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Assessment of Maternal Health Seeking Behavior and Service Utilization among Women of Reproductive Age in South-Eastern, Nigeria

Udeh Mary Department of Public Health Technology, School of Health Technology; Federal University of Technology Owerri, P M B 1526., Owerri, Nigeria

Ede Allison Department of Public Health Technology, School of Health Technology; Federal University of Technology Owerri, P M B 1526., Owerri, Nigeria

Amadi Chinasa Department of Public Health Technology, School of Health Technology; Federal University of Technology Owerri, P M B 1526., Owerri, Nigeria

Chukwuocha Adanna Department of Public Health Technology, School of Health Technology; Federal University of Technology Owerri, P M B 1526., Owerri, Nigeria

Chukwuocha Uchechukwu* Department of Public Health Technology, School of Health Technology; Federal University of Technology Owerri, P M B 1526., Owerri, Nigeria

Abstract: Health seeking behavior and utilization of maternal healthcare services are proximate factors that influence maternal morbidity and mortality in any society. We therefore assessed the pattern of health seeking behavior and types of maternal healthcare services utilized by women of the reproductive age in parts of Southeastern Nigeria. A cross sectional descriptive method involving the use of a well-structured pretested questionnaire was used to collect data from 521 randomly selected women between the ages of 15-49 years. Informed oral consent was obtained from these women prior to their recruitment for the study. Descriptive statistical analysis was performed on the data obtained using the Statistical Package for Social Science (SPSS). The mean age of the respondents was 32 ± 0.07620 years and most(50.5%) attained secondary education. There was a significant relationship between healthcare services and mother's age ($p<0.000$) with women between 29-35yrs (52.2%) utilizing healthcare services more than those in other age groups. Place of residence (r =0.568, $p\leq.001$) and religion (r = 0.784, $p\leq0.001$) were also significantly associated with health seeking behaviour. About 58% of the respondents understood that good maternal healthcare can reduce maternal mortality and morbidity. Our findings showed good health seeking behaviour and service utilization in the study area despite the identified hindering factors. These underscore the need to empower women of reproductive age as well as to put mechanisms in place that will increase their access to quality maternal health care services.

Keywords: Maternal health; Reproductive age; Determinants and Socio-demographic.

1. Introduction

Health seeking behaviour is the state in which a patient in stable health is actively seeking ways to alter personal health habits and/or the environment in order to move toward a higher level of health. The effective practice of this kind of health promotion will enhance the safety of women through pregnancy and childbirth and the chances of having a healthy infant. Women of the reproductive age are between the 15-49 years and most of them are faced with life threatening complications and health challenges in their bid to procreate and maintain the circle of life. These challenges are gynaecological cancers, sexually transmitted diseases, HIV, unsafe abortions, obstetric fistula, pelvic inflammatory disease, a ruptured uterus etc, in most cases maternal death [1].

In most developing countries, women of this age group experience inequalities in reproductive health services, these inequalities vary based on socioeconomic status, educational level, age, ethnicity, religion, parity and resources available in their environment [2]. In view of the above, low income individuals lack the resources for adequate health services and knowledge to know the appropriate strategy for maintaining reproductive health.

Maternal health is the health of women during pregnancy, childbirth, and the postpartum period. It encompasses the health care dimensions of family planning, preconception, prenatal, and postnatal care in order to reduce maternal morbidity and mortality. The major direct causes of maternal morbidity and mortality include hemorrhage, infection, high blood pressure, unsafe abortion, and obstructed labor. WHO Reports show that over

*Corresponding Author

500,000 women and girls die from complications of pregnancy and childbirth each year worldwide with approximately 99% of these deaths occurring in developing countries, with a maternal mortality ratio of 545 deaths per 100 000 live births [3-5].

Studies in some literature reveal a ratio of 1:15 African women who die from complications of pregnancy, delivery or puerperium; in Asia, the ratio is1:105; in Europe, 1:1895 and North America, 1:3750 [6]. Globally, approximately 536,000 maternal deaths occur annually of which over 95% occur in sub-Saharan Africa and Asia [7]. Africa has the highest burden of maternal mortality in the World. The lifetime threat of maternal death in sub-Saharan Africa is 1 in 22 mothers compared to 1 in 210 in North Africa, 1 in 62 for Oceania, 1 in 290 for Latin America and the Caribbean [7, 8].

Nigeria has a maternal mortality ratio of 1100 that is greater than the others with an estimated number of 59,000 maternal deaths [9]. Nigeria that has approximately two percent of the world's population contributes almost 10% of the Worlds maternal deaths globally and has the second highest maternal mortality deaths in the world after India [10].

In terms of maternal mortality ratio, India and Nigeria together accounted for a third of the deaths of pregnant women globally in 2010 [11], Then, Nigeria alone ranked eighth in sub-Saharan Africa behind Angola, Chad, Liberia, Niger, Rwanda, Sierra Leone and Somalia [12].

WHO [8], reported that for every woman that dies from pregnancy related causes, 20-30 of them might develop short and long-term damage to their reproductive organs such as obstetric fistula, pelvic inflammatory disease, a ruptured uterus etc [1]. Such health indicators of maternal morbidity and mortality makes maternal health a huge public health and reproductive health challenge in developing countries of the world like Nigeria. Based on the above significant indicators affecting maternal health, this study aimed to assess the pattern of health seeking behavior and types of maternal healthcare services utilized by women of the reproductive age in the study area. The study will help contribute to the body of knowledge on how socio-demographic factors (age, parity, educational attainment, religion etc) affect the rate at which women seek and utilize maternal health care service (MHCS). It will also enhance a better understanding of the different factors that affect health seeking and utilization among women of reproductive age.

2. Materials and Methods

This study was conducted in Ikeduru Local Government Area, Owerri, Imo State, South Eastern Nigeria. The major inhabitants of the area are Igbos. The population is homogenous in terms of culture, language and religion, they are predominantly Christians but with different faith beliefs. The population of the study consists of married women between the ages of 15- 49 years that seek health services in the available health care centers.

A sample of 521 married women was randomly drawn from both the rural and semi urban parts of the study area. Informed oral consent was sought and obtained from the women after the study objectives and protocols were clearly explained to them. Data was collected using a structured pretested questionnaire elicited in the local Igbo language and was coded into Statistical Package for Social Sciences (SPSS) version 20.0 for analysis. The Correlation coefficient (r) test was used to determine the level of associations between the components of maternal healthcare services and socio demographic factors.

3. Results

The Socio-Demographic Characteristics of the respondents are depicted in table 1. Their mean age was 32 ± 0.07620 years and most of the women (50.5%) attained secondary education. Farmers were 40.1% while the unemployed made up 5.2% of the respondents. About 53.2% of them had experienced 1-2 pregnancies.

Table 2 depicts the relationship between Socio-Demographic Characteristics of respondents and utilization of healthcare services. The women that engaged in utilizing healthcare services between 29-35yrs were (52.2%) and 121(51.4%) of them that utilized healthcare attained secondary education. Only 142(49.2%) of the respondents do not utilize healthcare services. Women that have farming as their occupation had higher percentage of not utilizing healthcare services (45.4%) while the public servants utilizing MHCS were 103(39.7%). Christian women that do not utilize healthcare services were 238(47.9%) against those that utilize it 259(52.1%). Mothers with 1-2 pregnancies that utilized healthcare services were 201(57.9%).

The multivariate analysis of place of residence showed that 284(54%) of women were found in urban area while women in rural areas were 236(46%). A significant association was found to be moderately related between place of residence and health seeking behavior ($\underline{r}$ =0.568, p≤.001) as shown in table 3**.**

The relationship between places of delivery (PoD) is shown in Table 4. A significant association was found between mothers and PoD in Ikeduru LGA (r =0.580, p≤=.000) in terms of public health facility 270(67.5%) and private health facility 130(32.5%). In addition,

Table 5 shows actual utilization of health care services and knowledge of its importance. About 321(61.6%) of the respondents actually utilize healthcare while 200(38.4%) do not. Also, 302(58.0%) understand that good maternal health care can reduce maternal mortality and morbidity while 219(42.0%) do not while 400(76.8%) understand that pregnancy and childbearing has many complications. About postnatal care among women of childbearing age, 244(46.8%) said they received postnatal care while 277(53.2%) said they did not. Mos (94.8%) of

the respondents were satisfied with the level of maternal health care services rendered by healthcare personnel while 5.2% were not satisfied.

Table 6 shows the knowledge of utilization of family planning as healthcare method, 59.7% of the respondents stated that they do not know what family planning means while 40.3% of them agreed that they knew. With regards to practice any type of family planning, About the method of family planning, use of condom was higher among others with 351(67.4%) followed by 110(21.1%) of pill use. 39(7.5%) were for injection use while withdrawal method had 21(4.0%). Family planning (FP) is significantly associated with utilization of health care services ($P<0.05$).

Figure 1 indicates the frequency of respondents reception of antenatal care as important factor in determining the level of utilization of healthcare services; (48.4%) of respondents had four times per pregnancy as the highest and least was (19.2%).

Figure 2 shows reasons given for not seeking help at public health centers. About 38% of the respondents attributed it to cost of the healthcare services. Those gave reasons such as distance, husband's refusal to seek for healthcare services at both public and private health centers, attitude of the health personnel toward the patients and no reason at all were as 30%, 22%, 13% and 7% respectively.

The estimated income of the respondents as figure 3 depicted that.6% earned as low as ₦1,000-20,000 while only 6.7% earned up to ₦61,000-80,000.

Figure four (4) describes the pattern of maternal health care services (MHCS) and its utilization across the communities and it presents utilization of healthcare services by Roman Catholic or Anglican across the communities. (53.7%) of the assessed women, received healthcare and Pentecostal or New generation churches had (40.5%). A statistically significant relationship was found between different religious worshipers and utilization of health care services ($\underline{r} = 0.784$, $p \leq 0.001$).

4. Discussion

The study showed that women of reproductive age in some parts of Southeastern of Nigeria have a positive attitude towards health seeking behavior and utilization of MHCS. Majority of the women in the study area actually seek and utilize MHCS. However lack of adequate healthcare facilities and health personnel could hinder whole some and effective utilization, as well as low socio-economic status and influences of cultural and religious misconceptions [13, 14].

Women in the Urban or semi-urban areas are usually associated and characterized as better users of MHCS because there is availability and accessibility of maternal healthcare services and other infrastructures like good roads and transport facilities. Furthermore, the results proved a statistical significant association between place of residence and health seeking behavior.

Galandanci, *et al.* [15], reported that many women in developing countries do not have access to MHCS and the use of such service remains low in sub-Saharan Africa including Nigeria. The study conducted by Babalola and fatusi, [7], indicated that 58% of women attended at least one antenatal (ANC) clinic during pregnancy which was contrary to the findings in this study where a good number of women attended antenatal at least four times before delivery.

Family planning as a component of maternal healthcare service recorded a low level of knowledge and utilization. It was reported that Nigeria has one of the lowest level of family planning use in Africa with 12% of the women using any form of family planning such as condom use, pills, inject able etc and women aged 19-24 years are aware of contraceptives [4]. Ikechebelu, *et al.* [16] and FMOH report [12] reported that the practice of Modern Family Planning (MFP) is low in Nigeria due to poor awareness from the healthcare workers.

Furthermore, this study observed that socio-demographic and economic factors such as education, age, occupation, parity and income strongly influence health seeking behaviour and MHCS utilization. The study conducted by Aluko and Oluwatosin [17] found that women between 20-29 years utilized maternal health care and less for women of age 17-19 years. The idea was that young women utilized maternal healthcare than older women do as also corroborated by AbouZahr and Wardlaw [18]. Some researchers have observed that younger married women received much care from their husbands and the healthcare delivery system tends to favour younger married women than older married ones [19]. Another reason given was that some health workers may feel fragile and inexperienced in matters of childbirth from old women and they may claim experience in first order birth that favours MHCS utilization [20, 21]. Other researchers confirmed that high parity women are less likely to seek and utilize maternal healthcare services [22-24]. This could be attributed to the fact that high parity women seven times above tend to have greater confidence and cumulative experience than the lower parity devoid of non-utilizing antenatal care. Also, larger family places more demand on a woman's time thereby limiting her ability to access healthcare [25].

In this study, education has consistently shown to be strongly and positively associated with health seeking behaviour and utilization of MHCS as the higher a woman goes in education the more likely she is to seek and utilize MHCS [26, 27]. In this study, a large number of women attained at least secondary education and this reflected the knowledge and ise of MHCS. Béhague, *et al.* [28] had opined that educated women would be able to comprehend the importance of seeking and utilizing MHCS.

Traditional beliefs and cultural practices of different group in the study area affected the rate at which they seek and utilize MHCS. Findings from this study indicated a strong correlation between different Christian worshippers

and utilization of healthcare services. It revealed that women of the Roman Catholic and Anglican faith utilized MHCS more than other different religion. Takyi and Christopher [29] reported that women of the Roman Catholic Church tend to have higher likelihood of seeking antenatal checkups compared to other Christian groups which was not different with this study due to the ideology and belief of the Roman Catholic and Anglican faith concerning diseases, life and health.

This study found that women living in the urban area utilized MHCS more than those in the typical rural communities. This is because women living in the urban areas have better social amenities and in turn have better access to MHCS. Abor and Abekah-Nkrumah [30] also observed that urban dwellers may be relatively closer to health care facilities than rural dwellers in most developing countries.

Majority of women in their reproductive age in the study area fall under the lower wealth index level. Considering the cost of accessing a quality health care, their wealth index status may serve as a hindrance to healthcare seeking. These results also confirm that wealth index has a positive and significant influence on health seeking and MHCS utilization [26, 31]. Many lack means of transportation to the healthcare center and it stands as a barrier to quality of healthcare services and utilization.

5. Conclusion and Recommendations

Our findings show that women in the study area actually seek and utilize maternal healthcare service. Some factors such as Socio-Demographic factors, availability and accessibility with regards to distance to health facility, religious misconceptions and belief, income were significant factors depending on the component of MHCS concerned.

To achieve optimal positive attitude to HSB and MHCS utilization, maternal health intervention programs should aim at making MH centers accessible, affordable and available at strategic points at different levels especially in rural communities. Health education interventions such as awareness campaigns in market places, churches, women forums and meeting places maternal healthcare should continuously be on place.

Furthermore, these women should be empowered towards improving their social status and education, as this is very likely to affect their decisions

Periodic monitoring and evaluation of MHCS centers are also very necessary to ascertain effectiveness and efficiency of MH programs.

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Table-1. Socio-Demographic characteristics of respondents

Variables	Frequency (N=521)	Percentage (%)	P-value
Age of respondents			
15-21 yrs	22	4.2	*0.000*
22-28 yrs	145	27.8	
29-35 yrs	262	50.3	
36-42 yrs	53	10.2	
43-49 yrs	39	7.5	
Total	521	100	
Educational levels of respondents			
No education	5	1	
Primary level	158	30.3	
Secondary level	263	50.5	
Tertiary level	95	18.2	
Total	521	100	
Occupation of respondents			
Public or civil servant	191	36.7	
Farmer	209	40.1	
Trader	94	18	
Unemployed	27	5.2	
Total	521	100	
Religion of respondents			
Christianity	490	94	
Islam	0	0	
Traditionalist	31	5.9	
Total	521	100	
Parity of mothers			
1-2	277	53.2	
3-4	136	26.1	
5-6	69	13.2	
7and above	40	7.6	
Total	521	100	

Correlations coefficient for age and education = 0 .901; P-value ≤ 0.000*

Table-2. Relationship between Socio-Demographic characteristics and utilization of healthcare services

Variables	Frequency/percentage	Utilized healthcare services	Not utilized healthcare services
Age of respondents, *P-value ≤0.000**			
15-21 yrs	22(4.2%)	9(3.4%)	13(5.2%)
22-28 yrs	145(27.8%)	84(31.5%)	61(23.9%)
29-35 yrs	262(50.3%)	139(52.2%)	123(48.3%)
36-42 yrs	53(10.2%)	23(8.6%)	30(11.7%)
43-49 yrs	39(7.5%)	11(4.1%)	28(10.9%)
Total	521(100%)	266(100%)	255(100%)
Educational level of respondents, *P-value ≤0.000**			

Continue

No education	5(1.0%)	2(0.8%)	3(1.1%)
Primary level	158(30.0%)	59(25.1%)	99(34.6%)
Secondary level	263(50.5%)	121(51.4%)	142(49.6 %
Tertiary level	95(18.2%)	53(22.5%)	42(14.6%)
Total	521(100%)	235(100%)	286(100%)
Occupation of respondents, *P-value ≤0.000**			
Public/Civil servant	191(36.7%)	103(39.7%)	88(33.6%)
Farmer	209(40.1%)	90(34.7%)	119(45.4%)
Trader	94(18.0%)	55(21.2%)	39(14.9%)
Unemployed	27(5.2%)	11(3.7%)	16(6.1%)
Total	521	259(100%)	262(100%)
Religion of respondents			
Christianity	497(95.3%)	259(52.1%)	238(47.9%)
Islam	1(0.2%)	1(0.3%)	0(0%)
Traditionalist	23(4.4%)	9(3.3%)	14(5.6%)
Total	521(100%)	269(100%)	252(100%)
Parity of mothers, r =0.80			
1-2	277(53.2%)	201(57.9%)	76(43.6%)
3-4	136(26.1%)	98(28.2%)	38 (21.8%)
5-6	79(15.2%)	37(10.6%)	42 (24.1%)
7 and above	29(5.6%)	11(3.1%)	18 (10.3%)
Total	521(100%)	347(100%)	174(100%)

*Significant, p<0.05, Age, education, occupation, parity strongly influenced the utilization of healthcare services for correlation coefficient (r) =0.80

Table-3. Pattern of health facility visit by place of residence

Place of Residence	Frequency	Health facility visit		P-value
		Yes	No	
Urban Area	284(54%)	184(65%)	100(35%)	
Rural Area	236(46%)	86(37%)	150(63%)	
Total	521(100)	270	250	0.0000*

Correlation coefficient for place of residence & health seeking behaviour = 0.568

Table-4. Shows the type of health care facility used by mothers

Place of Delivery	Frequency	Type of healthcare facility used		Correlation coefficient (r)	P-value
		Public health Facility	Private Health Facility		
Approved health Centers	363(69.6%)	221(60.8%)	142(39.2%)		
With the help of TBA	121(23.3%)	00(00)	00(00)		
At home with relatives/untrained	37(7.1%)	00(00)	00(00)		
Total	521(100)			0.58	0.000*

Correlation coefficient (r) = 0.580; P-value ≤ 0.000*

Table-5. Healthcare services utilization and Knowledge of its importance

Variables	Yes	No	P-value	Total
Utilization				
Utilization of health care services	321(62%)	200(38%)	0.000*	521
Good maternal healthcare services reduces mortality and morbidity	302(58%)	219(42%)	0.001*	521
Can reduce the risk of pregnancy and childbearing has many complications	400(77%)	121(23%)	0.000*	521
Knowledge of its importance				
Received postnatal care	244(46%)	277(53%)	0.003*	521
Satisfied with the level of maternal healthcare services	494(95%)	27(5.2%)	0.000*	521

Statistically significant, P-value ≤0.000*

Table-6. Knowledge and utilization of family planning as a components of MHCS

Variable	Frequency	Percentage	P-value
Knowing the meaning of family planning, *P-value ≤0.000**			
Yes	210	40.3	***0.000****
No	311	59.7	
Total	521	100	
Practiced any method of family planning			
Yes	321	61.6	
No	200	38.4	
Total	521	100	
Method of family planning practiced, *P-value ≤0.000**			
Use of condom	351	67.4	
Use of pill/ injection	110	21.1	
Others	39	7.5	
Withdrawal method	21	4	
Total	521	100	

Statistical significant, P-value ≤0.000*

Figure-1. show number of times received antenatal care

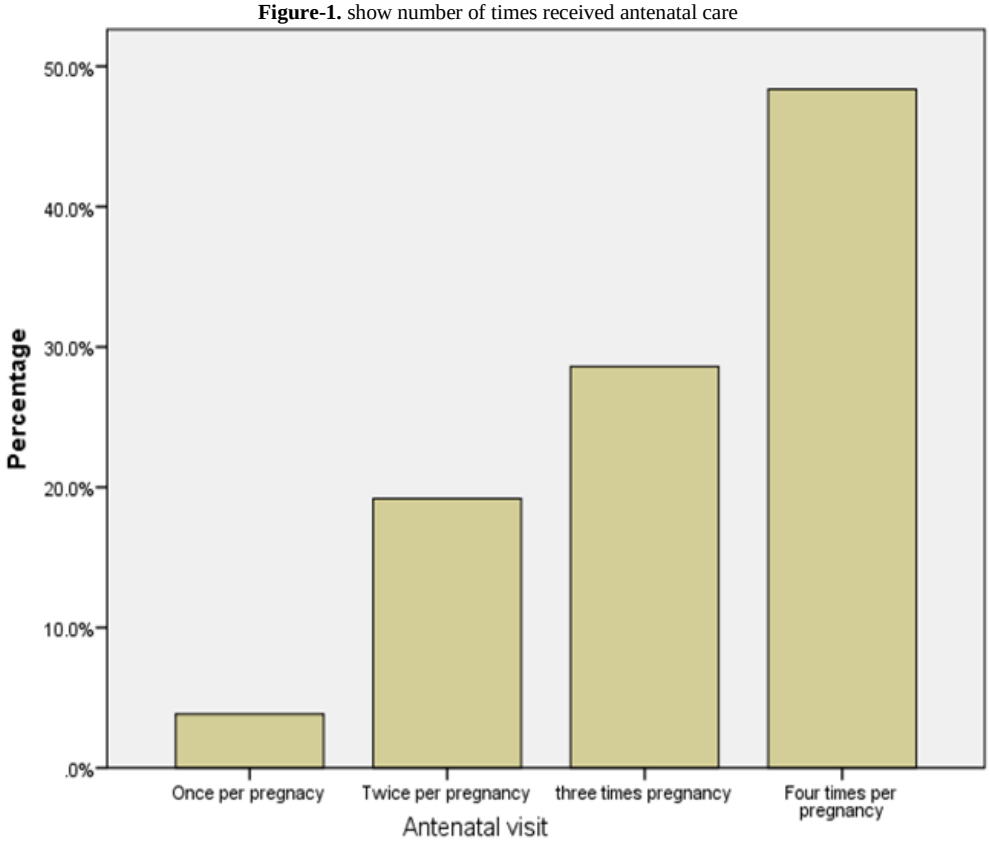

Figure-2. Barriers to healthcare seeking

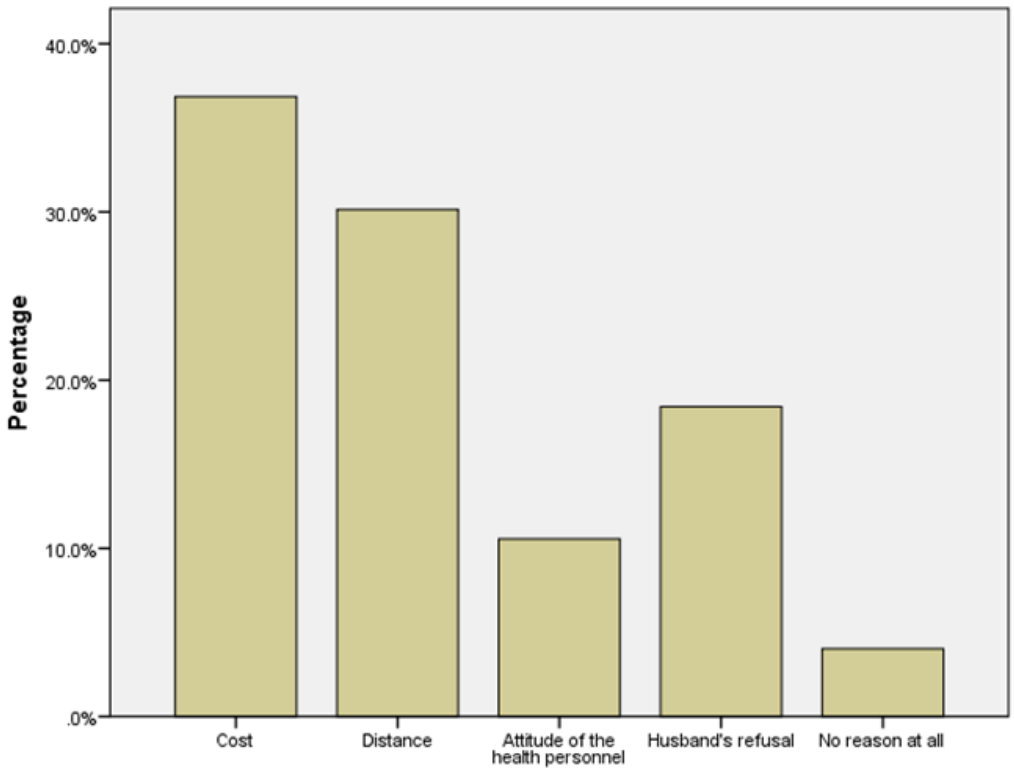

Figure-3. Shows the estimated income of the respondents on utilization of healthcare services

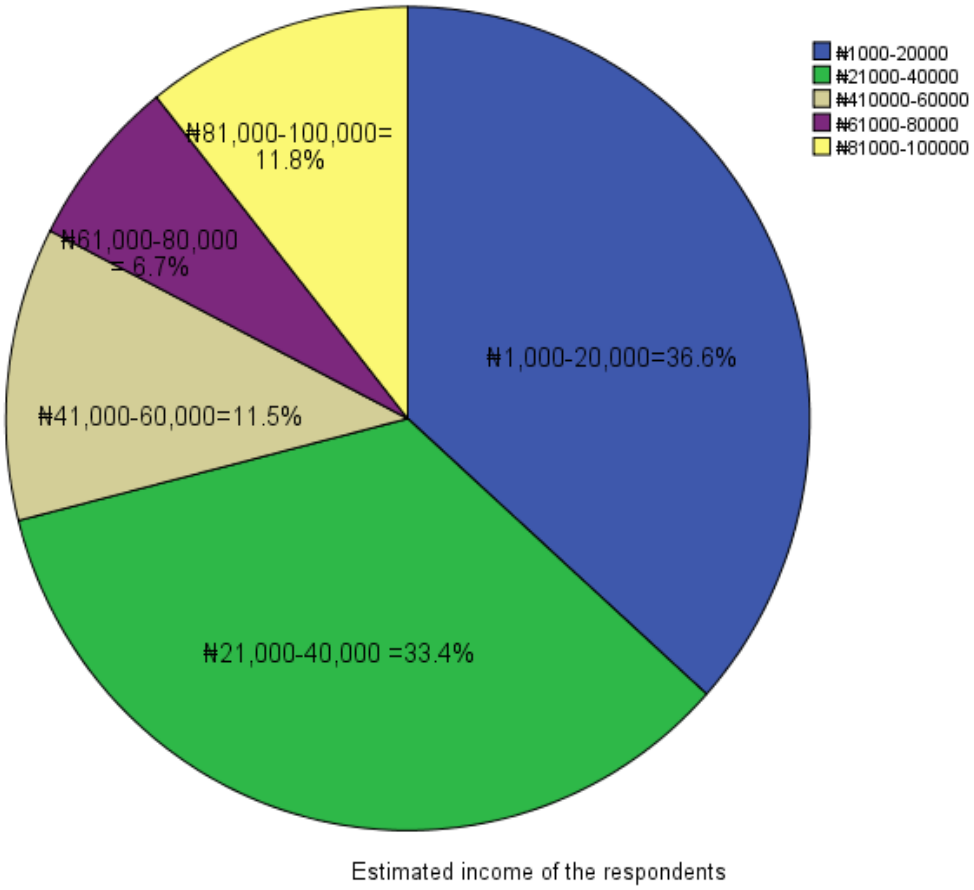

Figure-4. Utilization of health services by religious worshipers