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Title

A review of maternal health care utilisation in Edo South, Nigeria

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Abstract

This study examines the impact of cultural beliefs on maternal healthcare utilisation in selected communities of Edo South Senatorial District; implications for social work education and practice in Nigeria. The study adopted a sample survey research design. This model of research design was used due to the efficiency and accuracy it provides, the level of validity and how it objectively answers questions pertinent to the objective of the study. The population of this study were females within the reproductive age of 15-49 years that reside in the study area. The study adopted the cluster sampling method with the local government areas in the district constituting the cluster. Data generated in this study were analysed using both quantitative and qualitative approaches. Data were analysed with both descriptive and inferential statistics while results were presented in simple and understandable forms. The finding established that tradition and cultural practices in many communities in Edo South Senatorial district especially in the rural settlements influence health care utilisation. The nature of cultural orientation of the people in this area make them to consider formal healthcare services highly sophisticated, expensive and unaffordable to the local people hence women need the approval of their husbands or relations before they can visit the maternity centre.

Key words

culture, healthcare, maternal mortality, social work, utilisation, Nigeria

Key dates

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Introduction and Background

Loss from maternal-related causes is a significant social and personal tragedy that reflects one of the shameful failures of human development (Freedman, et al, 2013). Thus, a healthy maternal health implies progress of a functional human development index of any society. This is due to the significant roles women play in child upbringing and management of family affairs. Hence, they deserve to be given adequate care and attention during pregnancy, delivery and postpartum periods to enable them realise their full potentials (Owoseni, Adewumi & Alade, 2015).

In Nigeria, women still maintain high reproductive capacity with an average total fertility of 5.7 births in their life time and each pregnancy exposes them to the risk of maternal complications (Obasi, 2013). The outcomes of this maternal conception underscore the quality of healthcare services received during pregnancy and delivery which is important for the health of both the mother and the baby. Thus, when women's ability to seek healthcare is intact and not compromised, it reduces maternal mortality rate in child birth, however, some pregnant women in Nigeria do not receive the minimum number of antenatal care services (at least 4 times during pregnancy) as recommended by the World Health Organisation (WHO), hence increasing the chances of high maternal mortality rate (Joseph**,** 2019).

Annually, as many as 60,000 Nigerian women die due to pregnancy related complications making it second to India in terms of absolute number of maternal deaths (Dawud, 2016). About 80 percent of the maternal deaths are linked to haemorrhage, sepsis, unsafe induced abortion, hypertensive disorder during pregnancy, and obstructed labour (WHO 2005). These deaths are avoidable and compounded by low social economic background, weak management in the implementation of health policies/services and importantly by cultural factors (Yar'Zever, 2014).

According to Ugbor, et al. (2017), childbirth is a social and cultural event that is often governed by norms. However, in most societies, the dominant culture, expressed through social institutions such as the health care system, regulates how health issues are both perceived and addressed. Differences between the cultures of health care services and service users have been recognised as a major issue in service delivery (World Health Organisation [WHO], 2007). Hence, the normative order seems to be significant in women accessibility to maternal healthcare of any nation. This is because values and norms of a society has a way of restricting accessibility of healthcare as well as gender differences and racial discriminations which also increase inequality in access to healthcare. Thus, the study examines the impact of culture in utilisation of healthcare services among women of the reproductive age in Edo South senatorial district. It specifically examines why women fail to utilise healthcare institutions for antenatal care even when available.

The study examines the impact of culture on maternal healthcare utilisation in selected communities of Edo South Senatorial District.

Research Method

The study adopted a sample survey research design. This model of research design was used due to the efficiency and accuracy it provides, the level of validity and how it objectively answers questions pertinent to the objectives of the study (Ukponahiusi, 2017). The population of study includes females within the reproductive age of 15-49years that reside in the study area. There are 586,478 women aged 15-49 years residents in Edo South Senatorial District as at 2018. The study adopted the cluster sampling method with the local government areas in the district constituting the cluster. The sample size for this study was 484. Out of this number, 189 were picked from Oredo LGA, 161 from Egor, and 134 from Uhunmwode local government area. To get the stated number of participants in the three LGAs, the systematic random sampling technique was adopted. Every two houses in each street were evenly selected for the study. That is, house numbers 2, 4, 6, 8... were selected, and the heads of the households were administered the questionnaires. The selection of households was without prejudice to the sex of the research participant(s). The questionnaires were administered by two researchers, who also aided in the moderation of the in-depth interview. The variation (differences) in size of the LGAs selected shows the numerical strength of the population of the LGAs in question. Data generated in this study were analysed using both quantitative and qualitative approaches. Data obtain from structured questionnaires were analysed with descriptive statistics and presented in simple and understandable forms while the generated hypothesis was tested using chi-square statistical measure at alpha level 0.5.

Table 1: Percentage distribution of participants

Socio-demographic profile	Variables	Frequency	Percentage
Age	15-25years	120	25.6
	26-35years	91	19.5
	36-45years	59	12.6
	46-49years	17	3.6
	TOTAL	468	100.0
Marital Status	Single	120	25.6
	Married	285	60.9
	Widowed	28	6.0
	Divorced	35	7.5
	TOTAL	468	100.0
Educational qualification	Never went to School	23	4.9
	Primary School	109	23.3
	Junior Secondary School	8	1.7
	Senior Secondary School	91	19.4
	DIPLOMA/OND/NCE	146	31.2
	B.Sc./B.A/HND	91	19.4
	TOTAL	468	100.0
Religious Affiliation	Christianity	403	86.1
	Islam	39	8.3
	AR	16	3.4
	Others	10	2.1
	TOTAL	468	100

Source: field work, 2019

Table 1 showed the socio demographic characteristics of respondents in the study. The data distribution on respondents' last birthday indicated were for those aged 15 and 49years which is the global recognised reproductive age. The data revealed that respondents within the ages 41years and 45years were the highest in the study. Women within this age category were more relax and ready to participate in the research. This probably because they were more experienced in respect to the topic under discussion. For example, 181, representing 38.7% of the respondents were between 41years - 45years, 17 representing 3.6% of the respondents were between 46 - 49years were 17 or 3.6%. A total of 12.6% of the respondents or 59 persons were between the age brackets 31 - 35years. Furthermore, 28 representing 6% were between the age brackets 26 - 30years while respondents between 21years - 25yers old where between the ages bracket 83 representing 17.7%.

Data in Table 1 further revealed that, 37 respondents or 7.9% were between 15 - 20years old. This meant that opinion of respondents about the relationship between cultural factors and maternal healthcare utilisation by implication maternal mortality level differs according to the age of respondents. For example, respondents between 41 - 45years in the study were more. This indicated that those between 41 - 45years were more likely to utilise healthcare services before, during and after pregnancy than those from other age categories put together. That is, women within the reproductive age 41 - 45years old utilisation of healthcare services could be because they were more knowledgeable in terms of healthcare service use than younger women and adolescents. Sometimes, women of older age could have more influence in household decision making; hence more likely to use healthcare facilities for childbirth particularly when they are well experienced and have good financial status. The fact also that maternal age within this category is known to be a risk factor for poor maternal birth outcomes, and this may sometimes warrant the use of health facilities by older pregnant women (Ugbor, et al., 2017). Although this run a variance with the belief that older women are more likely to hold tenaciously to cultural beliefs than the younger mothers.

Data on educational attainment of the respondents revealed that a larger proportion of the respondents had formal education. Educational attainment levels were first grouped into formal and informal levels, and further regrouped into four categories according to the degree of qualifications. On the first grouping, data revealed that more than half of the respondents had formal education. While those without formal educations were mainly from the rural settlements in the study area. This limited opportunity to formal education in rural areas could be the reason for their non-possession of former education.

With regards to the religious affiliation of respondents, data in Table 1 showed that 403 of the respondents representing 86.1% were Christians, 39, respondents representing 8.3% of the respondents are Muslims, while 16 representing 3.4% of the respondents were African African worshipers (AR).

The table also revealed that 10 of the respondents representing 3.4% are into other forms of religious practices. This meant that a larger proportion of the respondents in the study were Christians. This is not surprising because Edo South inhabitants are predominantly Christians.

Research Question: What is the impact of cultural barriers on access to maternal healthcare utilisation in the study area? The question aim to ascertain the role of culture to healthcare services utilisation.

Table 2(a): Frequency distribution of respondents view on cultural barriers that hinder access to maternal healthcare

	Variable	Frequency	Percentage
Does your culture restrict women from accessing healthcare when pregnant?	Yes	99	21.2
	No	337	72.0
	Cannot Tell	32	6.8
	TOTAL	468	100.0
Do you think culture has role to play in determining whether a pregnant woman will access healthcare or not?	Yes	202	43.2
	No	199	42.5
	Cannot Tell	67	14.3
	TOTAL	468	100.0
Does your culture encourage African medicine as healthcare for women during pregnancy?	Yes	342	73.1
	No	78	16.7
	Cannot Tell	48	10.3
	TOTAL	468	100.0
Do you think gender differences can increase inequality in access to healthcare among pregnant women?	Yes	203	43.4
	No	195	41.7
	Cannot Tell	70	15.0
	TOTAL	468	100.0
Do the values and norms of your community restrict access to medical healthcare for pregnant women?	Yes	173	37.0
	No	230	49.1
	Cannot Tell	65	13.9
	TOTAL	468	100.0

Source: field work, 2019

Table 2(b): Cross tabulation of respondents views on cultural barriers that hinder access to maternal healthcare by religious affiliation

			Does culture restrict women from accessing healthcare?			Total
			YES	NO	CANNOT TELL	
Respondents	Christianity	Count	71	306	26	403
		% within Respondents	17.6%	75.9%	6.5%	100.0 %
	Islam	Count	20	19	0	39
		% within R Respondents	51.3%	48.7%	0.0%	100.0 %
	AR	Count	4	8	4	16
		% within Respondents	25.0%	50.0%	25.0%	100.0 %
	Others	Count	4	4	2	10
		% within Respondents	40.0%	40.0%	20.0%	100.0 %
Total		Count	99	337	32	468
		% within Respondents	21.2%	72.0%	6.8%	100.0 %

Source: field work, 2019

Discussion

Traditions and culture of a community seem to frown at formal healthcare medicine as too sophisticated, expensive and unaffordable to the local people hence women need the approval of their husbands or relations before they can visit the maternity centre. The notion of these communities is that the maternity is a death trap and no go area. Table 2(a) showed respondents response on question bothering on cultural barriers to maternal healthcare. Table 2(a) revealed that among the total respondents, majority agreed that the culture a woman holds invariably influences her decision as to the health services to utilise when pregnant. Thus, cultural inclination encourages African medicine/herbs for women during pregnancy. For example, 342 representing 73.1% of the respondents agreed that their culture encourages African medicine before, during and after pregnancy while 48 representing 10.3% of the respondents were undecided as to whether culture encourages women not to seek formal antenatal care.

The table also revealed that among the total respondents, 203 representing 43.4% of the respondents believed that cultural factors such as gender differences can increase inequality in access to healthcare, 195 of the respondents representing 41.7% however did not believe that gender difference could be issues in regard to inequality why women will not access healthcare while 70 representing 15% said they cannot tell. This suggests that majority of the respondents are of the opinion that gender differences increase inequality in access to maternal healthcare. That is, gender difference increases inequality in the level of access to healthcare. In a study conducted in Bangladesh, it was discovered that gender role expectations are primarily male dominated and limit the autonomous decision making of women when it comes to

prenatal and postpartum care, nutrition, and daily activities. These expectations may further increase the risk of problems during childbirth or in the postpartum period.

Many women delay in seeking healthcare because failure of their husbands to give consent. This is often the case in most patriarchal society where there is heavy male dominance in decision making. For example, in Northern Nigeria, the decision to seek healthcare is a matter that the husband must give consent to else it becomes stern issue between the man and the wife. Studies also showed that in countries like Bangladeshi, tradition dictates that women rely deeply on their husband and mother-in-law for direction regarding nutrition, healthcare, finances, and daily activities (Bloom, 2001). Tradition also dictates that women should be inactive during pregnancy and observe a 40-day waiting period for physical and sexual activity in the postpartum period. Furthermore, many women rely on African medicines and spiritual healers (Bloom, 2001). These are all cultural issues that hinder and cause low patronage of healthcare service hence the increase in maternal mortality. Nwosu (2012) also noted that "lack of adherence to medical advice arises mainly due to cultural beliefs. According to Dahab and Sakellariou (2020), cultural belief is one of the important barriers to maternal health. When some women are faced with complications during pregnancy and delivery such as narrow pelvics, low-lying placenta, breech, among others, they are advised to deliver through caesarean operations (CS). Such women often rejected it because of the cultural belief that they would be mocked and cajoled in the society as weaklings that could not bring forth a child". This is in collaboration with Mrs E, Z, R and P. Mrs P (a female research discussant) that opined that:

belief systems and culture are the same. Many women do not believe it is normal to give birth through CS possibly because their culture do not subscribed to that or because it is against their believe. During antenatal care, some women who are told that they will not be able to give birth through normal delivery always do not like that idea because of the belief that giving birth through CS is not normal. For example, women chose to pray or take African herbs because they do not want to undergo CS. They engage in this act of combining African herbs and orthodox medicine simplify because they do not want to give birth through CS. This in the process could cause complication and even death (IDI-2019).

According to Dr Y (a female research discussant):

cultural heritage, believe systems are the same. They all interlink. When expectant mother is sick, depending on her world view, she may begin to attribute the cause of her ill health to supernatural beings, evil, and her neighbour or distant relations as the cause. In other words, culture, belief system, religion view of the immediate family are essential and pointing of accusing fingers to neighbour is a determining factor to seeking healthcare among expectant mothers (IDI-2019).

This further conformed to the finding of Nwosu (2012); Ebere (2019) that revealed that in Ohuhu community of Eastern Nigeria:

people believed that if a multiple gravida woman with low-lying placenta were assisted through bilateral tubal ligation, she would not be able to have a child in her next reincarnation. Similarly, a woman that was advised to cut off one of her breast due to cancerous cell which was discovered early enough rejected the idea for fear that in her next world she would not be able to breast-feed a baby. Some woman who had fibroid and were advised on removal of the womb rejected and prefer to harbour the fibroid to avoid being barren in the next world. Some women also that had all female children had endangered their lives by having up to ten children or more in their quest for a male child despite the health implications. They reasoned that they might be thrown out of their husbands' home or their husbands opting to marry other wives. Moreover, they wanted to give their husband a male child that would project the name of the family. In comparison, the fate suffered by a barren woman is similar to the fate of a woman with all female children (Nwosu, 2005).

Mrs R however opined that culture might be there but it is not culture that determined whether a woman will seek healthcare or not. According to her:

my culture does not discriminate as to where and how you put to bed. People that do not utilise healthcare do so because they are ignorance not because they are constrained by cultural beliefs. All culture encourages healthy living.

Data in Table 2(a) also revealed respondents' perception on role of norm and value in seeking healthcare among pregnant women in the study area. Data in the table revealed that among the total respondents, majority were of the opinion that the values and norms of their community do not restrict accessibility to medical healthcare for pregnant women instead other variables stand as a cause. Table 2(b) showed the cross tabulation of respondents view on cultural barriers that hinder access to maternal health by religious affiliation. Among the total number of respondents who were Christians, 71(17.6%) agreed that culture restricts women from accessing healthcare, 306(75.9%) do not agreed while 26(6.5%) where undecided. Among the respondents who practiced Islamic

religion, 20(51.3%) agreed that culture restrict women from accessing healthcare, while 19(48.7%) do not agreed. 4(25%) of the respondents who are African worshippers agreed that culture restrict women from accessing healthcare, 8(50%) disagreed while 4 (25%) were undecided.

Implication for Social Work Practice in Nigeria

Social workers have a lot to do in the context of healthcare service utilisation among women of reproductive age in Nigeria. This is because of the philosophy and ideals of social work as a helping profession concerned with problem solving for its clients by reducing health service demands (Ukponahiusi, 2017) as well as facilitates timely and seamless transition through the health system (Ugiagbe, 2018). The domain of social work is constituted by discrepancies between needs and resources that various systems and social institutions have not dealt with adequately (Rosenfeld, 1983). Thus, social work is targeted at matching resources with needs to increase the goodness of fit between them (system and social institutions), largely by harnessing potential provider systems to perform this function (Gordon and Schutz, 1977)). Social workers aid in the realisation of the other's valued goals such as providing psychotherapy, supportive counselling or helping patient to expand and strengthen their network of social support. In this case, social workers focus efforts on reducing client's fear or helping them to gain interpersonal skill (resources) to reduce the mismatch between them and environmental (Hepworth & Larsen, 1990). Therefore, maintaining sustained advocacy in communities of Edo South senatorial district and Nigerian at large will help popularise and give relevance to healthcare utilisation and remove cultural practise/barriers that are inimical to healthcare utilisation.

Conclusion

The fining revealed that traditions and cultural practices in many communities in Edo South senatorial district especially in the rural settlements where there are strong ties with cultural hegemony, formal healthcare services are considered to be too sophisticated, expensive and unaffordable to the local people hence women need the approval of their husbands or relations before they can visit the maternity centre. The notion of these communities is that the maternity is a death trap and no-go area. This has serious implication because complication that arises from delivery does not happen at a time but a compilation of ignored health issues.

Recommendations

African birth attendance should be trained with modern equipment and replicated in all rural areas and urban slums in Edo south because they are still very much active participants in the health determinants of maternal health. In some cases, they are more popular than the primary healthcare centres as they are patronised by all and sundry.

Government, social workers and non-Governmental Organisations should initiate programmes and sensitisation campaigns on the need to seek medical healthcare while also letting them know the implication of not adherence to antenatal care as recommended by the World Health Organisation.

The healthcare should be given more attention with good state of the art facilities with functional health personnel. And made very affordable so women are not restricted by their spouse or fear of the cost.

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