ASSESSMENT OF UTILIZATION OF MATERNAL HEALTH CARE PROVISIONS IN ORUMBA NORTH LOCAL GOVERNMENT AREA OF ANAMBRA STATE, NIGERIA

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Abstract

Health services are crucial aspects of the welfare provisions for everyone especially the pregnant women who are most often, denied access to utilize maternal health care provisions. Previous studies on maternal health care focused on economic factor as reason for poor utilization of maternal health care provisions without looking at the availability of maternal health care facilities especially in rural communities. This study therefore, examined the utilization of maternal health care provisions in Orumba North Local Government Area, in Anambra State Nigeria. Structural functionalism theory provided the framework. Survey design was employed. Simple random sampling technique was used to draw the sample of 384 respondents who were all females. A structured questionnaire was used to collect data on respondents' demographic data and the utilization of modern maternal health care provisions. Descriptive statistics was used to analyse data generated from the field. Findings reveal that respondents utilize modern maternal health care facilities in the area very often (82%), the services rendered in the modern maternal health care were not satisfactory to respondents (84%), they was respondents unwillingness to utilize modern maternal health care provisions very often (88%) and respondents willingness to patronize Traditional Birth Attendants (TBAs) more than the modern maternal health care facilities (52%). This study therefore, recommends the equipment of modern health care facilities with both human and material resources to enhance their performance and productivity. Also, periodic training of TBAs are recommended to enable them render good and hygienic services that will reduce mortality rate among pregnant women who give TBAs high patronage.

1. Background and Statement of the Problem/ Justification

One major development and health challenge in Nigeria, is the unacceptably high level of maternal deaths arising from complications related to pregnancy and child birth. The current maternal mortality ratio is estimated to be 800/100,000 live births, thereby contributing approximately 10% of the global burden of maternal deaths. In Nigeria, an estimated 56,000 women die yearly from complications related to pregnancy and child birth. For every woman that dies about 20 suffer other illnesses or disabilities such as obstetric fistula. It is estimated that about 800,000 to 1 million women suffer from obstetric fistula in Nigeria with 20,000 women added yearly. Nationally, about 64% of pregnant women deliver without skilled birth attendants, while the statistics in Ebonyi State stands at about 48%. This is one of the key contributory factors to the high maternal mortality rates in the country. Maternal mortality is preventable and can be addressed if all women had access to Reproductive Health (RH) services, care during pregnancy and skilled medical attendance and emergency obstetric care to handle complications. Increasing the survival of mothers is a crucial national development challenge and calls for concerted actions of all stakeholders (UNFPA 2015).

Findings from numerous studies on infant and child mortality conducted in developing countries over the last decade show a nearly universal, positive association between maternal education and child survival, a relation which has persisted in many societies even when the household's socioeconomic status has been held constant (Cochrane, O'Hara and Lesley 1980, Rutstein 1984, United Nations 1985, Cleland and van Ginneken 1988, 1989). Much of the research on the cultural experience of childbirth has focused on specific rituals among specific cultures rather than on the experience of birth in several cultures in a setting that is unfamiliar and has traditions different from those of the labouring women (Ottani 2002). Scholars attention on factors which interplay in determining access to maternal health care provisions have shifted to economic with less attention on other factors. This study therefore, assessed the utilization of maternal health care provisions and services by pregnant women in Orumba North Local Government Area, in Anambra State Nigeria.

2. Literature Review

Women dying as a result of pregnancy related deaths across the globe have been estimated to be approximately 289,000 in 2013, while the death toll of newborn within the first 4 weeks of birth has reached at 3.6 million (Lawn et al 2010). According to the World Health Organization (WHO), current estimates of maternal mortality ratios are at more than 1000 per 100,000 live births in most African countries (WHO, 2005). In developing countries, specifically in sub-Saharan countries, many women do not have access to skilled personnel during childbirth (WHO, 2005). This lack of skilled attendance is one of the major factors responsible for the rising maternal and infant mortality (WHO, 2005).

In Nigeria, the choice to deliver outside hospital settings could be motivated by varying factors such as economic, social, physical, cultural, or institutional (Ahmed et al 2005). Outside the hospital setting, women can be assisted by an attendant who may be unqualified. This attendant could be a Traditional Birth Attendant (TBA), a village midwife, a member of the family, or neighbour (Ahmed et al 2005).

According to Ebuchi and Akintujoye, 2012, in a study of rural pregnant women attending primary health care clinics in Ogun State Nigeria has shown that most women patronize traditional birth attendants due to different reasons which ranges from being cheaper, closer and being more compassionate than the workers of orthodox medicine. Also, the study shows that traditional birth attendant services are more culturally acceptable to the pregnant women.

Similarly, in a study done in Edo State, South Western Nigeria, to assess the role of TBAs in health care delivery, respondents believed that TBAs could play meaningful roles in family planning, screening for high-risk pregnant mothers, fertility/infertility treatment, and maternal and child care services. Rural dwellers prefer to use the services of TBAs as compared with their modern maternal health care counterparts. Reasons for their preference included: the option of home delivery, TBAs' availability, accessibility, inexpensive services, and rural dwellers' faith in the efficacy of their services (Imogie, et-al, 2002). This no doubt shows that the most rural dwellers have trust and confidence in the traditional birth attendants and this explains why many pregnant women prefer them to orthodox medical practitioners for delivery.

In yet another study in Edo State of 45 TBAs, which assessed the services provided by them and their management practices (ie, management of complications, umbilical cord care, and infection control methods), findings, reveal their unsafe practices. It was recommended that a more holistic training program including monitoring and supervision should be provided to them (Ofili, et al 2005).

It has been documented that factors associated with the high rate of maternal death is not unconnected with the place of delivery. That is where the child is delivered. Place of delivery goes a long way in infant and maternal mortality. The use of traditional birth attendants has been found to increase maternal deaths which are mostly due to being unable to handle complications during pregnancy. This is as a result of inadequate skill to handle such complications. Owing to this, efforts are now made by government agencies and some NGOs to train traditional birth attendants.

Despite the increasing rate of infant and maternal death, many pregnant women still do not use health care service during delivery. They prefer to go to the Traditional Birth Attendants (TBAs) who they seem to trust and have confidence in. "The use of TBAs and home delivery were preferable for some community members despite the availability of modern maternal health care service providers. Physical distance and financial limitations were two major constraints that prevented community members from accessing and using trained attendants and institutional deliveries. A number of respondents reported that trained delivery attendants or an institutional delivery were only aimed at women who experienced obstetric complications. The limited availability of health care providers was reported by residents in remote areas. In these settings the village midwife, who was sometimes the only health care provider, frequently travelled out of the village. The community perceived the role of both village midwives and traditional birth attendants as essential for providing maternal and health care services". (Christiana, et al, 2010)

In the same vein, a recent study in India revealed that geographical and financial access were important barriers to accessing institutional delivery services in all districts, and among those

both above and below the poverty line. Access issues of greatest concern were high costs at private institutions, continuing fees at public hospitals and the inconsistent receipt of government incentives. However, views on quality of care that shaped delivery site preferences were deeply rooted in socio-cultural expectations for comfortable, respectful and safe care that must ultimately be addressed to change negative perceptions about institutional, and particularly public hospital, care at delivery (Sharon, et al, 2015).

In a study in Ghana, Dako-Gyeke, et al (2013) reveal that perceived threats in form of socio-cultural interpretation of pregnancy and other related matters make pregnant women to combine multiple source of care during pregnancy. Often times, the combination includes the use of institutional facilities and utilizing the services of a traditional birth attendant and/or a spiritual care. The socio-cultural interpretation increases women's anxieties. According to the study, the uses of multiple sources of care in some cases disrupt continued use of skilled provider. Furthermore, use of multiple forms of care is encouraged by a perception that facility-based care is useful only for antenatal services and emergencies. It also highlights the belief among some participants that care from multiple sources are complementary to each other (Dako-Gyeke, et al, 2013).

3. Theoretical framework

Structural functionalism is the theoretical framework for this study. Structural functionalism is an approach in Sociology which was developed at the wake of 19 century's industrial revolution. This theory was sociologically developed as an adequate tool for dealing with the interrelatedness of various traits, institutions, groups, and so forth, within the social system. Structural functionalism is as old as the history of sociology. This is evident in the works of the founding fathers of the discipline like Auguste Comte (1798- 1857) and Herbert Spencer (1820-1903).

Coser (1976) in Onyeneke (1996) attempts a definition of structural functionalism. Structure is seen to refer to a set of relatively stable and patterned relationships of social units. Functions are perceived as the consequences of social activities which make for adaptation or adjustment of a given structure or its component parts.

The functional approach in Sociology was borrowed from the analogy of organism in the biological sciences in which it is known that all the body organs, in any living organism, have a kind of interconnectivity which links them together. Each of these organs plays a certain role for the survival of the organism. In any situation where any of the organs malfunctions, it is believed that this malfunctioning might affect the life of the organism. The functionalists, therefore, argue that the society is made up of groups and institutions which constitute the whole society. They state further that each of these institutions that form the society plays a part for the survival of the system (Onyeneke 1996).

From the foregoing, therefore, functionalists view society as a system, a set of interconnected parts which, together, form a whole. This makes society the primary unit of functional analysis. The focus of attention is how the basic parts of the society, that is, the various institutions, such as the military, religious, family, political, economic, legal, health and educational institutions co-relate together and function for the survival of the society.

The main interest of the functionalists is the question of order. That is, how social order would be achieved and sustained for the smooth running of the society. The functional approach to the study of society tends to be conservative in nature because it seems, to a large extent, is against the theory of social change. Functional ideology believes that there are basic needs of a society, which must be met, for social life to go on.
These basic needs or necessary conditions of existence are known as functional prerequisites of society. Functional prerequisites refer to the fulfillments of the broadest conditions which are necessary for a system's existence and which, therefore, prevent its termination. To the functionalist school of thought, what constitute the basic needs of society must be identified and met before a society can survive. In this wise modern maternal health care provision are the basic health structures established in the society to help save the life of both mother and child during pregnancy. Health as an institution has a defined role to play in the maintenance of good health of the people in the society. The ability of women to utilize available modern maternal health institutions is a pathway to the reduction of high maternal mortality rate experienced among pregnant women all over the world especially in the developing countries of Africa. Therefore, the interaction between pregnant women and modern maternal health care provisions is inevitable as long as the well being of the pregnant mother is concerned. This is the need to anchor this study on structural functionalism theory.

4. Study Design

The study adopted the ex-post facto research design. This design was considered appropriate because the investigator could not manipulate the variables involved in the study.

4.2 Area of study

Orumba North Local Government is one of the Local Governments in Anambra State of Nigeria. Anambra State is one of the states in the Eastern Nigeria. The Local Government is bounded in the north and east by Aniocha LGA and in the west by Ekwulobia LGA. The people of the Local Government Area speak Igbo language and they are hospitable. Majority of the people are farmers while about 15% of the total population are public servants.

Study Population, Sample size and sampling technique

The subject of this study is made up of all women of child bearing age between 18 years and above. The sample for the study was drawn using Conchran's sample size formular as follows:

$$n= \frac{Z^2 P (1-P)}{d^2}$$

Where:
n= the sample size
Z= Z statistics for level of confidence
P= expected prevalence or proportion
d= precision

$$n= \frac{(1.96)^2 (0.05) (0.05)}{0.5^2}$$

n= 384

A total of **384** samples were drawn from the study area through random sampling method.

5. Methods of data collection

Relevant data for this study were generated in two ways: primary and secondary sources. The primary source of data was questionnaire administration. The questionnaire was both structured and unstructured. The structured aspect was used to capture the expected responses on thematic issues. On the other hand, the unstructured questions helped to know, without prejudice, the opinions of respondents on matters affecting utilization of maternal health care services. The questionnaire was divided into two sections. Section "A" deals with socio demographic data of respondents while section "B" handles issues on access to maternal health care services provisions. The secondary sources of data were information obtained from libraries and documents dealing on maternal health care, culture and health, community and health and so forth.

6. Data analysis

Both qualitative and quantitative data collected for this study were analysed. Qualitative data were content analysed while quantitative components of data generated were analysed at univariate level, using frequencies and percentages.

7. Results and Discussion

Using the sample size, the questionnaire was distributed to 384 respondents. Out of this, 365 questionnaires were returned. The analysis therefore was done on 365 respondents.

7.1 Section 'A': Demographic Characteristics of Respondents

Information obtained on demographic characteristics of respondents focused on their sex, age, religion, marital status and educational qualifications. Table 4.0.1 contains the data.

Table 4.0.1: Data on respondents' sex, age, religion, marital status and educational qualifications

Variables		**Frequency**	**Percentage**
Sex:	Female	365	100%
Age:	18 and 24	150	41%
	25 and 31	55	15%
	32 and 38	70	19%
	39 and 45	90	25%
Religion:	Christianity	240	66%
	Islam	20	5%
	Traditional	50	14%
	Others	55	15%

Marital Status:	Married	265	72.6%
	Divorced	70	19.2%
	Widowed	16	4.4%
	Single	14	3.8%
Educational status:	BSc /HND	170	46.6%
	SSCE/WAEC	90	24.7%
	FSLC	60	16.4%
	OND/NCE	40	10.9%
	Others	5	1.4%

Source: Field work 2015

Table 4.0.1 shows that all the respondents were females and that 41% of them were between the ages of 18 and 24 years. Those who were between the ages of 39 and 45 years were 25% while the least were those within the ages of 25 and 31 years. The implication is that those who were younger (between 18years and 24 years) were greater in number. On their religious background, 66% respondents were Christians, 14% were traditionalists while only 5% were Muslims. It indicates that majority of them were Christians.
Concerning their marital status, 72.6% respondents were married, 19.2% were divorced while 4.4% were widows. Among the respondent were 3.8% who were singles. This shows that majority of the respondents were married. Education wise, 46.6% had their first degrees/HNDs while those who had their WAEC/SSCE were 24.7%. The least were those who had their OND/NCE with a population of 10.9% respondents. From records, a good number of the respondents were educated up to first degree level. This is a clear indication that majority of the respondents were literate.

7.2: Section B: Assessment of the utilization of modern maternal health care provisions in Orumber North LGA, Anambra State, Nigeria

Views of respondents were sought on their utilization of the available modern maternal health care facilities in Orumba North LGA. Results generated on this are presented in table 4.1.1.

Table: 4.1.1: Responses from respondents on how often pregnant women utilize maternal health care facilities in Orumba North L.G.A, Anambra state, Nigeria

Variable	Certified	Not certified
You utilize modern maternal health care services in your area	300 (82%)	65 (18%)
The medical treatments in the modern maternal health care facilities in your area are satisfactory	60 (16%)	305 (84%)
Are you very much willing to visit the maternal health care centers in your area very often	45 (12%)	320 (88%)
You utilize the services of local birth attendants more than modern maternal health provisions in Orumba North LGA	190 (52%)	175 (48%)

(Sources: Field Survey 2015)

Data in table 4.1.1 indicates that 82% respondents were of the view that they utilize maternal health facilities in their area while those who stated that they did not utilize them often were 18% respondents only. The implication is that pregnant women in the area certified that they go to maternal health care provisions in their area for their antenatal and other maternal health care services.

Also assessed was the satisfactory nature of the medical services obtained from the maternal health care facilities in the area. On this angle, 84% respondents said they were not satisfied with the medical services in their Local Government Area. On the other hand, 16% respondents were of the view that they gain satisfaction in the services provided by trained health practitioners in the modern health facilities in their area.

In visiting the available maternal health care services in the area very often, 88% respondents said no. In their opinion, they will not visit the health provisions in their area very often. This is contrary to the beliefs of 12% respondents who were of the view that they were willing to visit health centers in their area very often.

Result also indicates that 52% respondents certified that they visit Traditional Birth Attendants (TBA) more often than they visit modern maternal health care facilities in the area. This set of respondents had strong confidence and trust on the efficacy of the services of the Traditional Birth Attendants more than the modern maternal health care service providers. This confirms the position of Ahmed et al (2005) that outside the hospital setting, women can be assisted by an attendant who may be unqualified. This attendant could be a Traditional Birth Attendant (TBA), a village midwife, a member of the family, or neighbour. In similar terms, Imogie, et-al, (2002) argue that rural dwellers prefer to use the services of TBAs as compared with their modern maternal health care counterparts. Reasons for their preference included: the option of home delivery, TBAs' availability, accessibility, inexpensive services, and rural dwellers' faith in the efficacy of their services. This position is corroborated by Christiana, et al, (2010). However, 48% respondents were stuck to the services of modern health care service providers. This set of respondents had confidence in the services they receive from modern health care facilities more than the TBAs.

8. Conclusion

From the position of this study, it is clear the fact that the provisions of health care facilities and services therein are very significant to the survival of both mother and child. The birth of a new baby is associated with a lot of issues especially where complications arise. The major determinant of the pregnant women's access to the provisions of modern medical services is a function of their belief and satisfaction of services received. Their value of health services provided is a major propeller to how often they visit modern maternal health facilities located within their area. Results show that 84% respondents stated that they were not satisfied with the services received from the modern health care facilities. This is the reason why 52% respondents strongly affirmed that they give high patronage to the services of the Traditional Birth Attendants more than they give to the modern health care service providers.

9. Recommendations

In view of the results of this study, the following recommendations are made:

1. Government should provide adequate medical equipments in the modern maternal health facilities in the area to enable health workers meet up with the demands of the teaming population of pregnant women.
2. More services of health workers should be engaged in the maternal health care provisions in the area. This will help them overcome the pressures associated heavy workload that could lead to workplace stress.
3. Government should organize periodic health seminars and workshops for the Traditional Birth Attendants. This will prepare them in terms of hygiene and top quality delivery services since they attract more patronage than the modern maternal health care service providers. This will help to reduce the risk associated with pregnancies which often lead to complications that result in the death of both mother and child.

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