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## Influence Of Selected Demographic Variables On The Health-Seeking Behaviour Of Pregnant Women In Benue State, Nigeria

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### **Abstract:**

*This study investigated the roles of some selected demographic variables (education, domicile and positions/order of pregnancy) on health-seeking behaviour of pregnant women in Benue State. Three Hundred and Thirty-four (334) pregnant women from four local government areas in Benue State – Nigeria participated in the study. A self – developed questionnaire was used for data collection. Means and Analysis of Variance (ANOVA) were used for data analyses. Results showed that education and domicile play significant roles in the health-seeking behaviour of pregnant women. The order or number of previous pregnancies does not. It was then concluded that a pregnant woman's level of education and where she lives can affect the way she seeks health-care. Therefore, women's education, among other things is important if maternal health must achieve its set goals.*

**Key words:** Demographic variables, Health-seeking behavior, pregnant women

### **1.Introduction**

It is worthy to note that of the over 6 billion inhabitants of this world, each came through a successful pregnancy (Matlins, 2000). Maternal mortality is the most important indicator of maternal health and well-being in any country (Ogujuyigbe & Liasu, 2008). With only 2% of the world's population, Nigeria contributes 10% of the world's maternal death (Abouzar, 2003), which is considered to be one of the highest in the world (Ogujuyigbe & Liasu, 2008). The tradition of patriarchy makes gender discrimination and favoritism of male children over female ones obvious right from infancy. In rural setting, females suffer more as a result than males. This is further compounded by social, cultural and economic factors including gender inequality in access to food, by burden of work as by special dietary requirements such as iron supplements (Chukuezi, 2010). This ugly situation usually goes unabated even when women are pregnant.

Failure to have children usually leads to frustration, disappointments, depression, dejection and sometimes divorce (Gbadegesin, 2001). In spite of these social challenges, for some women, the travails of pregnancy may still end with the death of mother and/or her baby. Most of the causes and/or complications of pregnancy are usually preventable. These complications include hypertension, haemorrhages, obstructed labour, septicaemia and ruptured uterus (Li, 1996). Positive health-seeking behaviour in the ante-partum, intra-partum and post-natal stages especially, the immediate post – partum, as per utilization of health care services would almost always prevent catastrophes resulting from any of these conditions. In developed countries, this is the case but yet to be so in developing countries. Paradigms usually used to assess maternal health have been in the area of utilization of health care services by pregnant women and estimate in maternal mortality and the estimates in turn are being used to assess the level of effectiveness of health care services (Ravindran and Berer, 2000). According to Babalola & Fatus (2009), focused antenatal care provides opportunity for early detection of diseases and makes for timely treatment including prophylaxis, immunisation and HIV counselling and testing (HCT). Early attendance to the maternity to take delivery is equally important. A lot of complications and consequences emerging from prolonged labour would almost be averted if women in labour made their ways to the health facility on time. Distances to health services and rural locations have been generally reported to be strongly and negatively associated with the use of maternal health services (Bloom, Wypij & Gupta, 2001). Some studies conducted in Turkey (Celik & Hotchkiss, 2000) and Southern India (Navaneetham & Dharmalingam, 2002; Bhatia & Cleland, 1995), however, did not show any significant difference in the use of antenatal care between urban and rural women.

In sub – Sahara Africa and Nigeria in particular, the prevalence and incident rates of maternal mortality is multi – dimensional. Medical, behavioural and socio – cultural factors impede and underscore maternal health. Cultural practices influence our abilities to seek health. For instance, among the Hausas, daughters-in-law are expected to seek permission of mothers-in-law before going to health-care providers (IRRAG, 1998). Some cultures promote early marriage with its attendant challenges such as obstructed labour and vaginal or rectal fistulae while others encourage women to have many children, as there is usually a ceremony after the tenth child (IRRAG, 1998). Obstructed labour is a major cause of morbidity and mortality with facilitating risk factors such as young age, short stature and first pregnancy. Certain religious groups offer negative contributions by discouraging blood transfusions, family planning methods and use of orthodox medicines while others conduct deliveries in non-clinical environments and may attribute complications in pregnancy or delivery to the woman's alleged lack of faith (Gbadegesin, 2001).

Poverty may also contribute in no small measure to the pregnant woman's choice of health care. Her inability to use a health facility may be a function of her low socio-economic status. Choice may therefore be based on availability and not necessarily desirability.

Other factors include the absence of an enabling power to make informed choices, inaccessibility of health care facilities, attitude of health-care providers and general/government policies and challenges in their implementation, coupled with inadequate provision of basic obstetric equipment further go to compound the issue. Maternal health assumes that "every pregnancy faces risk" and as such every pregnancy should be treated on its merit (Safe Motherhood, 2000). It should be noted that consequences of maternal mortality and morbidity are felt not only by the affected women but by their families and communities (Chukuezi, 2010). Women are primary care givers and with the increase in female – headed households, impact can be traumatic. The risks involved in having children are numerous.

The health of pregnant women continues to be a cause for concern in reproductive health circles. This is more so as pregnancy, childbirth and abortion continue to be unnecessarily hazardous for a majority of world's women. In spite of a century of accumulated knowledge on why maternal deaths and what can be done to avert them, nearly 600,000 women are still dying each year in developing countries, and preventing these deaths seem to be as elusive as ever in many countries (Ravindran & Berer, 2000).

In a study in Mexico by Langer, Hernandez & Garcia – Barrios (1995) using verbal autopsy to analyse factors leading to maternal mortality, they compared results of women who had died with those who had similar complications and were attended to in the same medical centres but survived. Key factors analysed were:

- Inability of the woman and her family to recognize that her symptoms are serious enough to justify medical care
- Concerns about quality and cost of health services
- Distance traveled to obtain care
- Women's lack of autonomy in decision – making

By comparing the women who died in a hospital with those who survived similar obstetric problems, the study hoped to identify circumstances or behaviours which increase the chances of survival so as to aid in identifying interventions in awareness of protective behaviour in the community. The only socio – demographic variable that was statistically significant in the comparison between the two groups was the number of years of schooling of the women and their partners. Among the deceased women, 16% had never gone to school and 37% had not finished primary school as compared to 8% and 18% among those who survived, respectively ( $P < 0.05$ ). Langer et al. (1995) then opined that there might have been an association between schooling and the results. Indeed, based on their findings, one can say that a high level of schooling helped the women to take decision to go to another health centre. It could also have encouraged a different attitude among health providers, who often referred women, with more education on to facilities where they received the needed care. This study goes to confirm, first, that maternal deaths occur mostly among poor, uneducated women with limited decision – making power and autonomy. Consequently, maternal deaths are the effects of a long and complex chain of delays, and not a mere once – off event.

A number of socio-psychological theoretical models of health-care utilization have been postulated of which two of these models are being considered. These are Health Behaviour and Illness Behaviour. Health Behaviour is the activity undertaken by a person who believes himself or herself to be healthy for the purpose of preventing disease, while Illness Behaviour is the activity undertaken by a person who feels ill and for the purpose of defining that illness seeks relief from it (Kasl and Cobb, 1966). The Health Behaviour or Health Belief Model of Rosenstock (1966) suggests preventive action taken by an individual for the sole purpose of avoiding disease. This action is due to the individual's perceptions of being personally susceptible and that the occurrence of the disease would have at least some severe implications of a personal nature.

In contrast to the Health Belief Model, Illness Behaviour pertains to persons who perceive themselves as sick already. It is the way in which symptoms are perceived, evaluated and acted upon by a person who recognizes some pain, discomfort or other signs of organic malfunction.

Health Behaviour and Illness Behaviour Models fit into women's health-seeking paradigms and more so for pregnant women. The ante-natal to detect and prevent illness while the maternity could fit into the Illness Behaviour Model as where the pregnant woman goes to deliver the baby and be delivered of her labour pains.

## 2.Statement Of The Problem

The need for a well-articulated positive health - seeking behaviour has been emphasized. This is necessary for controlling or reducing to the barest minimum, the high rate of maternal mortality and morbidity. One's educational status is symbolized by rank or standing usually acquired through a period of schooling. Such a period could be short or long depending on the individual's sustained interest to acquire education, motivation by close peers and relations, availability of funds, accessibility to facilities and so on. However, a United Nation's report on developing countries showed that 20% fewer female than males were enrolled in primary schools while in secondary schools 30% fewer females than males were enrolled (Aidoo, 1991). In Nigeria, there is still much talk about school enrolment disparity by gender. Also, in Nigeria, a majority of the people resides in rural areas. The situation is further worsened as females are more readily given out in marriage and/or employed for farm work. Even the few that attend schools are faced with numerous negative factors such as shortage of teachers, poor infrastructure, bad or inadequate learning materials, poverty among others. This could have implications on maternal health as the affected may not be able to perform activities that can make them independent and economically self-sufficient. While a number of studies (for example, Campbell, 1998; Okonofua, 1998) in maternal health have focused and reiterated on what ought to be for pregnant women and their children, not much attention is given to the women's perception of the various health-care providers or stakeholders in the

health-care delivery system. Neither has much investigation been carried out on what usually informs their choice of health care options while they are pregnant or at other times.

There are also not so many findings to show for response of pregnant women with regard to their level of education and where they go to in seeking health-care. Also in the views of Margaret Matlin (2000), the frequency of pregnancy is in gross contrast with respect to interest in the study of pregnancy related issues in psychology.

### *2.1.Purpose Of The Study*

The purpose of this study was to investigate some selected demographic variables (education, domicile and position or order of pregnancy) in health-seeking behaviour of pregnant women. Specifically, the study was designed to find out whether such demographic variables as levels of education, where one lives (whether rural or urban) and the gravida (parity) influence where and what a pregnant woman does to seek health

- Does educational status affect health – seeking behaviour of pregnant women?
- Is there a differential in the health – seeking behaviour of pregnant women in rural and urban areas?
- Does any difference exist between those pregnant for the first time (Primigravida) and those pregnant for more than once (multi – gravida) in their health – seeking behaviour?

### *2.2.Hypotheses*

The following hypotheses were postulated to guide the present study:

- There will be no significant difference in mean scores across the levels of education (low, middle and high) on the health-seeking behaviour of pregnant women
- There will be no significant difference in mean scores of rural and urban-based pregnant women on their health-seeking behaviour.
- There will be no significant difference in mean scores of primigravida and multigravida women on their health-seeking behaviour.

## **3.Method**

### *3.1.Participants*

A total of three hundred and thirty-four (334) pregnant women from four local government areas in Benue State participated in the study. These local government areas are Otukpo, Makurdi (Urban) and Ohimini, Obi, (rural). Only pregnant women were sampled and they were further grouped into two; that is those pregnant for the first time (primigravida) and those who had been pregnant for more than once (multigravida).

Another factor that was considered was the participants' educational qualifications.

- Low education – illiterate to primary six.
- Middle education – secondary education to NCE and Diploma.
- High education – University education (degree, HND and the like).

Selection of research participants was purposive as only those seen to be physically pregnant (enlarged abdomen) and those nursing babies of 0-42 days participated as these fall within the definition of pregnancy (WHO, 1997). The participants were stratified based on the fact that the study involved sub-group comparison. Stratification contributes to the efficiency of sampling if it succeeds in establishing classes that are internally comparatively homogenous with respect to the characteristics being studied (Ikeagwu, 1998).

### *3.2.Method Of Data Collection*

#### *3.2.1.Instruments*

The instruments were the self - developed Likert-type questionnaire with 35- forced-choice, scaled items. The questionnaire was sub-divided into two parts- socio-demographic variables and indices of health-seeking behaviour through the three stages of pregnancy; ante-partum, intra-partum and post-partum periods.

Participants were expected to respond to items using a five-point scale of strongly agree (five points), agree (4 points) undecided (3 points), disagree (2 points) and strongly disagree (1 point). Thus, the higher the score, the more positive the health-seeking behaviour, while lower points suggest less positive health-seeking behaviour.

To test for the content validity of the instrument, the initial items were given to ten (10) judges made up of doctors, midwives and mothers. Each judge was requested to indicate which of the items could be valued as a positive health-seeking index. Only items that a majority of judges (70% and above) classified as positive made up the final list. A pilot study using thirty participants selected from primary health maternity clinics was conducted. The responses from the study were subjected to item analysis to determine consistency and relevance. The items with a correlation co-efficient of not less than 0.60 were selected for the main study. This formed the measure of validity as it tests for consistency and relevance (Aiken, 1985).

### 3.2.2. Procedure

The instrument was administered in four (4) of the twenty-three local government areas of Benue State. These four local governments' areas are Otukpo, Ohimini, Makurdi and Obi. With the aid of assistant researchers, four hundred copies of the questionnaires were distributed to a hundred pregnant women or nursing mothers of less than eight weeks old infants in each of the four local government areas. The assistant researchers aided in the interpretation of the questionnaires in the three local languages (Idoma, Igede and Tiv) for participants who were unable to read and respond in English language. The participants were met in their homes, market places as well as other places of work.

### 3.3. Method Of Data Analysis

#### 3.3.1. Statistics

A 3x2x2 factorial design with three levels of educational qualification (high, middle, and low), two areas of domicile (rural/urban) and two positions of pregnancy (primigravida and multigravida) was used. Analysis of variance (ANOVA) with unequal sample sizes was used to analyze the data.

### 4. Results

Health-seeking behaviour was the independent measure. An analysis of variance (ANOVA) with unequal sample size showed that two out of the three main effects and one out of the interaction effects are statistically significant. Precisely, the findings reject the hypothesis that there would be no significant difference among the three educational categories on health-seeking behaviour,  $F(2, 322) = 11.82, P < .001$ . The second hypothesis which assumes there would be no significant difference in the health-seeking behaviour or rural and urban based pregnant women was also rejected,  $F(1, 322) = 6.30, P < .01$ .

However, the prediction that there would be no significant difference in the performance of primigravida and multigravida women has confirmed,  $F(1, 322) P < .01$ .

Source	Sum of Squares	df	Mean square	F
Educational				
Status (A)	5643.51	2	2821.76	11.82**
Domicile (B)	3815.54	1	3815.54	15.98**
Positions of				
Pregnancy (C)	219.66	1	219.66	<1
A x B	3008.48	2	1504.24	6.30*
A x C	82.83	2	41.41	<1
B x C	511.88	1	511.88	2.14
A X B X C	1301.736	2	650.87	2.73
Error	76871.06	322	238.73	
Total	7079933	334		
*p<0.01	**p<0.001			

Table 1 : Summary Of Educational Status X Domicile X Positions Of Pregnancy. Analysis Of Variance On Health-Seeking Behaviour Of Pregnant Women Using Unequal Sample Size

### 5. Discussion

The results presented in Table 1 show the directions of the hypotheses. The first hypothesis stating a no significant difference between educational status and health-seeking behaviour of pregnant women was rejected ( $F(2, 322) = 11.82, p < .001$ ). Also, the results of between group comparisons show that, women with high educational qualifications and those of middle educational qualifications when marched with the lower ones, was highly significant ( $F(2, 322) = 6.30, p < .01$ ). The finding corroborates earlier findings that well educated persons, especially of the upper income group, tend to have more knowledge of disease and are more sensitive to their conditions (Langer, et al., 1995).

The hypothesis postulated a no-significant difference in the health-seeking behaviour of rural and urban-based pregnant women, was rejected. Surprisingly, the result is skewed in favour of rural rather than urban pregnant women. The mean score of ( $X = 150.84$ ) suggests that pregnant women in rural areas have better health-seeking behaviour than urban ones ( $X = 140.08$ ). This result negates earlier findings of Suchman's (1965) parochial groups (rural) subscribing less to scientific opinions including health issues than cosmopolitan or urban groups. This particular finding may raise a concern on why yet high maternal mortality rates in rural areas if health-seeking behaviour is better in rural than urban. However, it should be noted that while the perception of pregnant women is vital to maternal health, it is not the only parameter used for evaluating effective management of a holistic maternal health concern.

The result in favour of rural rather than urban could also be in the “not-so-visible” improvement in public enlightenment campaigns. It may also mean that rural women aware of their disadvantages take more seriously issues of public education than their urban counterparts.

The third hypothesis was confirmed. It states that there will be no significant difference in the health-seeking behaviour of primigravida and multigravida women. This implies that those found to be pregnant for the first time are found not to differ in their health-seeking behaviour from those who had been pregnant previously. The finding is consistent with the postulation by Safe Motherhood (2000) that “every pregnancy faces a risk” and should be treated as unique.

Among the interaction effects, education x domicile was the only effect that proved to be statistically significant ( $p < 0.01$ ). This implies that a person’s level of education and where she resides can influence her health-seeking behaviour.

## 6. Recommendations/ Suggestions

- Since the various levels of education hold significant relationship to pregnant women’s health – seeking behaviour, empowerment of women and their families to freely access health care, and sensitization of health care workers regarding potential biases in their treatment of the poorest women, are both important. Also, policy – makers could pass a law enforcing free education for girls at all levels. Furthermore, an equitable allocation and concentration of resources for both urban and rural dwellers especially in the areas of maternal health is equally important.
- It is important to treat pregnancies on their own merit. This means that parity should not necessarily be the yardstick to granting pregnant women the care they invariably require during and after pregnancy. This is because parity may have little or no bearing to the complications that are likely to arise in subsequent pregnancies. This is crucial for women’s health – care providers and other stakeholders.
- Of the sampled population, 62.3% and 59% are between the ages of 12 – 29 years in the urban and rural areas respectively. This informs the need for the provision of youth – friendly maternal services which can be integrated into the current structures as we have them; be it antenatal or maternity clinic.
- Lastly, there is a need to restructure the health care delivery system to cater for the post – natal stratum especially the immediate post – partum period. This should be well – defined post – natal programme which should be holistic. Proper education with benefits of this programme should be a major focus during attendances at the antenatal clinics.

## 7. Conclusion

In conclusion, it can be clearly stated that a pregnant woman’s level of education as well as where she lives can affect the way she seeks health-care. This further goes to buttress the need for women’s education especially in achieving set goals in maternal health.

The result in favour of rural over urban in this study may show a rising level of improvement among rural pregnant women of appropriate health etiquettes during pregnancy. It should also be noted that the number of pregnancies a woman has had does not translate to experiences of better health-seeking behaviour.

There are other variables that are likely to show important roles in health-seeking behaviour such as age, marital status, occupations, that were not discussed. The study could be found useful for researchers in the sciences, social sciences as well as education. Policy-makers and Non-Governmental Organizations (NGOs) working in the areas of sexual and reproductive health could draw inferences and make improvements maternal health care in both rural and urban areas.

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