

**SOCIO-CULTURAL FACTORS INFLUENCING THE NON-USE OF MATERNAL
HEALTH SERVICES IN NIGERIA**

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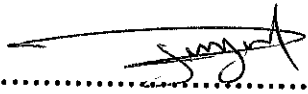
**A RESEARCH PROJECT SUBMITTED TO THE DEPARTMENT OF DEMOGRAPHY
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CERTIFICATION

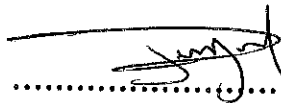
This is to certify that Olatunji Mosunmola Enitan of the Department of Demography and Social Statistics, Faculty of Humanities and Social Sciences, carried out a Research on the Topic “ Socio-Cultural Factors Influencing the Non-Use of Maternal Health Care Service in Nigeria” in partial fulfillment of the award of Bachelor of Science (B.Sc) in Federal University Oye-Ekiti, Nigeria under my Supervision


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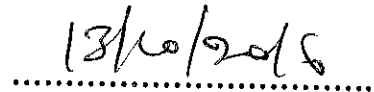
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EXTERNAL EXAMINER

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DEDICATION

The project is dedicated to Almighty God whose infinite mercies and favour saw me through and my beloved father, my hero, mentor, Mr. Mr. S.O Olatunji whose tireless efforts provided me with an opportunity to pursue my academics and also to the evergreen memory of my late Mother, Mrs. Janet Olatunji, may her loving soul continue to rest at the bosom of the Almighty God.

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ABSTRACT

This study examines the socio-cultural factors associated with the non-use of maternal health care services in Nigeria. In addition, to assess the perception women on health care utilisation during pregnancy and childbirth in Nigeria. Maternal health is one of the major concerns of the global health community. Pregnancy related mortality is avoidable if preventive measures are taken and adequate care is available. The study was carried out as a result of the high rate of maternal death despite the available maternal health care facilities in Nigeria. Three objectives were considered which were to: examine the level of non-use of maternal health care service (ANC & PNC) in Nigeria, to examine the socio cultural factors influencing the non-use of maternal health care services (ANC & PNC) in Nigeria and how women perceive health care utilization during pregnancy and child birth in Nigeria. The study adopted both quantitative and qualitative research method. The quantitative data was extracted from 2013 Nigeria Demographic and Health Survey (NDHS) and data were analysed at four levels using STATA. In-depth interview was adopted to generate qualitative data from women age 15-49 who had at least a child studies were analysed. The descriptive variables includes ethnicity, female autonomy, religion, age, level of education, marital status, age at first birth and number of children ever born. The study revealed that majority of the respondents was Hausa 34.33%, Igbo (14.41%) and Yoruba (14.15%). Decision about family health care is usually made by the husband in whom 35.42% of women do influence decision their family health care while 64.58% of respondents participate on decision about family health care. Also, 46.82% are Christian, 52.23% practice Islamic religion while 0.95% is traditionalists. In addition, 37.98% had no education while 17.22% and 35.69% had primary and secondary education respectively. The study revealed that 71.08% are married, 24.33% are single and 4.58% are either separated or

divorced. Furthermore, the socio-cultural variables such as ethnicity, female autonomy and religion have strong relationship ($\chi^2=0.000$) with the non-use of antenatal maternal health care. Therefore this study concluded that socio-cultural factors such as ethnicity, female autonomy and religion has great impact on improving maternal health and increasing negative health conditions of maternal morbidity and mortality. However, it is recommended that government should address many commonly held attitudes and behaviours, like gender roles and other cultural beliefs that are inimical to health are cultural issues, which can be achieved through community-based programmes. Health promotion and advancement education as a primary prevention approach will create opportunity for easier communication, dealing with the dynamics of knowledge, power and decision making process in the family, as part of the effort to ensuring good health during pregnancy.

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CHAPTER ONE

INTRODUCTION

1.0 BACKGROUND TO THE STUDY

The global intention of improving reproductive health in the world has created a demand for maternal research most especially in the regions where there is poor maternal health especially in developing countries. Maternal health, which is the physical well-being of a woman during pregnancy, childbirth and postpartum period (WHO, 2011; Fadeyi, 2007), has been a major concern of several international summits and conferences since the late 1980s, which was concluded to the Millennium Summit in 2000 (WHO, 2007). At Millennium Summit in 2000, it was jointly accepted that maternal health care play a vital role in the advance of reproductive health and women have the right to be well-informed and empowered to have unlimited access to safe, effective, affordable, acceptable and suitable health care service. These will enable women to be secured through pregnancy and childbirth and provide couples with the best chance of having healthy infants (United Nations, 1996).

While motherhood is often a optimistic and pleasing experience but for some women in sub-Saharan Africa, motherhood is often associated with distress, ill-health and even an early death to them, the most pathetic is the fact that, pregnancy-related complications are preventable if appropriate measures are taken and adequate care for pregnant women is available (WHO, 2011; Idris, 2010). Therefore maternal health warrants attention because pregnancy requires normal, life-enhancing process of reproducing which carries a high risk of death. This process of women's reproduction has been socially constructed by medical sciences as pathological abnormal and unnatural or at least in need of continual monitoring (Fausto and Sterling, 1992; Riessman, 1983; Zita, 1997; Dillaway, 2005).

The mother's body often goes through a lot of physiological, anatomical and psychological metamorphosis that is required to be handled properly in order to limit maternal morbidity and mortality rates (Hunter, 1994). A lot of diverse literatures have reveals that women face a lot of challenges in their attempts to ensure good health but unfortunately they lost their lives as a result of health problem related to pregnancy and child bearing.

A lot of Non-Governmental Organizations (NGOs), government health ministries and international organizations such as WHO have put together some policies in order to enhance maternal health outcomes throughout the world through the provision of maternal and child health programmes which are aimed at enhancing primary prevention of maternal morbidity and mortality through education and services, early detection and treatment. Specific programmes interventions include emphasizing prenatal attention, clean and safe deliveries, postnatal care, family planning, and essential obstetric care (Fadeyi, 2007; Lubbock and Stephen, 2008). While these programmes support women access to maternal health services, women continue to be capable of admitting health complications due to some irrelevant social and cultural factors.

Furthermore, a maternal and child health approach has often focused on medical and facility-based involvements. However the issues involved in maternal health also include social, cultural, economic, legal and even religious factors, which equally need to be addressed for any meaningful improvement in maternal health especially in developing countries (HERFON, 2006). Consequently, safe motherhood which eludes many women due to inadequate knowledge about reproductive health is complicated by unmitigated socio-cultural and economic backgrounds of women (Okemgbo, Kutey, and Odimegwu, 2002) such as poverty, high risk social environment, inconsiderate working policies as well as role conflicts that lead to both emotional and physical stress which ultimately induce complications during pregnancy

irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental and incidental causes (WHO 2007; Ogunjuyigbe and Liasu, 2007; khama et.al 2006).

It is within this conceptual framework that the Millennium Development Goal Target 5A calls for a declining in maternal mortality ratio by three-quarters by 2015. At its present rate, still, the world will fall short of the target for maternal mortality reduction because the data so far accumulated suggested that to reach the target the global Maternal Mortality Rate (MMR) would have had to be reduced by an average of 5.5% a year between 1990 and 2015. The current average rate of reduction is less than 1% a year. The annual rate of reduction in maternal mortality in sub-Saharan Africa was estimated to be 0.1% annually where levels of mortality are highest which is slower than that is obtained in other regions of the world (UNICEF, 2008). Although Nigeria constitutes only two percent of the world's population, Nigeria accounts for over 10% of the world's maternal mortality, and ranks second globally only to India (Okonofua, 2007; Abdul Aziz, 2008).

Nigeria maternal health status is poor which is being defined by maternal mortality of 59,000 per annum due to pregnancy-related causes, this has been known as the major cause of death among women of reproductive age in Nigeria (Idris, 2010). Reducing maternal health complications was one of the critical issues which received attention at the Beijing conference on women development in 1995 (Kaba and Dagnachew, 2001; Lule. 2005; Daily Independent, 2010). Unfortunately, the Beijing declaration has not been fully implemented in Nigeria despite its poor record of maternal health as many women still die prematurely or suffer debilitating ill-health from reproductive processes which are, to a large extent, preventable (Alubo, 2010). Accordingly, it will be justifiable to submit that the decline of maternal mortality and morbidity

needs a multifaceted approach that includes inscribing both social risk and medical factors that are related with increasing susceptibility among women. Maternal health obstacles just do not appear in a day as a challenge, they are as a result of constellation of many precautions that ought to have been in place before and during pregnancy. Availability of health care service is only one element require for safe pregnancy. There are other factors militating against healthy pregnancy that need to be examined to ensure maternal health and to prevent maternal complications. The issue of maternal mortality in Nigeria has been adduced to both medical and social factors and it is believed that the way to take on maternal mortality is to deal with all factors simultaneously (HERFON, 2006; Global Medial, 2010).

However, while many studies have concentrated on the medical factors that are dangerous to maternal health while few studies have concentrated on the socio-cultural context of non-use of maternal health care services. It is therefore very important to know these factors that are kindred with the non-use of maternal health care to adequately inform health care policy makers these factors. This background of socio-cultural factors associated with maternal mortality, though narrow, are overwhelming in determining maternal health. This study is initiated to examine the socio-cultural factors influencing the non-use of maternal care services with particular reference to Nigeria.

1.1 Statement of the Problem

The World Health estimated 2013 that 289,000 women die each year due to pregnancy or child birth (in which there is decline compare to 523,000 in 1990). The ten countries with utmost burden of maternal mortality includes India, Nigeria, Democratic Republic of Congo, Ethiopia, Indonesia, Pakistan, Tanzania, Kenya, China, and Uganda which accounted for 60% of these deaths. Nigeria accounts for about 13 percent of the worldwide maternal mortality rates with an

estimated 36,000 women dying in pregnancy or at child birth annually. At least 5500 of these deaths are among teenage mothers. Maternal mortality is the most essential indicator of maternal health and safety in any country (HERFON, 2006). From current estimates, the figure of mortality each year from maternal causes worldwide decline from 536,000 in 2005 to an estimated 358,000 in 2008 and 273,500 in 2011. For each woman that dies, approximately 20 more suffer injuries, infection and disabilities in pregnancy or childbirth (IHME, 2012; UNICEF 2008; WHO, 2007).

Even though maternal mortality is a worldwide phenomenon, the serious issues related with it are mostly found in developing countries. Hence, of the estimated number for maternal mortality worldwide, developing countries account for 99 per cent (WHO, 2008), with an estimated 265,000 maternal mortality occurring in sub-Saharan Africa (UNICEF, 2008) situation is even more disturbing in Nigeria. For example, in the year 2000, the maternal death ratio per 100,000 live births was 800 compared to 540 for Ghana and 240 for South Africa. However, by 2003, the maternal mortality ratio in Nigeria had risen to 948/100,000, in 2005 it was 1100/100,000 and 840/100,000 live births in 2008, while Nigeria Demographic Health Survey (NDHS) 2008 has put it at 545 per 100,000 live births (Berlin Institute for Population and Development, 2011; UNICEF, 2010; Zozulya, 2010; NDHS 2008; Ogunjuyigbe and Liasu, 2007). therefore, the probability of a Nigerian woman dying from reproductive health disorders and complications was put at 1 in 10 in 2002 (Population Reference Bureau, 2002), 1 in 18 in 2005, and 1 in 23 in 2008, putting the Nigerian woman at far bigger risk than her counterpart in the developed world, where the risk is estimated to be 1 in 17,800 and 1 in 10000 in countries such as the Republic of Ireland and Singapore respectively (World Bank, 2011; UNICEF, 2010; Media Global, 2010; UNICEF, 2008; UNFPA, 2005). Some of the implications of these

estimates are the reduction of the country labour force and the general oppressive of rapid development.

Many studies have revealed that in spite of the differences in maternal death ratio between developed and less developed nations, the pattern of maternal death and morbidity did not vary over the years. Yet, the most frequent major causes are infection, haemorrhage, hypertensive disorders, obstructed labour, sepsis unsafe and abortion. The reasons that are adduced for this is the persistent tradition of deliveries in domiciliary settings in unsafe and unhygienic conditions by untrained or poorly trained birth attendants (Begun; Aziz-un Nis and Begun, 2003; Izugbara and Ukwai, 2004) though maternal mortality in Nigeria are principally as a result complications of pregnancy and delivery, it is the socio-cultural factors that influence the non-use of maternal health services that pave the way for these complications and deaths. While we're on the subject very few studies have focused exclusively on this aspect of maternal health. This study, for that reason, attempts to fill this space.

In an attempt to address maternal mortality and morbidity most scholars have emphasized on the medical causes. This is more or less focusing on symptoms and malfunctions of the body without allowing for the socio-cultural factors hindering use of maternal health care services within which pregnant women interact. Many studies, such as, Orubuloye and Ajakaiye (2002); Ogunjuyigbe and Liasu (2007); Falkingham (2003); Das Gupta (1997), have only assessed the socio-cultural factors in relation to health care utilization not in relation to adequate quality of maternal health. Socio-cultural factors such as female autonomy, ethnicity and religion thereby exacerbating maternal mortality. The socio-cultural factor such as religion, ethnicity and role of gender which often includes spousal influence affect women looking for health services which may worsen maternal mortality. The require to address this issue is essential because the

incapability to show any direct relationship between health care expenditures and maternal mortality may affect negatively the availability of funds for future health care. This situation becomes even more dangerous as resources become more constrained to health competes and government incapacity to focus on other sectors of the economy that will enhance development in the country .

1.2 RESEARCH QUESTIONS

Based on the statement of problem, the following research questions are addressed.

1. What is the prevalence of non-use of maternal health care service (ANC & PNC) in Nigeria?
2. What are the socio-cultural factors influencing the non-use of maternal health care services (ANC & PNC) in Nigeria?
3. How do women perceive health care utilization during pregnancy and child birth in Nigeria?

1.3 OBJECTIVES OF THE STUDY

The general objective of the study is to identify the socio cultural factors influencing the non-use of maternal health care service Nigeria. In order to achieve this, there are the specific objectives which include:

1. To examine the prevalence of non-use of maternal health care service (ANC & PNC) in Nigeria.
2. To investigate the socio-cultural influencing the non-use of maternal health care services (ANC & PNC) in Nigeria.
3. To assess the perception of women on health care utilization during pregnancy and childbirth in Nigeria.

1.4 JUSTIFICATION FOR THE STUDY

One of the expected goals of the Millennium Development Goals (MDGs) is the advance of maternal health and the decrease in maternal mortality by 75% by the year 2015. Nigeria poor record of maternal death, it is obvious that the global MDG goals cannot be achieved without a momentous result from Nigeria in terms of reductions in rates of maternal morbidity and mortality. Although results of recent trends reveal that the country is making advancement in reducing maternal mortality rates, the rate of reduction still remains too sluggish to attain the MDG goal. Thus, a sociological study of maternal mortality is a means to gain more insight into those visible socio-cultural barriers to wellbeing and what can be done to improve the condition.

The studies of the socio-cultural factors that influence the non-use of maternal health in Nigeria such as religion, gender inequality, ethnicity, female autonomy etc are important and necessary for several reasons. First, some women are being subjected to their orders almost in all form including health seeking services the maternal health status in Nigeria is poor, based on the high rate of maternal mortality. Among the health and mortality indicators, levels of maternal mortality show remarkable differences according to level of development. Maternal death is a responsive indicator of the position of women in society, as well as right to use to health care and sufficiency of the health care system in responding to their desires. The maternal mortality rate (MMR) in Nigeria without any hesitation calls for vital attention.

Secondly, Nigerian women are still faced with challenges due to pregnancy-related illness. The drop maternal mortality calls for intensive efforts particularly in the region of research that will enlighten our understanding of the socio-cultural elements associated with maternal health. Efforts to deal with these problems will not only advance maternal health in Nigeria but will also make a payment to achieving a key section of the SDGs and safe the

country in good light in the global comity of nations. Therefore, addressing maternal health's line of attack in a country in sub-Saharan Africa is not only relevant for women's empowerment but also for women in development in Africa and Nigeria in particular.

1.5 Operational Definition of Terms

For the purpose of clarity, the key words of this study have been given operational definitions as follows:

Maternal Health; this is defined as the physical wellbeing of a mother in relation to her pregnancy. Maternal health includes prenatal care and postnatal care of the mother and of the child up to the age of five years.

Maternal Mortality; The World Health Organization (WHO, 2007) in the international statistical classification of diseases and related health problems, tenth revision (ICD-10), has defined maternal mortality as the death of a woman while pregnant or within 42 days of a termination of a pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental and incidental causes.

Maternal Morbidity; describes pregnancy and childbirth related illness and injury. Maternal Mortality Ratio (MMR) Number of maternal deaths during a given time period per 100,000 live births during the same time-period, usually a year (WHO, 2007).

Maternal Mortality Rate; this is the number of maternal deaths in a given period per 100,000 women of reproductive age during the same time-period (WHO, 2007).

Reproductive Health; according to the United Nations Concise Report on Reproductive Rights and Reproductive Health, reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the

reproductive system and to its functions and processes (United Nations, 1996).

Risk factors; these are factors, situations, beliefs etc. that is unfavourable to maternal health.

Socio-cultural factors; these are the surrounding societal and cultural factors or situation, which sway or hinder maternal health. They are also the social and cultural framework in which an individual function.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.0 INTRODUCTION.

This chapter presents a detailed review of the literature as it relates to maternal health which follows a logical sequence by reviewing how scholars have interrogated the concept of maternal health and insinuation of such conceptualization on government policies in the direction of providing of health services. Owing to the fact that the study is concerned with the socio cultural context of maternal health, an extensive review of literature on important factors that have been identified by scholars is next presented followed by the theoretical framework.

2.1 LITERATURE REVIEW

World Health Organization (WHO) defined health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (Jegade, 2010). Although this definition has been broadly adopted, a number of scholars still identify some problems with it example, Badru (2003) has observed that there is a problem of identifying and observing such conceptual notion as psychological and social wellbeing, even if the bodily aspect can be subjected to several measurement. Similarly, Asakitikpi (2007) also pointed out the neglect of the spiritual dimension of health especially as it relates to African societies. It has been experimental that most health issues and mortality in the African society are ascribed to sacred causes (Mensah, 2008). An increasing number of researches have been published within the last 20 years and reviews have examined the connections between spirituality religiousity, health and quality of life and its potential to prevent, heal or cope with diseases (Koenig, Larson and Larson 2001).

Religion and spiritualism are very much alive in Africa and their influence on health and illness cannot be ignored in contemporary African societies, since notions of illness causation and healing span the physical and spiritual domains (Mensha, 2008). Also health is a situation of being free from physical disease or pain or mental disorder or freedom from emotional or spiritual drudgery. In addition, according to Badru (2003), patterns of health as well as disease differ from one society to the other. For example, as observed by Akintunde (2006), among the Yoruba in Western Nigeria, it is true that health is vital, health is wealth, whoever have good health has everything. The absence of good health is illness and illness is understood in three particular ways primarily, it is normal or physical, such as poisoning, pain. Secondly, it is mystical or spiritual, including attacks by witches or wizards. Thirdly, it is spiritual, which attributed to spirits and divinities for punishment of offences against them. Therefore, to better understand the concept of health, Jegede (2010) claimed that for the WHO definition to be complete and satisfactory there must be maintenance of body stability, physical and emotional balance, cultural and political balance, and spiritual and ideological balance.

Maternal health is the physical wellbeing of a mother during pregnancy, childbirth and postpartum (WHO, 2010). Maternal health includes antenatal care and postnatal care of the mother and of the child up to the age of five years (Fadeyi, 2007). Many biological, economic, social and cultural factors such as poverty, malnutrition, working condition, child marriage and gender inequities may compromise the health of pregnant women (Graczyk, 2007). Scholars such as Ufford and Menkiti (2001) and Lanre-Abass (2008), have identified early childbearing, cultural, logistical, and poverty, as a multifaceted condition that has many dimensions. Among the dimensions are poor access to public services and infrastructure, unsanitary environmental surrounding, illiteracy and ignorance, poor health, insecurity, voicelessness and social exclusion,

as well as household income and food insecurity are life-shortening which can also increase a women's risk of dying in the process of reproduction et al. Ensuring reproductive health does not only engage stipulation of contemporary quality health services and attendance to the same, but also individual health awareness during pregnancy at the same time as, some scholars and writers have advocated for the accessibility of basic widespread and formal obstetric and gynaecological care in order to significantly decrease the occurrence of maternal mortality, other researchers have found out that even when official skilled care is obtainable, women may not seek or receive it (Igun, 1989). This is especially so in countries such as Nigeria where informal and formal healthcare services coexist and are viewed as veritable options for reproductive healthcare (Izugbara and Ukwai, 2004).

The importance of starting prenatal care as early as possible, even before pregnancy was emphasized by Ben-Joseph (2007), even though this may not always be possible or practicable. The earlier healthy lifestyles commence in pregnancy, the healthier the probability of ensuring the mothers health and that of the baby. Ideally, antenatal care should start before the pregnancy. It is essential for a woman to get prepared for pregnancy, to ask a health care provider for a complete medical check up to make sure she is in good health. Healthy lifestyles add both to the broad health of pregnant women and to that of their babies. For the baby sake and that of the mother, it is important for a woman to take good care of herself during pregnancy.

Also, safety of food has been identified by different scholars as one of the major factors that determine maternal health. For this motive, pregnant women should give extraordinary consideration to food safety because food borne pathogens can be hazardous during pregnancy. Two of the deadliest pathogens that have been identified are *Listeria monocytogenes* and *toxoplasma gondii*. These pathogens are most often found in undercooked, poultry or seafood,

products made with unpasteurized milk and unpasteurized juice. To keep away from food borne illness, pregnant women should wash their hands thoroughly prior to preparing or eating food and also the fruits they consume (Insel and Roth 2004).

Also, Graczyk (2007) renowned that family planning can decrease maternal mortality and morbidity occurrence. Accordingly, reproductive health care, including family planning services can help women and adolescents to prevent unwanted pregnancy, complications during pregnancy and delivery, as well as unsafe abortion. Universally, over 200 million women have no access to modern and effective contraception (USAID, 2006). In the developing world, lack of access to family planning results in some 76 million unintended pregnancies each year with unfortunate consequences. Experts say that contraceptive use can prevent up to 35% of maternal deaths and when contraceptive use increases, countries infant mortality rates decline (UNFPA, 2005). In countries where less than 10 percent of women use contraception, the infant mortality rate is 100 deaths per 1,000 live births compared to 52 per 1,000 in countries where over 30 percent of women use contraception (UNFPA, 2000). It is very obvious that a good family planning programme can reduce fertility even in very poor countries (Jain and Ross, 2012) and save the lives of mothers by preventing the exposure of women to the risks of pregnancies which they do not want and by allowing women to plan their pregnancies to take place at times that are more favourable for safe childbearing.

These are high-quality healthy choices for a woman. If a woman is in good physical shape, there is no motivation to anticipate complications with the pregnancy and delivery (United Nations, 1991). Studies conducted before to the 1994 Cairo meeting established that family planning programmes are most effectual when a strong programme is implemented in a good social setting (Jain and Ross, 2012).

MEDICAL CAUSES OF MATERNAL MORTALITY AND MORBIDITY

Different factors such as dietary status, age, income, education, social status and availability of health services add to maternal morbidity and mortality. Therefore, it is essential to discern that apart of health sector activities. Other factors such as educational level also influence maternal health consequence. As a result, the causes of maternal death have been classified as direct and indirect (Khama.) The ICD defines indirect causes as those resulting from previous existing disease or disease that developed during pregnancy and which was not due to direct obstetric causes but was increased by physiologic effects of pregnancy (Garenne, 2011; Khama). The while Direct Obstetric Deaths are those consequential from obstetric complications of the pregnant state from interventions or incorrect treatment. According to Dillaway (2005) and Garenne (2011), pregnancy needs continual monitoring because it is associated with major physiological changes that may increase susceptibility to infectious and non-infectious diseases particularly, pregnancy has possibility of inducing transient despair of cell-mediated immunity and is frequently associated with anaemia and hypertension, situation that may have an consequence on the pathogen of a variety of diseases some common direct medical cause that result to maternal morbidity and mortality are gestational diabetes also known as diabetes of pregnancy (which is caused by a problem dispensation of blood sugar in the blood stream), Eclampsia, Postpartum sepsis. (an infection of the genital tract happening at any time between the rupture of membranes or labour and the day postpartum in which two or more of the following are present abnormal vaginal damage WHO (2009), Placenta Previa (placenta is lying low in the uterus), Miscarriage (spontaneous abortion) etc in which all these can be curb with adequate maternal health care facility.

ACTIONS ON MATERNAL MORTALITY IN THE WORLD

There are number of regional, national and international old declarations initiatives on maternal health in the world. The healthy Motherhood Initiative was launched by the World Health Organization (WHO) and other international agencies in 1987 and was instantly supported by International Confederation of Midwives (ICM, 2012). The second was the International Day of Action for Women Health on 28 May 1988, launched by the Women Global Network for Reproductive Rights and the Latin American and Caribbean Women Health Network through a call to Women for Action to Prevent Maternal Mortality, which had been endorsed by participants at the 5th International Women and Health Meeting in 1987 in San Jos, Costa Rica (Ravindran & Berews, 2000). At that time a lot of women maternal deaths worldwide were estimated to be at least 600,000 per year with 99% of deaths happening in the developing world (ICM, 2012). More countries have now made a promise to Safe Motherhood than ever before through the Programme of Action of the International Conference on Population and Development (ICPD) in Cairo in 1994, the Technical Consultation on Safe Motherhood in Colombo, Sri Lanka in 1978 and the ICPD review process in New York in 1999. At the ICPD in 1994, all governments agreed to reduce maternal mortality by one half of the 1990 levels by the year 2000 and by a further half by 2015.

SOCIO-CULTURAL CONTEXT OF MATERNAL HEALTH

Culture influences health behaviour in so many perspectives. For instance, Nigeria culture affect the way in which illness is been reacted to (Erinosho, 2005). Cultural factors include gender norms, child marriage, early pregnancy, nutritional taboos, particularly during pregnancy, certain birthing practices, female genital mutilation and widow inheritance. The

result for individual women and girls is mitigation of their health or their quality of life. These factors affect women's reproductive attitudes in the aspect of the number of children they want and how they want their births to be spaced. Women do not always get the support they need to fulfil their reproductive intentions. In some settings fearing reprisal from disapproving husbands or others, many resort to clandestine treatment, especially in the use of family planning (UNFPA, 2000). Therefore, cultural restrictions limit choice of women of their reproductive intentions. These restrictions mean that women are dependent on the decisions of others about medical intentions. It can be difficult for women to raise reproductive health issues such as menstrual bleeding irregularities are especially hard to discuss. Women may be unable to get their problems addressed until their conditions are serious and treatment options are more restricted and costly (UNFPA, 2000).

Also, it has been argued that perception of illness is affected or influenced by different belief systems in societies (Jegade, 1998; Kitts and Roberts, 1996). As Nwabuzze (2003) has explained, the social perspective on health has it that though the presence of disease may be a biological phenomenon, the culture of the people may sometimes contain anti-health social habits. For instance, most of the time they rely on home remedies to solve minor problems. Jegede (1998 41) has observed that it is not all the time you go to the hospital. In those days our grandparents used to single-handedly handle their wards medical problems without much recourse to any external help.

Women are often forced to choose whether to further a career or whether to devote more time to their home and family. To maintain the role of a good mother, the female must satisfy either her work commitment or her family commitment in fewer hours or sacrifice sleep. The tolls paid by women to maintain this illusory balance is their health (Runte and Mills, 2004).

However, its negative impact on women health is greater in the developing countries (Idowu et al, 2011) and it also denotes a cultural value of male dominant role in patriarchal societies (Jegede, 1998). This reduces the promptness with which medical assistance is obtained anytime an illness is suspected during pregnancy (Idowu et al, 2011). An individual may personally disregard gender expectations, but society may disapprove of his or her behaviour and impose external social consequences. On the other hand, an individual may feel internal shame if he or she experiences emotions or desires characteristic of the opposite sex (Encyclopaedia of Mind Disorder, 2009). Gender role conflict results when there is a discrepancy between how one believes he or she should act based on gender role expectations learned in childhood and how one actually thinks, feels or behaves. If these discrepancies are unresolved, gender role conflict contributes to poor health (Encyclopaedia, 2007).

The health impact of stressful events not only depends on the nature of these events but also on the individual's ability to cope with the crisis and on the extent to which they receive social support from relatives, friends and other members of their status (Stroebe, 2000). Indeed, such aspects of conjugal relations as the intimacy between spouses and decision making process can be expected to influence women's health. Studies have shown that conjugal role deprivation, which was reflected in strained relationships within marriage, was felt among the women either because they did not secure the kind of husband or the type of marriage they wanted or because of divorce or an unhappy current marriage (Omideyi, 1990). The feelings and fears experienced during pregnancy are intense and varied. These feelings and concerns are a normal part of pregnancy. Each woman comes to terms with the changes in her own way, with the support of her partner or family (Kitts and Roberts, 1996).

Social support from others such as relatives, friends and neighbours can play a vital role in fostering the physical and psychological health of women (Kitts and Roberts, 2003) and can greatly influence the health-seeking behaviour of women. Abdul'Aziz (2008) noted that family support networks are generally weaker in cities than in villages, leaving many women without support of the extended family in obtaining adequate antenatal and obstetric care. Social heterogeneity and stratification on the basis of ethnicity, occupation and place of origin and so on are typically more common in cities than in villages and may lead to selective provision of service to clients by practitioners and at worst to poor or inadequate service as a result of discrimination. These factors relate to circumstances that a woman finds herself that indicate whether she may be more susceptible to pregnancy related health challenges. This review has provided how social circumstances contribute to maternal health complications in Nigeria. The central point to appreciate is that while medical service is important for enhancing maternal health, its reach and impact depends greatly on the socio-cultural context within which it operates. Reduction in maternal morbidity and mortality depends on many factors.

2.3 THEORETICAL FRAMEWORK

In order to interpret the research data and integrate them within a cohesive body of knowledge therefore this study has adopted a theoretical framework that synthesizes interrelated theoretical perspectives of Structural Functionalism. The logic of this framework is anchored on the strength of structural functionalism perspective and how it will fuse into one complete whole to explain maternal health. Functionalism is adopted because of socio-cultural factors as social facts that constrain people's behaviour towards maternal health care services. Therefore, this will explain the situation of women based on their position in the society.

Structural Functionalism Theory

Functionalism is a theoretical perspective which traces social order to biological root. It views society as a system made up of interrelated parts which together form a whole (Haralambos and Holborn, 2008). It focuses on the structures of society and their functional significance (positive or negative consequences) for other structures. The primary concern of functionalism is the large-scale social structures and institutions of society, their interrelationships and their constraining effects on actors (Ritzer, 2003). In a society their social structures are interdependent. For a society to survive, its interdependent parts must function in harmony. Functionalists hold that survival depends on cooperation and that cooperation depends on agreement on basic values and rules for behaviour. Under normal conditions the various parts of society work together toward shared goals, producing order, stability and equilibrium. Viewed from this perspective, conflict is a symptom of “disease” in the social organism (Gelles and Levine, 1995).

The function of structural functionalism to our society implies that each society has certain needs in that there are a number of activities that must be carried out for social life to survive and develop. Goods and services must be produced and distributed in order for people to survive, there must be some administration of justice, a political system must exist and some family structure must operate so as to provide a means to reproduce the population and maintain social life on a daily basis (Ogunbameru, 2008). In the structural functional model, individuals carry out each of these tasks in various institutions and roles that are consistent with the structures and norms of the society. Functionalist analysis looks on social systems as having certain needs and society as a system of social structures. If the needs are being met, then it is the social structures that meet these needs. The structures are thus functional in the sense that they

help society to operate dependently (Ogunbameru, 2008). The interconnections exist within and among these structures; individuals and groups are constrained by these structures.

In Talcott Parson Functionalism, the concept of adaptation signifies that a system must adjust to its environment and adjust the environment to its needs. More specifically, a system must cope with external situational dangers and contingencies. A system cannot remain long at odds with its environment. If it did, it would be in grave danger of perishing because of the lack of fit. The main idea of functionalism is its focus on the question of how social systems are maintained.

However, in Merton's view, functions are defined as observable consequences that help a particular system adapt to a situation. However, there is a clear ideological bias when one focuses only on adaptation and adjustment, for the consequences are always positive. It is important to note that one social structure can have negative consequences for another social structure. To rectify this serious omission in early structural functionalism, Merton developed the idea of a dysfunction. Just as structure or institutions could contribute to the maintenance of other parts of the social system, they also could have negative consequences on them (Ritzer, 2003). He contended that not all structures are indispensable to the workings of social system. Some parts of our social system can be eliminated. If there are aspects of a people's culture that are injurious to their health or detrimental for societal progress, they can be eliminated (George, 2010). Therefore, there is the need to study maternal health from an actor perspective through critical analysis. Within this theoretical framework, maternal health care services and its attendant complexities cannot be fully understood by some universal variables. Rather, the social and cultural context that sustains it must be understood from a particular exploration.

This theory shows the capability of larger society to create stressful situations where

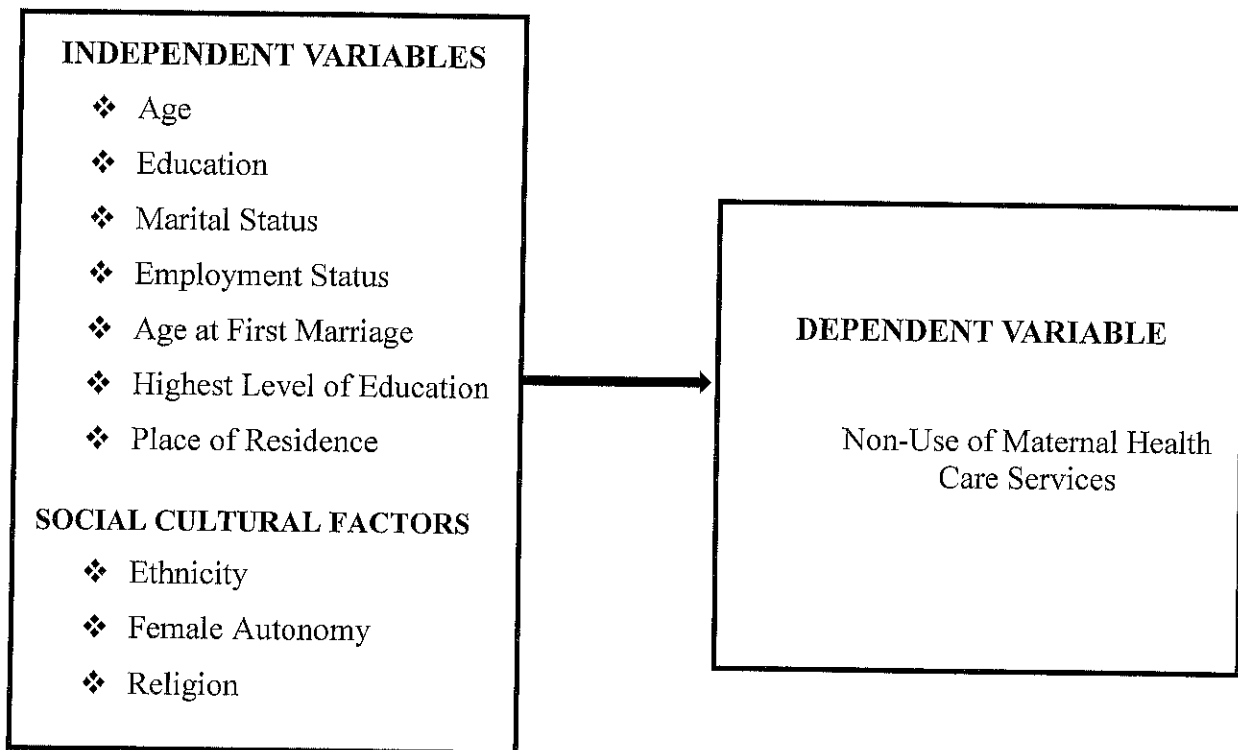
people are forced to respond to conditions not by choice. Functionalism helps us to recognize that macro-level social events can affect health in a variety of ways through stress and that the effects of stress can be mitigated through social supports (Cockerham and Scrambler, 2011). The theory explains how illness, health and health care affect and is affected by other aspects of social life. The functionalist perspective draws attention to latent dysfunctions or unintended and often unrecognized negative consequences of social behaviour. For example, high rate of illiteracy among women had led decrease of the awareness of maternal health care services which is now a major threat to maternal health. According to this perspective, social change involves structural change and not a change in the basic functions of social systems (Kakepoto, 2008). No doubt, social change has a direct impact on the basic structure and functions of the social institution. Even though technology has elevated the status of women in the family, it has put the fabric of the social relationships at stake. This can be responsible for much distress being witnessed in maternal health. Some interventions have also increased the level of illiteracy and therefore widened the inequality in recent years. In this light, political, economic and other social structures within society hinder women from meeting their health needs and reaching their full potential.

2.3 CONCEPTUAL FRAMEWORK

A conceptual framework of socio-cultural factors influencing the non-use of maternal health services in Nigeria is presented here for a better understanding of their causal relationships. This is designed to outline the expected interrelationships between socio-cultural factors and the non-use of maternal health services in figure 2.1. These interrelationships are organized, making interventions on maternal health care services understandable in figure 2.1. The expected relationship among these variables and non-use maternal health care are identified.

While these are observations from the literature reviewed, they stand to be confirmed and corrected by the outcome of the research data analysis.

Figure 2.1: Schematic representation of the relationship between socio-cultural factors and non-use maternal health care services.



2.4 RESEARCH HYPOTHESIS

In line with the theoretical framework, this hypothesis is drawn:

Ho: socio cultural and demographic characteristics factors such as age, level of education, religion affiliation, female autonomy and religion may likely influence the non-use of maternal health care services in Nigeria.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 INTRODUCTION

This chapter contains the study area, sample design, sample size, data sources, target populations, the dependent and independent variables, method of data analysis and as well as the limitation of the study.

3.1 BACKGROUND OF THE STUDY AREA

Nigeria lies on the west coast of Africa between latitudes $4^{\circ}16'$ and $13^{\circ}53'$ north and longitudes $2^{\circ}40'$ and $14^{\circ}41'$ east. It occupies about 923,768 square kilometres of land stretching from the bay of Guinea on the Atlantic coast in the south to the outer edge of the Sahara Desert in the north. The protective boundaries are distinct by the republics of Niger and Chad in the north, the Republic of Cameroon on the east and the Republic of Benin on the west. Nigeria is the most densely inhabited country in Africa and the 14th largest in land mass. The country's 2006 Population and Housing Census placed the country population at 140,431,790. Nigeria is geographically diversified, rich in culture cultural and numerous natural potentials, favourable climate, with over 270 distinct tribes and more than 374 languages.

Nigeria came to a reality as a main nation-state in 1914 through the merger of the northern and southern protectorates. Before Nigeria was colonised there were various independent ethnic, cultural and linguistic groups such as the Benin, Hausa-Fulani, Kanem-bornu, Jukun, Nupe and Oyo empires. The British made one of the empires a crown colony type of government after the amalgamation. In 1942, a small number of Nigerians became involved in the administration of the country. In 1950s, Nigeria achieved incomplete self-government with a legislature in which the greater parts of the members were chosen into a decision-making council

of which most were Nigerians. In October 1960 Nigeria became fully independent as a federation of three regions which are Northern, Western and Eastern region under a constitution that provided for a parliamentary system of government in which Lagos state was made the federal capital territory of Nigeria then. Also, Nigeria became a democracy nation on October 1, 1963, with diverse administrative structures. Agriculture was the basis of Nigeria economy before the detection of oil in January 1953. Pending that point, the country had depended more or less entirely on agricultural production for food and agro-industrial raw materials for foreign exchange earnings through the commodity trade. At the point in time of independence in 1960, agriculture provided lucrative employment and a suitable livelihood to more than 90 percent of the population. Over the years, the main role of agriculture in the economy, especially in terms of the country's foreign exchange earnings, gave means to petroleum exports.

Today the country's economic power is largely derived from its oil and gas treasury. As at 2013, Nigeria gross domestic product (GDP) was 262.6 billion (World Bank, 2013). Nigeria is made up of 36 states along with a federal capital territory, grouped into six geopolitical zones North Central, North East, North West, South East, South-South and South West. There are 774 constitutionally known local government areas in the country. Presently Nigeria population is 140, 778, 561 of which 1 person is been added in every second (United Nations estimates). Nigeria total land area is 910,802 km² 351,662 sq. 48.1 % of the population resides in the urban (91,668,667 people in 2016) areas.

3.2 TARGET POPULATION

This study is limited to merely the women who had at least a birth in the last five years prior to the survey. Therefore the eligible respondents for this study are women aged 15-49 years from all the six (6) Geo-political zones of Nigeria.

3.3 SOURCES OF DATA

The study adopted primary and secondary data.

3.3.1 QUANTITATIVE DATA SOURCE

The secondary data for this study was extracted from Nigerian Demographic and Health Survey 2013. The 2013 NDHS was a multi-stage cluster sample survey of 38,0567 women aged 15-49 years in randomly selected households across all the states in Nigeria including the Federal Capital territory (FCT). Each local government was further divided into different census enumeration areas. A representative sample of 40,680 households was selected for the survey with a minimum target of 943 completed interviews per state. All women aged 15-49 who were either permanent resident of the households sampled or visitors present in the households on the night before the survey were eligible to be interviewed.

3.3.2 QUALITATIVE DATA SOURCE

The primary data was obtained through in-depth interview with women of child bearing age who have had at least a child within the last five years. An In-depth interview was also used to examine the perception of women towards socio-cultural factors that influence the non-use of maternal health care services in Nigeria. The information obtained from the respondents included socio-demographic and cultural characteristics, number of children ever born and their health care utilization during pregnancy and child birth in Nigeria.

3.4. DEPENDENT VARIABLE

The non-use of maternal health care services was measured using categories of women who attended maternal health care services while they were pregnant and after given birth (antenatal) and who didn't attend maternal health care services while they were pregnant after given birth (postnatal).

3.5 INDEPENDENT VARIABLES

3.5.1 SOCIO-CULTURAL CHARACTERISTICS OF RESPONDENTS

The socio-cultural characteristics include ethnicity, female autonomy and religion.

❖ Ethnicity

Ethnicity of the respondent was measured in Fulani/Hausa, Igbo, Yoruba and others.

❖ Female autonomy

Female autonomy was measured in their participation on decision about their family health care.

❖ Religion

Religions of the respondent were measured in three categories; the groups were Christians, Muslims and traditionalist.

3.5.2 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

The socio-demographic variables are age of respondent, place of respondent, level of education, number of children ever born, age at first birth and region.

❖ Age of respondents

Nigeria Demographic Health Survey (NDHS) grouped the age of women of reproductive age into 5 years interval which are 15-19, 20-24, 25-29, 30-34 and 35+ years.

❖ Place of residence

The type of place of residence is grouped into two categories i.e. the rural and urban area according to the Nigeria Demographic Health Survey (NDHS). The region in Nigeria is divided into six (6) geographical zones by the Nigeria Demographic Health Survey (NDHS 2013) which includes the North Central, North East, Northwest, South East, South-South and South West.

❖ Level of education

This is a categorical variable that is divided into four categories. These are no education, primary, secondary and higher education. This is coded by the Nigeria Demographic Health Survey (NDHS).

Others demographics characteristics includes type of residence, currently working, current marital status, total children ever born.

3.6 METHOD OF DATA ANALYSIS

The Nigeria Demographic and Health Survey (NDHS) data sets from 2013 individual recode was processed and analysed using STATA application package (STATA 12.0). Four levels of data analyses were employed in order to achieve the objectives of this study. The descriptive statistics involved the use of frequencies and percentages. The bivariate and multivariate analyses were employed for the inferential aspect of the study and kappa statistics was done to reveal the level of agreement among the variables. The bivariate analysis involved the use of cross tabulation tables between two distinct variables and chi square test of significance. Also binary logistic regression was also used for multivariate analysis in order identify the strength of association and examine predictors of non-use of maternal health care services in Nigeria. Also In-depth interview was used to assess the perception of women on health care utilization during pregnancy and child birth in Nigeria to enhance the reliability of the data.

3.7. ETHICAL CONSIDERATION

The study used secondary data in large part. NDHS 2013 has already taken care of ethical issues at the collection and collation stages, hence no risk of breaking any interview confidentiality. For the in-depth interview, the code of ethics for research on human subject was followed. Participants were properly and fully informed about nature of the study, that

participation was voluntary and were assured of the anonymity and confidentiality of the information given.

3.8. THE SCOPE AND LIMITATIONS OF STUDY

The study has limitation as a result of NDHS details; it is defective in measuring the perception of women on health care utilization during pregnancy and childbirth in Nigeria. Also, there was no adequate administrative system that monitors women's attendance to maternal health care services pregnancy and childbirth adequately in Nigeria.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.0 INTRODUCTION

The primary purpose of this study was to examine the socio-cultural factors influencing the non- use of maternal health services in Nigeria. The secondary purpose was to examine the level of non-use of maternal health care service (ANC & PNC) in Nigeria. This study equally assessed the perception of women on health care utilization during pregnancy and childbirth in Nigeria maternal health. However, data extracted from Nigerian Demographic and Health Survey and In-depth interview methods were organized and analysed. The trends, patterns and relationship among data were identified and interpreted. The data classification has been carried out on women of reproductive age 15-49. The hypotheses formulated for this study guided the arrangement of the tables. A summary of the main findings follows each table. The analysis was divided into antenatal and postnatal maternal health care and answers were given to each research questions and results of hypothesis testing.

TABLE 4.1: DISTRIBUTION OF RESPONDENTS BY SOCIO-CULTURAL VARIABLES

VARIABLES	FREQUENCY	PERCENT %
Ethnicity Respondents		
Hausa/Fulani	13,064.822	34.33
Igbo	5,482.3531	14.41
Yoruba	5,385.68416	14.15
Others	14,123.788	37.11
Autonomy Status of Respondent		
No	13,218.142	35.42
Yes	24,092.404	64.58
Religion of Respondent		
Christian	17,817.8	46.82
Islam	19,875.4	52.23

Traditionalist	362.9455495	0.95
Total	38,056.656	100.00

Source: NDHS DATA, 2013RESULTS

Socio-cultural characteristics of respondents

Table 4.1 revealed socio-cultural characteristics of the respondents. The table shown that about 34.33% of the respondents were Hausa followed by Igbo (14.41%) and Yoruba (14.15%). Decision about family health care is usually made by the husband in whom 35.42% of the respondents do influence decision about their family health care while 64.58% of respondents participate on decision about their family health care. Furthermore, the data revealed that 46.82% are Christian, 52.23% practice Islamic religion while 0.95% is traditionalists.

TABLE 4.2 DISTRIBUTIONS OF RESPONDENTS BY DEMOGRAPHIC CHARACTERISTICS

VARIABLES	FREQUENCY	PERCENTAGE (%)
Respondent's Current Age		
15-24	14,350.255	37.71
25-34	12,222.45	32.12
35+	11,483.951	30.18
Current Marital Status		
Never Married	9,260.8034	24.33
Married	27,051.765	71.08
Others	1,744.0877	4.58
Place of Residence		
Urban	15,986.473	42.01
Rural	22,070.183	57.99
Highest Level of Education		
No Education	14,453.0758	37.98
Primary	6,551.9605	17.22
Secondary	13,581.405	35.69
Higher	3,470.2149	9.12
Respondents Occupation		
Not Working	14,004.1021	37.80
Working	24,052.554	63.20

Number of Children Ever Born		
0-4	26,947.833	70.81
5+	11,108.824	29.12
Age of Respondent at First Birth		
<18	10,766.40	40.19
Older	16,019.75	59.81
Number of Antenatal Visited During Child Birth		
No	6,869.43	34.89
Yes	12,818.04	65.11
Baby Postnatal visit within two months		
No	14,105.289	71.65
Yes	5,582.1754	28.35
Total	19,687.464	100.00

Source: NDHS DATA, 2013

Table 4.2 presented information on the socio-demographic profile of respondents. The table revealed that 37.71% of the respondents were between ages 15-24; 32.12% were 25-34 years and the rest (30.18%) were 35 years and above. It was further revealed that majority of the respondents have no education. In particular, 37.98% had no education while 17.22% and 35.69% had primary and secondary education respectively. The data further shows that about 57.99% of the respondents reside in the rural area. Almost 37% of the respondents are not working. Women that had 4 children or less at the time of the survey are 70.81%. The table showed that more than half of the respondents (71.65%) did not go for immunisation of their baby two months after birth while 35% of the respondents reported not to attend antenatal care during their pregnancy. Furthermore, the data revealed that 71.08% are married, 24.33% are single and 4.58% are either separated or divorced.

TABLE 4.3 CROSS TABULATION OF SOCIO-CULTURAL AND NON-USE OF ANTENATAL MATERNAL HEALTH CARE SERVICE

ANTENATAL VISITS DURING PREGNANCY					
VARIABLES	NO	YES	TOTAL	χ^2	P-Value
Ethnicity					
Hausa/Fulani	4,208 (64.22)	3,395(26.36)	7,603(39.12)	3400	0.000
Igbo	90 (1.37)	1,900 (14.75)	1,990 (10.24)		
Yoruba	67 (1.02)	2,257(17.52)	2,324 (11.96)		
Others	2.18 (33.38)	5,329 (41.37)	7,516(38.68)		
Autonomy Status of Respondent					
Yes	1,989 (30.97)	6,877(54.99)	8,866 (46.84)	982.7	0.000
No	4,433(69.03)	5,630(45.01)	10,063 (53.16)		
Religion					
Christians	1,338 (20.42)	6,600(51.24)	7,938 (40.85)	1700	0.000
Islam	5,099 (77.82)	6,188(48.04)	11,287(58.08)		
Traditionalists	115 (1.76)	93(0.72)	208 (1.07)		
Total	6,552(100.00)	12,881(100.00)	19,433 (100.00)		

Source: NDHS DATA, 2013

In table 4.3, the socio-cultural variables, such as ethnicity, female autonomy and religion have strong relationship ($\chi^2=.$ 000, $p<0.05$) with the non-use of antenatal maternal health care services in which several studies have supported the direct causal relationship between ethnicity and female autonomy and maternal health care. “Women are controlled with those local customs, whereby a woman can make no decision by herself, until the husband has decided” (Kowalewski et.al, 2000). The results indicated that the non-use of antenatal health care services during pregnancy was highest among the Hausa ethnic group (47.22%) in Nigeria and the lowest was found among the Yoruba ethnic group (1.02%). Thus the use of maternal health care service increases as female autonomy increases. Similar pattern is observed for ethnicity and religion which play significant roles in maternal health usage.

TABLE 4.4 CROSS TABULATION OF SOCIO DEMOGRAPHIC CHARACTERISTICS AND NON-USE ANTENATAL CARE SERVICE

Variables					
Antenatal Visits During Pregnancy					
Age of respondents	No	Yes	Total	χ^2	P-Value
15-24	1,900(29.00)	3,098(24.05)	4,998 (25.72)	62.72	0.000
25-34	2,865 (43.73)	6,251(48.53)	9,116(46.91)		
35+	1,787(27.27)	3,532(27.42)	5,319(27.37)		
Place of Residence					
Urban	699(10.67)	5,728(44.47)	6,427(33.07)	2200	0.000
Rural	5,853(89.33)	7,153(55.53)	13,006 (66.93)		
Highest Educational Level					
No education	5,092(77.72)	3,846(29.86)	8,938(45.99)	4300	0.000
Primary	892(13.61)	3,051(23.69)	3,943(20.29)		
Secondary	549(8.38)	4,729(36.71)	5,278(27.16)		
Higher	19(0.29)	1,255(9.74)	1,274(6.56)		
Respondent's Occupation					
Not working	2,498(38.13)	3,174(24.64)	5,672(29.19)	382.09	0.000
Working	4,054 (61.87)	9,707(75.36)	13,761(70.81)		
Current Marital Status					
Never married	110 (1.68)	410(3.18)	520(2.68)	52.66	0.000
Married	6,278(95.82)	12,023(93.34)	18,301(94.17)		
Others	164(2.50)	448(3.48)	612(3.15)		
Total Children Ever Born					
0-4	3,555 (54.26)	8,476(65.80)	12,031(61.91)	245.43	0.000
5+	2,997(45.74)	4,405(34.20)	7,402(38.09)		
Age of Respondent at 1st Pregnancy					
<18	3,549(54.17)	4,026(31.26)	7,575(38.98)	958.45	0.000
Older	3,003(45.83)	8,855 (68.74)	11,858(61.02)		
Total	6,552(100.00)	12,881(100.00)	19,433(100.00)		

Source: NDHS DATA, 2013

In table 4.4, the place of residence distribution revealed that 89.33% of the respondents living in the rural area did not attend antenatal during. Then the table further showed that high number of non-use of antenatal care was found among the married respondents (95.83%) in which 1.68% of never married respondents didn't use antenatal care. Also,. The highest use of antenatal care was found among the respondents that are working 75.36%. Education appears as

an important factor that determines maternal health. Women without formal education appear to ignore antenatal (77.7%) while as educational level increases the probability of attending antenatal equally improves. Although, attendance of antenatal is high generally among women with higher education.

Table 4.5 CROSS TABULATION OF SOCIO-CULTURAL VARIABLES AND NON-USE OF POSTNATAL CARE

Variables	Baby postnatal check within 2 months				χ^2	P-Value
	No	Yes	Total			
Ethnicity of Respondents						
Hausa/Fulani	6,546 (47.22)	1,057(18.98)	7,603(39.12)	2100	0.000	
Igbo	1,232(8.89)	758(13.61)	1,990(10.24)			
Yoruba	912(6.58)	1,412(25.35)	2,324(11.96)			
Others	5,173(37.32)	2,343(42.06)	7,516(38.68)			
Autonomy Status of Respondent's						
Yes	5,451(40.25)	3,415(63.39)	8,866(46.84)	828.82	0.000	
No	8,091(59.75)	1,972(36.61)	10,063(53.16)			
Religion						
Christian	4,728(34.11)	3,210(57.63)	7,938(40.85)	913.97	0.000	
Islam	8,957(64.61)	2,330(41.83)	11,287(58.08)			
Traditionalists	178(1.28)	30(0.54)	208(1.07)			
Total	13,863(100.00)	5,570(100.00)	19,433(100.00)			

Source: NDHS DATA, 2013

In table 4.5, the non-use of postnatal care was high among the Hausa/Fulani (47.22%) ethnic group while non-use of postnatal care is low among Yoruba (6.58%) and Igbo (8.89%). The highest non-use of postnatal care occurred among women who practice Islamic religion (64.61%) followed by Christians (34.11). Also, women who participate in deciding their family health care do visit postnatal care (63.39%) than women who do not participate in determine their family health care (59.75%).

TABLE 4.6 CROSS TABULATION OF SOCIO DEMOGRAPHIC AND NON-USE OF POSTNATAL CARE

Variables		Baby postnatal check within 2 months			
		YES	TOTAL	χ^2	P-Value
Respondent's current age	NO				
15-24	3,735(26.94)	1,263(22.68)	4,998(25.72)	41.82	0.000
25-34	6,344(45.76)	2,772(49.77)	9,116(46.91)		
35+	3,784(27.30)	1,535(27.56)	5,319 (27.37)		
Type of Place of Residence					
Urban	3,569(25.74)	2,858(51.31)	6,427(33.07)	1200	0.000
Rural	10,294 (74.26)	2,712(48.69)	13,006 (66.93)		
Highest Educational Level					
No education	7,784(56.15)	1,154(20.72)	8,938(45.99)	2400	0.000
Primary	2,679(19.32)	1,264(22.69)	3,943(20.29)		
Secondary	2,889(20.84)	2,389(42.89)	5,278(27.16)		
Higher	511(3.69)	763(13.70)	1,274(6.56)		
Current Marital Status					
Never married	320(2.31)	200(3.59)	520(2.68)	28.814	0.000
Married	13,126(94.68)	5,175(92.91)	18,301(94.17)		
Others	417(3.01)	195(3.50)	612(3.15)		
Total	13,863(100.00)	5,570(100.00)	19,433(100.00)		
Total Children Ever Born					
0-4	8,160(58.86)	3,871(69.50)	12,031(61.91)	190.60	0.000
5+	5,703(41.14)	1,699(30.50)	7,402(38.09)		
Age of Respondent at 1st Pregnancy					
<18	6,081(43.86)	1,494(26.820)	7,575(38.98)	485.22	0.000
Older	7,782(56.14)	4,076(73.18)	11,858(61.02)		
Total	13,863(100.00)	5,570(100.00)	19,433(100.0)		

Source: NDHS DATA, 2013

Table 4.6 revealed that few respondents went for postnatal check within two months regardless of their age. The table also shows that, 74.27% of respondent who do not visit postnatal health care within two months resided in the rural areas while 25.740% resides in the urban areas. Also, 56.15% of the respondents who do not visit postnatal health care were not

educated while 20.84% were with secondary education. Furthermore, 94.68% of the respondents who do not visit postnatal care within two month after their birth were married. The highest use of postnatal care was found with women who had their first child at age 19 and above (73.18%). 58.86% of respondents that had 0-4 children do not visited postnatal health care within two month of their birth. There is a strong relationship among the non-use of postnatal care and respondent's marital status, place of residence, educational level, total number of children ever born and respondent age at first birth are statistically significant with probability value $p= 0.05$, $\chi^2=0.000$.

BINARY LOGISTIC REGRESSION ANALYSIS

This part of the chapter contains the results of tested hypotheses and the interpretation of the results. A hypotheses were tested to confirm the relationship selected variables of interest such as (ethnicity, female autonomy, religion, age, marital status, education, working status, place of residence, total number of children ever born and age at first birth) and variables used to measure maternal health care. The result of the multivariate logistic regression analysis is displayed on table 4.7 and 4.8.

TABLE 4.7 **Model 1**
Logistic Regression of the influence of socio-cultural on antenatal health care

Variables	Odds Ratio	Std. Err.	P-value	[95% Conf. Interval]	
Ethnicity				Lower Limit	Upper Limit
Hausa/Fulani	RC				
Igbo	8.684164	1.125926	0.000	6.735463	11.19666
Yoruba	9.499781	1.315202	0.000	7.242168	12.46116
Others	2.276525	.1145374	0.000	2.062749	2.512455
Female autonomy					
Yes	RC				
No	.9628359	.0418081	0.383	.8842836	1.048366
Religion					

Christian	RC				
Islam	1.722982	.1110577	0.000	1.518502	1.954999
Traditionalist	.4259947	.075117	0.000	.3015152	.6018651
Age of Respondent					
15-24	RC				
25-34	.9726299	.0496814	0.587	.8799717	1.075045
35+	.917944	.0641437	0.220	.8004538	1.052679
Residence					
Rural	RC				
Urban	.3426961	.0174136	0.000	.3102106	.3785836
Level of Education					
No Education	RC				
Primary	2.840023	.1500295	0.000	2.560681	3.149838
Secondary	5.380935	.3526713	0.000	4.732267	6.118518
Higher	23.62287	5.638726	0.000	14.79629	37.71487
Working Status					
No working	RC				
Working	1.424368	.0580392	0.000	1.315037	1.542789
Marital Status					
Never married	RC				
Married	1.522458	.1974216	0.001	1.180776	1.963013
Others	1.517237	.2458295	0.010	1.104429	2.084342
Number of Children					
0-4	RC				
5+	.9705467	.0499251	0.561	.8774664	1.073501
Age of 1st birt					
<18	RC				
Older+	1.280854	.0510627	0.000	1.184583	1.384949
Constant	.440568	.0700778	0.000	.3225661	.6017376

*** $p < 0.05$ ***

Source: NDHS DATA, 2013

In table 4.7, ethnicity (Hausa, Igbo, Yoruba and others) is significantly associated with non-use of maternal antenatal health care services. The result from the multivariate regression shows that Hausa women will not use antenatal care. For instance, the odd that Hausa woman will not use antenatal care during pregnancy is almost 9 times higher when compared with Yoruba. Also, female autonomy is a significant predictor associated with the non-use antenatal

health care service. Women who didn't partake in decision relating to family health care have a slightly higher odd of non-using antenatal care than those who involve in the decision making relating to family health care. Also the study also finds that religion of a woman is statistically significant. The odd show that women who practice Islamic religion will not use antenatal care is 1.7 times higher than Christians.

TABLE 4.8 **MODEL 2**
LOGISTIC REGRESSION OF THE INFLUENCE OF SOCIO-CULTURAL ON
POSTNATAL HEALTH CARE

Variables	Odds Ratio	Std. Err	P-value	[95% Confidence interval)	
				Lower Limit	Upper Limit
Age of Respondent	RC				
15-24					
25-34	1.019876	0.40	0.690	.9258864	1.123406
35+	1.047826	0.71	0.479	.9207194	1.19248
Ethnicity					
Hausa/Fulani	RC				
Igbo	1.306797	3.38	0.001	1.118749	1.526453
Yoruba	2.911161	15.13	0.000	2.534828	3.343367
Others	1.686437	.40	0.000	1.512276	1.880656
Female Autonomy					
Yes	RC				
No	.7595397	-6.30	0.000	.6972354	.8274116
Religion					
Christian	RC				
Islam	1.096231	1.76	0.079	.9895841	1.214371
Traditionalists	.5335217	-2.98	0.003	.3530153	.8063261
Residence					
Rural	RC				
Urban	.6024207	-12.50	0.000	.5564005	.6522472
Level of Education					
No Education	RC				
Primary	2.050623	13.19	0.000	1.843052	2.281571
Secondary	3.038354	19.78	0.000	2.721469	3.392136
Higher	4.473871	18.61	0.000	3.820847	5.238503
Working Status					
No working	RC				

Working	1.162455	3.47	0.001	1.067829	1.265466
Marital Status					
Never married	RC				
Married	.890713	-1.11	0.269	.7256139	1.093377
Others	1.132649	0.93	0.351	.8720139	1.471186
Children Ever Born					
0-4	RC				
5+	.9463977	.0468749	0.266	.858843	1.042878
Age at1st Birth					
<18	RC				
Older	1.117161	2.61	0.009	1.02786	1.214221
Constants	.1951716	-11.78	0.000	.1487189	.256134

*** $p < 0.05$ ***

Source: NDHS DATA, 2013

As presented in table 4.8, at the bivariate level the result indicate that education of women is statistically significant. Also, education of respondent is a significant predictor of non-use of postnatal care. As woman's education increases, her odd of non-use postnatal care consistently declines. For instance, the fact a woman with no education will not use postnatal care is 2.05 times higher than woman with primary education, 3.03 times higher than women with secondary education and 4.47 times higher than women with higher education. This indicates that as women become more educated their odds of non-use of postnatal care reduce. The same pattern is observed with regards to the working status of women. Women who are working have a lower odd of non-use of postnatal care in which women who are not working is 1.16 times not likely to use postnatal maternal health care than women.

Overall, respondent age at first birth reported by women is correlated with increased odds with non-use of postnatal care. The higher the age of women at first birth translates to decrease of non-use of postnatal maternal health care. For instance, women who reported to have their first birth at the age <18 are 1.11 times more likely not to use postnatal care than women who reported to have their first birth at age >18.

TABLE 4.9 PARAMETRIC TESTS

To buttress the relationship between the dependent variable (non-use of maternal health care) and other independent variables such as ethnicity, female autonomy, religion, current age of respondent, working status, marital status, place of residence, highest level of education, total number of children ever born and age of respondents at first birth. The study adopts the use of Kappa statistics in order to examine the level of agreement between the dependent and independent variables.

TABLE 4.9

Independent Variables	NON-USE OF ANTENATAL CARE				
	Agreement	Kappa	Std. Err.	Z	Prob>Z
Ethnic		-0.1143	0.0022	-51.14	1.0000
Female Autonomy	25.93%	0.0780	0.0025	31.35	0.0000
Religion	30.95%	0.0944	0.0023	41.32	0.0000
Residence	27.08%	0.0967	0.0020	47.34	0.0000
Level of Education	21.92%	0.1822	0.0037	49.42	0.0000
Working	28.96%	-0.0374	0.0019	-19.55	1.0000
Marital Status	19.35%	-0.0243	0.0034	-7.24	1.0000
Children Ever Born	63.33%	0.0438	0.0028	15.67	0.000
Age at 1 st Birth	41.04%	-0.0690	0.0022	-30.96	1.0000

Source: NDHS DATA, 2013

Table 9 present the level of agreement between non-use of antenatal maternal health care service and socio-cultural and demographic factors. In ethnicity of respondents only 25.93% agree that the ethnicity of respondents influence the non-use of antenatal maternal health care while only 30.95% of the respondent that are reported in the female autonomy category agrees that female autonomy influence the non-use of antenatal maternal health service. Also, the religion of the women respondents, only 27.08 % agrees that religion will influence the non-use

of antenatal maternal health care. The table further illustrate that that level of women education agrees by influencing the non-use of antenatal service with only 27.08%, working will agree with non-use of antenatal health care with 19.35, level of education with 28.69%, children ever born with 25.84%.

TABLE 4.10 PARAMETRIC TESTS

VARIABLES	NON-USE OF POSTNATAL CARE				
	Agreement	Kappa	Std. Err.	Z	Prob>Z
Ethnicity	11.21%	-0.0650	0.0018	-36.48	1.0000
Autonomy	13.33%	0.0544	0.0019	28.79	0.0000
Religion	11.71%	0.0545	0.0018	30.17	0.0000
Age of Respondent	7.37%	-0.0094	0.0015	-6.15	1.0000
Residence	9.48%	0.0577	0.0017	34.25	0.0000
Level of Education	38.63%	0.1293	0.0041	31.66	0.0000
Working	8.37%	-0.0223	0.0016	-13.84	1.0000
Marital Status	28.90%	-0.0088	0.0017	-5.32	1.0000
Children Ever Born	17.75%	0.0264	0.0019	13.81	0.0000
Age at first Birth	11.17%	-0.0392	0.0018	-22.03	1.0000

Source: NDHS DATA, 2013

Table 4.10 revealed the level of agreement between the non-use of postnatal health and other independent variable. For ethnicity the data it shows there is 11.21% levels of agreement in which ethnicity affect the non-use of postnatal health. Also, the autonomy respondent revealed there is 13.33% level of agreement at which ethnicity can influence the non-use of postnatal health care. It was further revealed that there is 11.71% in which religion can influence the non-use of postnatal health care. Furthermore, the data also shown 11.17% of age at first birth, 17.75% of children ever born, 28.90% of marital, 8.37% of respondent working status, 9.48% of place of residence of respondents and age of respondent at 7.37% of respondent at which these

variables their level of agreement to influence the non-use of maternal health care. Also, information on education shown that have higher tendency to influence the usage of postnatal health care at 38.63%.

4.11 QUALITATIVE ANALYSIS

4.11 In-depth interview on how do women perceive health care utilization during pregnancy and child birth in Nigeria?

While holding the variables analysis constant, the first and second model shown that there is a strong association among the non-use of maternal health care and socio-cultural and demographic factors such as ethnicity, female autonomy, religion (socio-cultural variables), age, place of residence, current marital status, etc. The reports from In-depth Interview on perception of women on health care utilisation during and after child birth in Nigeria. Socio-cultural factors influencing the non-use of maternal health care service. In measuring the perception of women toward non-use of maternal health service the following excerpt from the discussion.

My religion is not against it but I don't know of others but some traditional affect you coming to the hospital and even hospital will not support a pregnant woman taking any convulsion before coming or after leaving the hospital. During pregnancy some people believe that eating snail is a taboo but medically it is good for the health of the baby and mother because they do tell us that it is a source of iron for the baby. I attend Gospel Faith Mission, Concerning my religion they do encourage us to take good care of ourselves and children. So my religion is not against it and my husband support me and I support him too whenever we want to do anything in our house. Going for check up during pregnancy is very good except on have personal reason for not going. I believe if a women is

educated she will find it important. (trader, 29 years, Oye Ekiti)

I used to attend my antenatal when it is my appointment day. Since my father in-law is alagbo (herbal medicine practitioner), no need of wasting money to go and complain for dizziness in the hospital I always complain to him and he will give me the remedy (full house wife, 23 years old, Oye Ekiti).

Although the role of traditional medicine and its potentials have been receiving attention in the past decade.

Some people believe in traditional form of delivery and they won't be able to know whether the baby is healthy or not. Using herb is not good because there is no prescription when taking it and it affect the baby inside, (23, tailor, Oye Ekiti).

Another respondents said this;

Although, one will surely want to behave like one's parent. In the olden days' people believe in traditional form of delivery because parent wants their children to follow their path. But now due to civilisation people prefer to go to the hospital but also add some traditional form in order to easy their child bearing. But hospital is better because in traditional method one will not be known the position of the baby (35 years, unemployed, NCE holder. Oye Ekiti).

Another respondent

Yoruba tradition is a very good one, it encourages changes in the environment and it doesn't force anyone to do a particular thing and it doesn't really prohibit pregnant women from going to the hospital. My husband and I are educated so it is very easy for us to adopt the of antenatal and postnatal maternal health care (32 years, civil servant).

Another respondent said this

I am from Efik, Calabar, my culture doesn't hinder me from going to the hospital even my religion and my husband, they even advice you to do more, even the bible heaven help those who help themselves (24 years, student)

4.12 DISCUSSION OF FINDINGS

The growing recognition of the maternal health challenges and Intervention strategies are primarily related to medical condition of women, whereas, there are socio-cultural conditions that need to be observed in order to reduce the rate at which maternal do not use available maternal facilities in order to reduce the risk maternal health complications. Women are expected to have a minimum of four antenatal visits throughout the pregnancy, with the first visit in the first trimester. Three socio-cultural factors were considered which includes ethnicity, female autonomy and religion. The results from the bivariate analysis shown there is strong relationship between the dependent variable (non-use of maternal health care and the socio-cultural status). Whereas the benefit of maternal care to maternal is unquantifiable. Maternal care influences the outcome of pregnancies depend largely on the timing of quality maternal health care received from medical practitioners and quality of service provided (Phoya and Kamgoma, 2005). The findings revealed that 34.33% of the respondents are from the Northern part of Nigeria. Also, 57.99% do participate in decision concerning the health of their family. A substantial proportion of Hausa ethnicity doesn't visit antenatal health service during pregnancies (64.22%). The study also showed that Islamic is the predominant religion practice in the study is (52.23). Also, the age group distribution respondents revealed that 37.71% of the respondents were between ages 15-24, 32.12% were 25-34 years and only 30.18 were 35 years. As for the occupational status of the respondents 17.22% and 35.69% had primary and secondary education respectively.

The data further shows that women with 4 children or less at the time of the survey was 70.81% and 71.65% did not go for immunisation of their baby.

The present pattern of routine of the antenatal care in Nigeria consists of a first antenatal followed by monthly visits up to 28 weeks, fortnight visits up to 36 weeks and weekly visits thereafter. Observational studies suggest an association between gestational age at initiation of antenatal care and outcomes for mothers and babies (Gortmaker 1979, Ryan, Sweeney, Solala, 1980 and Quick, Greenlick and Roghmann, 1981). The socio-cultural variables, such as ethnicity, female autonomy and religion has a strong relationship ($\chi^2=.000$) with the non-use of antenatal maternal health care services in which several studies have supported the direct causal relationship between ethnicity and female autonomy and maternal health care. The highest of non-use of antenatal occurred among the Hausa ethnic group 4,028(47.22%) in Nigeria and the lowest 67 (1.02%) among the Yoruba ethnic group. Thus the use of maternal health care service increases as female autonomy increases. Similar pattern is observed in ethnicity and religion which plays a significant role on maternal health usage. Antenatal care is generally acknowledged as an effective method of preventing adverse outcomes in pregnant women and their babies such foetus loss, miscarriage etc. Majorly, antenatal screening tests is use for the early detection of foetal anomalies, Down syndrome and biochemical screening for neural tube defects which takes place during the first trimester or early in the second trimester of pregnancy.

The interaction effect of the socio-cultural variables on postnatal maternal health in Nigeria was further explored by examining the cultural beliefs, female autonomy and religion associated with non-use of postnatal care in Nigeria. The results of the second bivariate analysis revealed a significant influence of socio-cultural beliefs and practices on postnatal maternal health. Religion, ethnicity and female autonomy have been found to be one of the main factors

affecting maternal health in Nigeria.

The findings on postnatal maternal health care reveals that highest non-use of postnatal maternal health care occurred among women who practice Islamic religion 6,546 (47.22%) followed by women in which their participation is low in determining their family health care 8,091 (59.75%) and the highest use of postnatal maternal care service was found with women who had their first child at age 19 and above (73.18%) followed by women who participate in deciding the family health care (64.61%) which are statistically significant with probability value $p= 0.05$ and their $\chi^2=0.000$. These factors have resulted in low use of antenatal and postnatal care as revealed by findings of studies conducted in Africa.

In order to show the level of agreement between the dependent and independent variables, the adopted the use of kappa statistics to revealed their level of agreement. The result of kappa statistics at the non-use of antenatal revealed that there is 25.93% agree that the ethnicity influence the non-use of antenatal maternal health care while only 30.95% of the respondent that are reported in the female autonomy category agrees that female autonomy influence the non-use of antenatal maternal health service. Also, the religion of the women respondents, only 27.08% agrees that religion will influence the non-use of antenatal maternal health care. The table further illustrate that that level of women education agrees by influencing the non-use of antenatal service with only 27.08%, working will agree with non-use of antenatal health care with 19.35, level of education with 28.69%, children ever born with 25.84%. Also for postnatal, it revealed the level of agreement between the non-use of postnatal health and other independent variable. For ethnicity, there is 11.21% levels of agreement in which ethnicity affect the non-use of postnatal health. Also, the autonomy respondent revealed there is 13.33% level of agreement at which ethnicity can influence the non-use of postnatal health care. It was further

revealed that there is 11.71% in which religion can influence the non-use of postnatal health care. Furthermore, the data also shown 11.17% of age at first birth, 17.75% of children ever born, 28.90% of marital, 8.37% of respondent working status, 9.48% of place of residence of respondents and age of respondent at 7.37% of respondent at which these variables their level of agreement to influence the non-use of maternal health care. Also, information on education shown that have higher tendency to influence the usage of postnatal health care at 38.63%

The women perception about maternal health can increase the usage of maternal health which can be worsened by socio-cultural influencing the non-use of maternal health situation. The unprecedented negative cultural factors is increasingly influencing maternal health outcome. Majority of the respondents have their perception on the use of maternal health care. When women were asked on their perception of maternal one of them said the following emancipate

Some people believe in traditional form of delivery and they won't be able to know whether the baby is healthy or not. Using herb is not good because there is no prescription when taking it and it affect the baby inside, doctors are the best to determines the position of baby for easy birth (23, tailor, Oye Ekiti)

Similarly, another respondent noted that:

So my religion is not against it and my husband support me and I support him too whenever we want to do anything in our house. Going for check-up during pregnancy is very good except on have personal reason for not going. I believe if a woman is educated she will find it important. (29 years, Oye Ekiti)

Although women expressed dissatisfaction with using the maternal care only.

Although, one will surely want to behave like one's parent. In the olden days' people believe in traditional form of delivery because parent wants their children to follow their

path. But now due to civilisation people prefer to go to the hospital but also add some traditional form in order to ease their child bearing. But hospital is better because in traditional method one will not be known the position of the baby (35 years, unemployed, NCE holder. Oye Ekiti).

Moreover, the literature has emphasized the importance of strong social supports. Strong social supports have influence on health outcomes. There is considerable evidence in the medical literature about the positive effects of community and individual social capital as well as social interaction on various measures of health and well-being (Kodzi et al, 2010).

CHAPTER 5

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.0 INTRODUCTION

In assessing the impact of socio-cultural factors on maternal health care, this study set out to examine the socio-cultural factors influencing the non-use of maternal health care service in Nigeria. This chapter focuses on the summary of the work, conclusion and recommendations. The study was designed to generate knowledge on the influence of socio-cultural factors of maternal health care. Both quantitative research employed Nigerian Demographic and Health Survey, 2013 and qualitative research approaches which were employed independently and in-depth interviews case was done enhance the data. The study population comprises women ages 15-49 years who meant the criteria of inclusion in the NDHS survey. Descriptive statistical methods were used to analyze the quantitative data and the data were analyzed in order to examine the relationship of variables using the Stata 16 software. First, the characteristics of the study sample were described using univariate analyses (frequency distributions and simple percentages) and the patterns of relationships were determined using cross tabulation. Also, the multivariate logistic regression analyses were performed to test the hypotheses in order to estimate the relative influence of the independent variables on maternal health care. The notes from the key informant interviews were analyzed and common responses were identified for each topic included in the interview guide.

5.1 SUMMARY OF FINDINGS

The findings of this study have highlighted the socio-cultural factors influencing the non-use of maternal health care services in Nigeria. The finding showed that higher proportion of the respondent is 34.33% which are from the Northern part of Nigeria and majority of the

respondents are rural dwellers constituting 57.99% of the women interviewed in NDHS 2013 do participate in decision concerning the health of their family. The findings of qualitative data differ from the findings in quantitative data. A substantial proportion of Hausa ethnic group do not visit antenatal health service during pregnancies (64.22%). the study also showed that Islamic is the predominant religion practices in the study are (52.23%).

The bivariate analysis further showed a significant relationship between the non-use of antenatal maternal health care and ethnicity; between the non-use of antenatal maternal health care and female autonomy; between the non-use of antenatal maternal health care and religion at $p < 0.05$. Also the bivariate illustrate a significant relationship between the non-use of postnatal health maternal health care and ethnicity; between the non-use of postnatal health maternal health care and female autonomy; between the non-use of postnatal health maternal health care and religion also at $p < 0.05$. The multivariate analysis further showed that, ethnicity is significantly associated with non-use of maternal antenatal health care services. Also the study also finds that religion of a woman is statistically significant. The odd show that women who practice Islamic religion will not use antenatal health care is 1.7 times higher than the Christians. In model two studies revealed that women education is a significant predictor of non-use of postnatal maternal health care. As woman's education increases, her odd of non-use postnatal maternal health care consistently declines. The same pattern is observed with regards to the working status of women. Women who are working have a lower odd of non-use of postnatal maternal health care in which women who are not working is 1.16 times not likely to use postnatal maternal health care than women.

5.2 CONCLUSION

In conclusion, this study has shown that maternal health challenges will continue to affect national indicators on health which will negatively have negative influence on other development issues, improving maternal health is one of the eight Millennium Development Goals. It is widely accepted that the use of maternal health services helps in reducing maternal morbidity and mortality. The utilization of maternal health services is a complex phenomenon and it is influenced by several factors. Therefore, the factors at different levels affecting the use of these services need to be clearly understood. if adequate attention is not provided. it is imperative for women to actively take part in decision making about issues in the home and by doing so they will freely and actively take decision with respect to their own reproductive behaviours. There is need to raise the level of education for women in Nigeria. The objective of this study was to social cultural factors influencing the non-use of maternal health care with special reference to antenatal care (ANC) and postnatal care (PNC).

Analysis of factors influencing the non-use of maternal health services revealed interesting findings, which have very important implications for evidence based programming for maternal health. The socio-cultural such as ethnicity, female autonomy and religion were the most important factors associated with the non-use of ANC and PNC, therefore empowering women and promoting mother's education would yield greater results in increasing the use of maternal health services. The results of our study showed that, the non-use of ANC decreases the odds of higher education and which later increases the use of PNC. Hence it is very important to promote the use of ANC among pregnant women. The access of certain groups such as Hausa tribes and Islamic religion to maternal health services should be further emphasized.

5.3 RECOMMENDATIONS

Most maternal deaths are preventable as the health-care solutions to prevent or manage complications are well known. All women need access to antenatal care in pregnancy, skilled care during childbirth, care and support in the weeks after childbirth. Maternal health and newborn health are closely linked. Approximately 2.7 million newborn babies die every year and an additional 2.6 million are stillborn. It is particularly important that all births are attended by skilled health professionals, as timely management and treatment can make the difference between life and death for both the mother and the baby.

As this study had revealed, the socio-cultural factors have influence on maternal health. Therefore, revealing the relationship between maternal health and socio-cultural factors must begin by dealing with the issues of maternal health throughout Nigeria as a whole by not restricting the analysis of maternal health to hospital care services, such as, provision of Emergency Obstetrics Care (EOC). Attendance of antenatal and postnatal care and there should a policy that require the development of indicators of cultural and social conditions that generate the needs related to the quality of maternal health in Nigeria. As proposed by functionalism, under normal conditions, the various parts of society work together toward shared goals, producing order, stability, and equilibrium which is viewed from this perspective, conflict is a symptom of "disease" in the social organism (Gelles and Levine, 1995).

Also, government should address many commonly held attitudes and behaviours, like gender roles, and other cultural beliefs that are inimical to health are cultural issues, which can be achieved through community-based programmes. Health promotion and advancement education as a primary prevention approach will create opportunity for easier communication, dealing with the dynamics of knowledge, power and decision making process in the family, as

part of the effort to ensuring good health during pregnancy.

Furthermore, there should be improvement in the implementation of public health interventions in terms of both coverage and effectiveness in order to provide prompt and adequate medical attention and referral when it is needed. Also, service providers need constant training and support to provide sensitive Emergency Obstetric Care. Improvements are needed in the quality of care in the country, and particularly in reproductive health. Attention is required also, in demand issues, which include identification of limitations on women capacity to seek health care when complications arise.

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**APPENDIX I: QUANTITATIVE DATA DO FILE (EXTRACTED FROM NIGERIA
DEMOGRAPHIC AND HEALTH SURVEY 2013)**

```
use "C:\Users\RotimoOnPoint\Desktop\Virus Infected Files\Files\Data Bank\Stata NDHS 2013  
Recodes\NGIR6AFL.DTA", clear  
numlabel, add  
ta v131  
drop if v131==998 | v131==999  
ta v131  
gen Ethnic=.  
replace Ethnic=1 if v131==109 | v131==130  
replace Ethnic=2 if v131==138  
replace Ethnic=3 if v131==298  
replace Ethnic=4 if v131!=109 & v131!=130 & v131!=138 & v131!=298  
la def Ethnic 1 "Hausa/Fulani" 2 Igbo 3 Yoruba 4 Others  
la val Ethnic Ethnic  
la var Ethnic "Ethnicity of respondents"  
ta Ethnic  
ta v743a  
ta v743b  
ta v743c  
ta v743d  
gen autonomy=.  
replace autonomy=1 if v743a==1 | v743b==1 | v743d==1 & v743a==2 | v743b==2 | v743d==2  
replace autonomy=2 if v743a!=1 & v743b!=1 & v743d!=1 & v743a!=2 & v743b!=2 & v743d!=2  
ta autonomy  
la def autonomy 1 Yes 2 No  
la val autonomy autonomy  
la var autonomy "Autonomy Status of respondents"  
ta autonomy  
ta v106  
ta v130
```

```

drop if v130==99
recode v130 (1 2=1 Christians) ( 3=2 Islam) ( 4/96=3 Traditionalists), gen(religion)
ta religion
recode v012(15/24=1 "15-24") (25/34=2 "25-34") (35/max=3 "35+"), gen(age)
ta age
ta v717
recode v717 (0=1 Working) (1/max=2 Working), gen(working)
ta working
drop working
recode v717 (0=1 "Not working") (1/max=2 Working), gen(working)
ta working
ta v501
recode v501 (0=0 "Never married") (1 2=1 Married) (3/max=2 Others), gen(mstatus)
ta mstatus
recode v201 (0/4=1 "0-4") (5/max=2 "5+"), gen(ceb)
ta ceb
ta v212
recode v212 (min/17=1 "<18") (18/max=2 older), gen(age_at_birth)
ta age_at_birth
ta m14_1
drop if m14_1 ==98 | m14_1==99
ta m14_1
recode m14_1 (0=0 Yes) (1/max=1 No), gen(anc)
ta anc
ta m70_1
drop if m70_1==8 | m70_1==9
ta m70_1
*****Univarite Analysis*****
gen wt=v005/1000000
ta age [iw=wt]
ta Ethnic [iw=wt]

```

ta autonomy [iw=wt]

ta religion [iw=wt]

ta v025 [iw=wt]

ta v106 [iw=wt]

ta working[iw=wt]

ta mstatus [iw=wt]

ta ceb [iw=wt]

ta age_at_birth [iw=wt]

ta anc [iw=wt]

ta m70_1 [iw=wt]

*****Bi -variate Analysis Antenatal*****

ta age anc, col chi

ta Ethnic anc, col chi

ta autonomy anc, col chi

ta religion anc, col chi

ta v025 anc, col chi

ta v106 anc, col chi

ta working anc, col chi

ta mstatus anc, col chi

ta ceb anc, col chi

ta age_at_birth anc, col chi

*****Bivariate Postnatal*****

ta age m70_1, col chi

ta Ethnic m70_1, col chi

ta autonomy m70_1, col chi

ta religion m70_1, col chi

ta v025 m70_1, col chi

ta v106 m70_1, col chi

ta working m70_1, col chi

ta mstatus m70_1, col chi

ta ceb m70_1, col chi

ta age_at_birth m70_1, col chi

*****Multivariate*****

logistic anc i.age i.Ethnic i.autonomy i.religion i.v025 i.v106 i.working i.mstatus i.ceb

i.age_at_birth

logistic m70_1 i.age i.Ethnic i.autonomy i.religion i.v025 i.v106 i.working i.mstatus i.ceb

i.age_at_birth

*****kappa statistics*****

kap anc age

kap anc Ethnic

kap anc autonomy

kap anc religion

kap anc v025

kap anc v106

kap anc working

kap anc mstatus

kap anc ceb

kap anc age_at_birth

*****kappa for postnatal*****

kap m70_1 age

kap m70_1 Ethnic

kap m70_1 autonomy

kap m70_1 religion

kap m70_1 v025

kap m70_1 v106

kap m70_1 working

kap m70_1 mstatus

kap m70_1 ceb

kap m70_1 age_at_birth

APPENDIX II: INDEPTH INTERVIEW GUIDE (WOMEN AGES 15-49 WHO HAD AT

LEAST ONE CHILD BIRTH IN THE LAST FIVE YEARS)

Introduction

Good day Ma. My name is Olatunji Mosumola. I am a student of Federal University, It, department of Demography and Social Statistics conducting social health survey on rural factors influencing the non-use of maternal health care services. I will be grateful if you would participate by granting me audience. Information you supplied would be used for an academic purpose and will be treated with utmost confidentiality.

1. What age are you at your last birthday?

2. Religion affiliation.....

3. Your ethnicity.....

4. What is your marital status?

5. What is your level of education?

6. How many children do you have for now?

7. At what age did you have your first child?

8. What is your occupation?

9. Do you use antenatal care when you are pregnant?

10. After delivery do you go for check up for yourself and newly born baby?

11. What do you think about antenatal and post natal health care services you received (their

perception)?

Thank you.