from traditional birth attendants, and spiritual healers as alternatives for health care services (El-sefly, 2001 and Mairiga, 2003). Unfortunately, the major factor responsible for high maternal mortality rate in Nigeria is poverty, where more than a quarter of Nigerians live on earnings below #150 per day (Benjamine C. Ozumba, 2012). Most times, traditional beliefs, religion, ethnicity and so on are the major determinants of the cultural backgrounds that somehow influence the beliefs and values of households in relation to the utilization of maternal health care

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(Elo, 1992). According to World Health Organisation (2005), the utilization of maternal healthcare services by women is greatly constrained by their lack of decision making, especially in Africa, where there is strong patriarchal system, which greatly hinders women's decision making power. No doubt, various studies have depicted that cultural belief hinder a woman from utilizing maternal health care services. For example, Northern Nigeria's culture emphasizes privacy of the women's body (that is, purdah). With this belief, women in the Northern part of Nigeria are not likely patronise maternal health care services during the delivery of their babies. Although, some studies have ignored polygamy which is a customary practice where by a man has more than one wife, it's a practice that is very rampant, especially among traditionally inclined people. Evidence has shown that women involved in polygamous marriages are less likely to utilize maternal healthcare services (Stephenson et al; 2006). Studies on occupation reveals that women in paid employment tend to start going for antenatal visits earlier (Magadi, 2004). In essence, they are likely to have more knowledge about pregnancy and giving birth, due to freedom outside household confinement. This further exposes women to information on the maternal healthcare services available to them and needed by them. In-fact, a prominent study also indicated that women with low-income occupations (especially subsistence farming) are less likely to utilize maternal healthcare services (Nwakoby, 1994). Nevertheless, the occupation of husband is very crucial in the sense that it determines the family's income, and an increase in his income would enable him to be financially responsible for the utilization of modern healthcare service for his wife (Elo, 1992).

However, this study is justified with the fact that previous studies shows that the utilization of maternal health care services is directly related to the cultural, obstetric and socio-economic characteristics of the women who are being surveyed (Bell et, al 2003). If women are well informed and educated on crucial areas of their lives such as: family planning, use of birth-attendant during delivery, and antenatal and postnatal care, it would go a long way in reducing the maternal mortality. Also, this study is justified with the fact that it has not been systematically carried out in Amuwo Odofin Local Government Area of Lagos state, Nigeria.

At this point, it is pertinent to note that this study intends to answer the follow questions: Firstly, what is the relative importance of educational status on the use of maternal health care services? Secondly, how does income level affect the usage of maternal health care services? Thirdly, how does culture determine the usage of maternal health care services? Fourthly, what influence does occupation have on the utilization of maternal health care services?

Therefore this study intends to examine the socio-economic factors influencing the utilization of maternal healthcare services among women of reproductive ages in Amuwo Odofin Local Government Area of Lagos state, Nigeria.

Methods and Materials

The study area for this research is Amuwo Odofin local Government Area of Lagos state, Nigeria. Amuwo Odofin Local Government Area is one of the 57 Local Government Councils that make up Lagos State, which was created out of the old Amuwo Odofin Local Government on the 27th of October 2003. It covers a land mass of 100sqkm, divided into two distinct geographical spheres of upland and riverine areas. The estimated population size of Amuwo Odofin Local Government in 2006 Nigeria's population census was 524,974. The total population for male in Amuwo Odofin Local Government Area is 301,012 while that of female is 223,959. At this juncture, it is vital to reiterate that the choice of Amuwo Odofin Local Government Area of Lagos state is premised on the fact that it is close to the researcher base.

The data collection was collected in this study by interviewing women through questionnaires administration. The scope of study is women of child bearing age, particularly, those who belong to the age bracket of 15-49 years. They are majorly pregnant women or might have given birth to a child or children.

From onset, a total sample size of 250 women of child bearing ages (15-49 years) was interviewed. The first level of selection was done through simple random sampling of 5 health care centres from private and public health care centres in Amuwo Odofin Local Government Area. 50 questionnaires were administered in the selected five (5) health centres in the study area. The health centres were picked through lottery method, and in each health care centre, 10 questionnaires were administered. However, due to loss of questionnaires, 230 respondents were returned. The technique used in this research is a quantitative approach. The target population was divided into 3 quotas, namely: churches, market place and schools. A simple random sample was used in selecting the women, from the different locations where 100 questionnaires were administered to schools, 50 to churches and 50 to market place. The analysis of the data collected was done by using the univariate, bivariate and the multivariate analysis using the SPSS software (Version 15.0).

Table 1: Percentage Distribution of Selected Socio-Economic and Demographic Factors

VARIABLE	FREQUENCY	PERCENT
AGE OF RESPONDENTS		
15-24	30	13.0
25-34	88	38.3
35-44	89	38.7
45-49	23	10.0
Total	**230**	**100.0**
RELIGION		
Christianity	146	
Moslem	50	63.5
Traditional	13	21.7
others	21	5.7
Total	**230**	**9.1**
MARITAL STATUS		100.0
Married	182	79.1
Single	28	12.2
Divorced	6	2.6
Others	14	6.1
Total	**230**	**100.0**
ETHNIC GROUP		
Yoruba	81	35.2
Ibo	75	32.6
Hausa	35	15.2
Others	39	17.0
Total	**230**	**100.0**
EDUCATION OF RSPONDENT		
No education	33	14.3
Primary	66	28.7
Secondary	80	34.8
Tertiary	51	22.2
EDUCATION OF HUSBAND		
No education	15	6.5
Primary	39	17.0
Secondary	80	34.8
Tertiary	77	33.5
Total	**211**	**91.7**
INCOME OF RESPONDENT		
#10,000 & below	102	44.3
#10,000 – 50,000	110	47.8
#50,000 & above	16	7.0
Total	229	99.6
INCOME OF HUSBAND		
#10,000 & below	24	10.4
#10,000 – 50,000	136	59.1

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Table 1: Contd.,

#50,000 & above	44	19.1
Total	**205**	**89.1**
OCCUPATION OF RESPONDENT		
Farmer	16	7.0
Trader	122	53.0
Civil servant	42	18.3
Fulltime house wife	28	12.2
Schooling/unemployed	21	9.1
Total	**229**	**99.6**
OCCUPATION OF HUSBAND		
Farmer	9	3.9
Trader	111	48.3
Civil servant	83	36.1
Full time house wife	2	.9
Schooling/unemployed	0	0
Total	**205**	**89.1**

Source: Field Report, 2014

Interpretations on Table 1 Frequency Distribution

The table above shows the percentage distribution of the respondents' socio-demographic characteristics. For the age of respondent, a slightly higher percentage of respondents (38.7) who belong to age category 35-44 years compared to their counterparts who belong to 25-34 years category with 38.3 percent. No doubt, Christians dominated the study with 63.5 percent compared to their Moslem counterparts with 21.7 percent. Married respondents constituted a greater percentage (79.1) compare to their counterparts who are single (12.2 percent) in the study. Ethnicity showed that higher percentage of Yoruba people (35.2) were interviewed compared to Ibo counterparts (32.6 percent). By educational status, a slightly higher percentage of respondents acquired secondary education (34.8) compared to those who acquired primary education (28.7) in the study area. Also, the respondent's husband education revealed a slightly higher percentage (34.8) of those who acquired secondary education than those who acquired tertiary education (33.5) in the study. With reference to income level, a greater percentage of respondents (47.8) received income ranging from #10,000 and above compared to those (44.3 percent) who earned the income within the range of #10,000 - #50,000 in the study. Furthermore, the income of respondent's husband showed that a greater percentage (59.1) earned between #10,000 and #50,000 while 19.1 percent received #50,000 and above in the study. The occupational status depicted that a higher percentage of respondents (53.1 percent) engaged in farming while their counterparts are civil servants (36.1 percent) in the study.

**Table 2: Cross Tabulation of Income, Education, Occupation with
'Those Who Render Assistance to the Respondents during Delivery'**

VARIABLES		**THOSE WHO RENDER ASSISTANCE TO RESPONDENTS DURING DELIVERY**									
		Midwife (%)		**Relation (%)**		**Friend (%)**		**Traditional Attendant (%)**		**Total (%)**	
Respondent's Educational status	No Education	5	15.2%	18	54.5	3	9.1	7	21.2	33	100
	Primary Education	30	45.5%	14	21.2	3	4.5	19	28.2	66	100
	Secondary Education	51	63.8%	9	11.3	5	6.3	15	18.8	80	100
	Tertiary Education	49	96.1%	0	.0	1	2.0	1	2.0	51	100
Total		**135**	**58.7**	**41**	**17.8**	**12**	**5.2**	**42**	**18.3**	**230**	**100**
		Midwife (%)		**Relation (%)**		**Friend (%)**		**Traditional Attendant (%)**		**Total (%)**	

Table 2: Contd.,

Husband's Educational status		Midwife	(%)	Relation	(%)	Friend	(%)	Traditional Attendant	(%)	Total	(%)
Husband's Educational status	No Education	3	20.0	8	53.3	2	13.3	2	13.3	15	100
	Primary Education	8	20.5	11	28.2	2	5.1	18	46.2	39	100
	Secondary Education	42	52.5	18	22.5	6	7.5	14	17.5	80	100
	Tertiary Education	70	90.9	0	.0	0	.0	7	9.1	77	100
Total		**123**	**58.3**	**37**	**17.5**	**10**	**4.7**	**41**	**19.4**	**21**	**100**
		Midwife (%)		Relation (%)		Friend (%)		Traditional Attendant (%)		Total (%)	
Husband's income Level	#10,000 &below	5	20.8	8	33.3	3	12.5	8	33.3	24	100
	#10,000 - #50,000	74	54.4	24	17.6	6	4.4	32	23.5	136	100
	#50,000 & above	41	93.2	3	6.8	0	.0	0	.0	44	100
Total		**121**	**59.0**	**35**	**17.1**	**9**	**4.4**	**40**	**19.5**	**205**	**100**
		Midwife (%)		Relation (%)		Friend (%)		Traditional Attendants		Total (%)	
Level of income	#10,000 &below	35	34.3	31	30.4	10	9.8	26	25.5	102	100
	#10,000-#50,000	83	75.5	10	9.1	2	1.8	15	13.6	110	100
	#50,000&and above	15	93.8	0	.0	0	.0	1	6.3	16	100
Total		**134**	**58.5**	**41**	**17.9**	**12**	**5.2**	**42**	**18.3**	**229**	**100**
		Midwife (%)		Relation (%)		Friend (%)		Traditional Attendants (%)		Total (%)	
Occupation	Farmer	2	12.5	8	50.0	1	6.3	5	31.1	16	100
	Trader	71	58.2	19	15.6	9	7.4	23	18.9	122	100
	Civil Servant	41	97.6	0	.0	0	.0	1	2.4	42	100
	Full housewife	8	38.6	11	39.3	1	3.6	8	28.6	28	100
	Schooling/unemployed	12	57.1	3	14.3	1	4.8	5	23.8	21	100
Total		**134**	**58.5**	**41**	**17.9**	**12**	**5.2**	**42**	**18.3**	**229**	**100**
		Midwife (%)		Relation (%)		Friend (%)		Traditional Attendant (%)		Total (%)	
Husband's Occupation	Farmer	1	11.1	3	33.3	1	11.1	4	44.4	9	100
	Trader	43	38.7	28	25.2	7	6.3	33	29.7	111	100
	Civil servant	76	91.6	3	3.6	1	1.2	3	3.6	83	100
	Fully at home	2	100	0	.0	0	.0	0	.0	2	100
Total		**122**	**59.5**	**34**	**4.4**	**9**	**4.4**	**40**	**19.5**	**205**	**100**

Source: Field Report, 2014

Interpretations of Cross Tabulation Results of Income, Education, Occupation with 'Those who Render Assistance to the Respondents During Delivery'

Table 2 reveals the cross tabulation of respondents' education, income and occupation with those who render assistance to them during delivery. Greater proportion of respondents with tertiary education (96.1 percent) received assistance from midwives during delivery compared to their counterparts who acquired secondary education (63.8 percent) in the study. No doubt, a higher proportion of respondent's husband with tertiary education (90.9 percent) indicated that their wives received assistance from midwives during delivery compared to their counterparts who acquired secondary education (52.5 percent) in the study. Obviously, more proportion respondent's husband (93.2 percent) with income level between #50,000 and above said that their wives received assistance from midwives during delivery than their counterparts (54.4 percent) with income level between #10,000 and #50,000 in the study. Moreover, a greater proportion of respondents (93.8 percent) with income level between #50,000 and above indicated that they received assistance from midwives during delivery compared to their counterparts (54.4 percent) with income level between #10,000 and #50,000 in the study location. In-fact, the occupational status showed that higher proportion of respondents (97.6 percent) who are civil servants received assistance from midwives during delivery compared to their counterparts (58.2 percent) who are traders. Furthermore, a greater proportion of respondents (100 percent) whose husbands are 'fully at home' indicated that they

received assistance from midwives during delivery compared to their counterparts (91.6 percent) who are civil servants in Amuwo Odofin Local Government Area of Lagos state.

Table 3: Chi-Square Test

Variables	Maternal Health Care Services		
	Chi-Square (a,b)	Df	Asymp. Sig.
Secondary education	16.873	1	0.000
Low Income	10.105	1	0.000
Monogamous is more Polygamous families	77.652	1	0.000

Source: Field Report, 2014

Interpretations on Chi-Square Test

Table 3 displays the relationship of secondary education, low income and more monogamous than polygamous family with the use of maternal health care services in the study location. At p=0.000, there is a high significant relationship between women with secondary education and their use of maternal health care services. This implies that secondary education of women has significant influence on the utilization of maternal health care services in Amuwo Odofin Local Government Area of Lagos state, Nigeria. Also, at p=0.000, there is a high significant relationship between women with low incomes and their use of maternal health care services. This implies that the low incomes of women have strong influence on the utilization of maternal health care services in the study area. Obviously, when p=0.000, there is a high significant interaction between the use of maternal health care services and women with monogamous than polygamous families. This implies that women with monogamous families are more likely to patronise the maternal health care services in their vicinity. The emphasis is that monogamy as a 'culture' has significant influence on the patronage of maternal health care services in the study area.

Table 4: One-Way Analysis of Variance (Anova)

Characteristics	Sum of Squares	Df	Mean Square	F	Sig.
Occupation between Groups	10.479	2	5.240	4.641	.011
Within Groups	250.650	222	1.129	-	-
Total	**261.129**	**224**			

Source: Field Report, 2014

Interpretations on One-Way Analysis of Variance

From Table 4, when p=0.011, it can observed that there is a significant relationship between the occupational status of the women, and their use of maternal health care services. The implication is that women who are gainfully employed have greater tendencies to register and attend antenatal and postnatal clinics in the study.

Summary of Findings

This recent study focused on the socio-economic factors influencing the use of maternal healthcare services by women of childbearing ages (15-49 years) in Amuwo Odofin Local Government Area of Lagos state, Nigeria. Evidences from chi-square tests showed that education, income and culture have significant influences on the utilization (use) of maternal health care services in the study location. Further finding from One-way Analysis of variance revealed that occupation has significant influences on the utilization (use) of maternal health care services in the study.

CONCLUSIONS

This study is concluded with the following facts: firstly, the finding of this study corroborate that of Orubuloye (1998); which posits that women who are educated tend to seek better health treatment for themselves and their children.

Secondly, this study buttressed that women with low incomes can not afford to pay for maternal health care services because they survive on income of 150 naira per day (Benjamine C. Ozumba, 2012). Thirdly, the result of this study also agreed with the previous finding of Stephenson (et al; 2006) which indicate that women with polygamous families are less likely to utilize maternal health care services. Fourthly, this recent is in support of the finding of Nwakoby (1994); which indicated that women with low occupation (farming) are less likely to utilize maternal health care services. From the above evidences, it can be inferred that socio-economic factors have influenced the utilization of maternal health care services in Amuwo Odofin Local Government Area of Lagos state, Nigeria.

Recommendations

The recommendations of this study are stated as follows: Firstly, there should be urgent policy that would be geared towards raising the level of female education to tertiary level in Nigeria. Secondly, there should be realistic provision of small and medium loan schemes that are accessible by the Nigerian women in order to boost their trading and business activities. Thirdly, Nigerian men should restrict themselves to monogamous families so that they can fully provide for their families especially maternal health care. Fourthly, there should be creation of more jobs by the governments and wealthy individuals with special consideration to engage more women in every sector of economy in Nigeria. In a nut shell, this study recommends that the government should channel more of her resources and attention to ensuring a more sustainable growth of women's socio-economic status in Nigerian society.

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