Socio-Cultural Determinants of Utilization of Health Facilities among Women Attending Antenatal Care Clinic in Ota Nigeria.

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Extended Abstract

Introduction

Pregnancy and child birth are two critical areas which affect the health of the mother and her child. Both reflect national health standards and development. Even though both antenatal care and intra-partum care are essential for saving the lives of mothers and children, utilization of maternity care has been very poor in Nigeria, as over 62% of births are conducted outside the modern health care facilities (NDHS 2008). In spite of both national and international efforts on reducing deaths among pregnant mothers, maternal mortality is still soaring in Nigeria, as more than half a million women die from pregnancy and related causes annually. Maternal mortality ratio in Nigeria is put officially at 800 per 100,000 live births (Federal Ministry of Health 2005). Although utilization of health services is a complex behavioral phenomenon, improving program me use would likely reduce the incidence of maternal deaths in Nigeria. Nigeria ranked second globally as the country with the highest estimated number of maternal deaths with 37,000 cases of maternal deaths. India occupied the first place with 136,000 maternal deaths and Pakistan was in the third place with 26,000 deaths. A woman’s chance of dying from pregnancy and childbirth in Nigeria is 1 in 13. Of the estimated 529,000 maternal deaths that occur globally every year, Nigeria contributes approximately 7%; although its population size is only about 2% of the global population figure (FMOH 2007). Several other studies have confirmed that the multifaceted factors such as socio-economic, demographic, cultural, health and political affect poor utilization of health facilities (Shaikh and Hatcher 2004; Addai...
Examining and addressing the social-cultural dimensions of the problem is therefore as vital as dealing with the medical dimensions of maternal mortality. While existing interventions intended to benefit target group is yet to be met, the targeted Millennium Development Goal is yet to be realized. This means that there are other factors causing restraint to accessing health care service usage by pregnant women in addition to medical factors. No doubt some studies have been carried out in this area in Nigeria but they concentrated on intervention measures to boost maternal health services, no study has dealt exclusively at micro level on the reasons for the retardation or poor utilization of the services. Therefore, in order for maternal health program me to remain focused, and to make a quantitative evaluation of program me’s results, maternal mortality statistics must be available at local and national levels to prioritize the health services.

The objectives of this paper are:

1. To examine major socio-cultural factors challenging maternal access to and use of health care services during pregnancy and childbirth.

2. To proffer informed intervention strategies for policy makers from the results of the study, for improving the current low usage of health care facilities by pregnant mothers.

Study Area in Context

Ogun State is one of the six States in South-West geopolitical zone of Nigeria. It is an agricultural, industrial and educational centre located approximately between longitudes 2° 45'E and 4° 45'E; and latitudes 6° 15'N and 7° 60'N. Official Statistics show that between 1991 and 2006 the population of the State grew from 2,333,726 to 3,728,098, representing about 1.7 times increase over a 15-year period (National Population Commission 2006, National Bureau of Statistics 2008). With an estimated population of 527,242 according to 2006 population census and land area of 1,263 Square Kilometers, Ado-Odo/Ota stands out as the second largest Local Government Areas in Ogun State. The Local Government is made up of 16 political wards with its headquarters at Ota which house the only State government hospital.

Methodology
The study was conducted in Ado-odo/Ota Local Government Area in Ogun State Nigeria. Respondents consist of 458 women 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 and attending antenatal care clinic in State Hospital Ota. The study evolved systematic sampling procedure in the selection of respondents who were interviewed with the aid of questionnaire instrument. The hospital register served as sampling frame and care was taken to make sure that no woman was interviewed twice in the process. The data generated were analyzed using SPSS.

Results and Discussions

The results of the analysis are based on few selected variables, to examine the reasons why pregnant mothers do not patronize health facilities. The results (Appendix table not given) shows that over three-fifths of the respondents fall below 29 years (63.1%), the educational attainment of the respondents is very poor with substantial proportion of the population having only secondary education (31.7%). This is serious in view of the importance of education as a vital force in shaping the whole gamut of individual’s life particularly mother’s empowerment.

The study revealed that almost 50% of the respondents felt that the only state hospital Ota is very far from them. This is a problem, especially as the road network is poor or virtually not in existence coupled with lack of efficient transportation system. A pregnant mother will prefer to visit the next door traditional birth attendant (TBA) rather than to work for kilometers to the health facility where she has little or no confidence in the service. This calls for immediate revitalization of the PHCs within the local government. The study showed that while orthodox health facilities captured 44.8% of the deliveries, home deliveries and delivery at TBA’s place registered 26.8% and 28.4% respectively. On examination of the cost of service, substantial proportion of respondents (39.1%) perceived it to be expensive. Cost may reduce women’s use of maternal health services from having hospital –based deliveries or seek care even when complications arise.

The low status of women is manifested on participation in decision making, 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 including Nigeria where culturally male dominance and women subjugation are normal ways of life. In the study area, while 59.6% of respondents agreed that they participate in decision making
process, 78.2 percent 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 (71.4%); and the dependency on husband for hospital visitation was high (74.2%) in the study area. 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 even in case of emergency. 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.

Feeling is an internal mechanism that drives one to his or her directional behavior. When the feeling is not right about the health facility, the propensity to patronize such facility will be lacking. The general feeling of respondents about the services the health facility provides is considered in this study. While respondents who feel satisfied with the services account for 51.7 percent, those who feel otherwise account for bothersome proportion (48.3%). Regression analysis (Table not given) showed family type, respondent’s education, perception of cost of antenatal service, treatment place decision, husband perception of pregnancy, respondents dependency on husband for health facility visitation and service satisfaction are significant (P= .000, .023, .001, .005, .000, .000, .000) towards use of health care services by mothers in the study area. While the paper provided a guide for informed policy decision on maternal health services in the country, it also suggests boosting of health information system, involvement of males in reproductive health issues and improving the status of women and their empowerment through education and provision of job opportunity.

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 use of maternal health services in the study area. Success in the scaling up the use of health care services requires adequate and friendly services to boost confidence of the masses on health care service providers. In addition, culturally appropriate health education especially on harmful traditional practices and benefits of safe motherhood should be explored and employed as short term measure and raising the status of women may be work out on a more permanent pattern.