

SOCIAL SUPPORT AS A PROXIMATE DETERMINANT OF UTILISATION OF MATERNAL HEALTH SERVICES (MHS) AMONG WOMEN IN NNEWI, SOUTHEAST NIGERIA

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Abstract

Utilisation of antenatal care, skilled delivery care, postnatal care and family planning services are recognized as key maternal health services (MHS) that improve maternal health outcomes. The study ascertained the extent of utilisation of maternal health services and social support as a proximate determinant of utilisation of maternal health services in Nnewi South East Nigeria. Two research questions guided the study. Descriptive cross-sectional Survey research design was adopted for the study and a sample size of 420 women of child bearing age (15-49 years) selected through multistage random sampling technique. Instrument for data collection was a pre-tested 30-items semi-structured questionnaire. Research questions were answered using mean, simple regression analysis and Anova. The findings of the study indicated that women have high utilisation of maternal health services in Nnewi. The study also revealed that social support to a great extent determines utilisation of maternal health services in Nnewi. Based on the findings of the study, recommendations among others were that men should be encouraged to participate in any maternal health program or even in utilisation of MHS to create the social support needed by the women.

Keywords: Social support, Proximate determinants, Maternal Health, Maternal health Services, Utilisation.

Background to the Study

Introduction

Maternal health is an essential indicator of the quality of health care in any country and therefore improving maternal health is a significant global development challenge most especially among low-resource countries including Nigeria. Maternal health according to World Health Organisation (WHO, 2014) is “the health of women during pregnancy, childbirth and the postpartum period”. It encompasses the health care dimensions of family planning, preconception and prenatal, antenatal and postnatal care in order to reduce maternal morbidity and mortality (WHO, 2013a). Improving maternal health and reducing maternal

mortality has continued to be the focus of many international health programmes especially the more recent Sustainable Development Goals (SDGs) which laid emphasis on the promotion of women's health and safe motherhood; improving the health and nutritional status of women, especially of pregnant and nursing women (WHO, 2015). The SDGs came up in 2015 with 17 goals and 169 targets among which is to reduce the global maternal mortality ratio to less than 70 per 100,000 live births when it is clear that the millennium development goals (MDGs) have not been achieved (WHO, 2015). All these show that the challenge of improving maternal health has been acknowledged globally, Africa and Nigeria in particular have not been left out either. These initiatives have yielded fruits to a certain extent with a reduction in maternal mortality rate (MMR) from 800 in 1990 to 576 in 2013(NPC & ICF, 2014).

Data from Nigeria's Five-Year Countdown Strategy for achieving MDGs and the report of NDHS show that although maternal mortality fell from 800 deaths per 100,000 live births in 2003 to 545 deaths per 100,000 live births in 2008 and 576 deaths per 100,000 live births in 2013, maternal mortality rate for Anambra state is 260-280 per 100,000 live births; progress related to this goal has been slow and challenges remain (Federal Republic of Nigeria, 2010; NPC & ICF International, 2014). These reports suggest that the maternal mortality ratio (MMR) between these surveys instead of decreasing is increasing. Although Nnewi South East Nigeria constitutes 0.12% of Nigerian population, it records 1.4% of maternal deaths (WHO, 2015). All this no doubt hinges on improved utilisation of quality MHS by the women. The objectives of MHS are to ensure that as far as possible pregnant women should remain healthy throughout pregnancy, deliver healthy babies and recover fully from the physiological changes that take place during pregnancy and delivery. MHS in this study is adopted from the four pillars of safe motherhood by WHO (2007) which informed the organisation of maternal healthcare services in Nigeria into antenatal care, delivery care, postnatal care and family planning (contraceptive) services.

Antenatal Care (ANC), use of skilled institutional delivery attendants, postnatal care (PNC) services and family planning (FP) are maternal health services that can significantly reduce maternal mortality and morbidity, this is because skilled care before, during and after child birth saves the lives of women and new-born babies. ANC is the routine or higher-level medical care received by a pregnant woman before delivery and provided by a skilled attendant. Skilled delivery care is the care given to a woman and her new-born during pregnancy, childbirth and immediately after birth by an accredited and competent health care provider in a health facility. PNC on the other hand is healthcare given to mothers following childbirth to recuperate from injuries associated with childbirth, which seems to undo the physiological changes that took place during pregnancy and delivery, and to restore the body to its pre-pregnancy state. This care is provided to both mother and infant continuing up to six weeks. During this period, breastfeeding is established, and family planning is introduced to avert early occurrence of another pregnancy. Family planning services provide confidential, low-cost preventive health care to both men and women to help with their sexual and reproductive health needs. Family planning is meant to ensure that individuals and couples have the information as well as services needed to plan the timing, number and spacing of pregnancies.

Utilisation of ANC, skilled delivery attendants, PNC and FP services are recognised as key MHS that improve health outcomes for women and children. However, utilisation of

MHS in this study can be referred to as the measure of the way by which the maternal health services available in Nnewi are being used among women of childbearing age. Evidence shows that high maternal, neonatal and child mortality rates are associated with inadequate utilisation of and poor quality maternal health care services (Maine et al, 1997 cited in Chomat et al, 2014; WHO, 2012; WHO, 2018). Evidently in Anambra state with the whole array of tertiary, secondary as well as primary health care facilities maternal mortality still remains at 260-280 per 100, 000 live births, utilisation of ANC and FP services is 58% and 35% respectively while facility delivery is high (85%) and PNC services (56.1%) (NPC & ICF International, 2014).

Social support is one of the important functions of social relationships. Social support refers to various types of assistance/help, which people receive from others. The presence of social support during pregnancy has been shown to provide psychological benefits and influence ANC use. Also, mothers in the postnatal period have reported that help received from their husbands and mothers, both with household chores and infant care, to be of great importance to them. Research has identified spousal communication and partners' levels of support are associated with use of modern contraception, as has the perception that the partner approves of contraceptive use (Azuike et al, 2017; Duze & Mohammed, 2006). It is evidently not only during pregnancy but also when trying to conceive or still hoping on conceiving. Reassurances and support gives the woman the much-needed buffer to carry on and like the Traditional Danish Proverb, "no one is rich enough to do without a neighbour".

Women do not have babies within a social vacuum therefore, the social context of pregnancy and childbirth are important considerations in maternal health. A strong support system can be essential in helping a woman obtain prenatal care as well as engage in behaviours that promote health of both the mother and the infant. These relationship especially from the significant others, mother-in-laws and grandmothers in a typical African setting show how a family structure can affect women's health. Many women in developing countries need a husband's permission to visit a health facility, or must be accompanied, particularly when the husbands are away from home. Moreover, in many parts of Africa, women's decision-making power is extremely limited, particularly in matters of reproduction and sexuality. In this regard, decisions about maternal care are often made by husbands or other family members. Also, in developing countries women rarely have time for themselves as they spend more time on their multiple responsibilities for care of children, collecting water or wood for fuel, cooking, cleaning, growing food, and trade than on their own health. The availability of help in the house through the social support system will give time to the woman to take care of matters pertaining to her health especially in a larger family size.

In cases of domestic violence to include both verbal, physical or sexual violence, women are at direct risk of maternal mortality or morbidity as there has been instances of violence during pregnancy contributing to miscarriages, stillbirths, and premature rupture of membranes (Stephenson et al, 2008). Fear of violence reduces the likelihood that a woman will initiate or negotiate sexual and reproductive decisions with her partner, which further puts her at risk for unintended pregnancies and sexually transmitted infections, contributing to poor reproductive and maternal health outcomes (Azuike et al, 2017; Stephenson et al, 2008). A strong support system can be essential in helping a woman obtain prenatal care as well as engage in behaviours that promote health of both the mother and the infant.

The extent of utilisation of MHS determines the effectiveness of these services. Social support is one of the factors presumed to determine effective utilisation of MHS. In this study therefore, social support as a factor was considered. The information obtained could be used by health educators to sensitise childbearing mothers and pregnant women on the importance of effective utilisation of available maternal health services.

Statement of the Problem

Utilisation of maternal health services by women of child bearing age has been known to have direct effect on maternal health outcomes. A reduction in maternal mortality has traditionally been used as a critical measure of progress in improving maternal health. The extent to which maternal health services are utilised determines how effective these services are. Social support has been identified as one of the factors that determine effective utilisation of MHS. This study therefore ascertained social support as a proximate determinant of utilisation of MHS.

Purpose of the Study

The main purpose of the study was to ascertain the extent to which social support determines utilisation of MHS among women in Nnewi, South East Nigeria. Specifically, the study determined:

- 1) The extent of utilisation of maternal health services among women in Nnewi, South East Nigeria
- 2) The extent social support determines utilisation of maternal health services among women in Nnewi, South East Nigeria

Research Questions

The following research questions guided the study;

- 1) What is the extent of utilisation of maternal health services?
- 2) To what extent does social support determine utilisation of maternal health services?

Hypothesis:

1. The extent of utilisation of maternal health services is low.
2. There will be no significant difference in the extent of utilisation of maternal health services by women based on social support.

Methods

This is a descriptive cross-sectional survey of the extent social support determines utilisation of maternal health services among women of child bearing age (15-49 years) in Nnewi Southeast Nigeria carried out between January 2018 and May 2018. The multi-stage sampling technique was employed to arrive at the sample size of 420 according to Cohen, Manion, and Morrison (2007) on sample size. The first stage involved randomly drawing of one market from each of the four quarters of the town without replacement. The second stage involved randomly drawing of 105 eligible women (all eligible women in the market at the time of selection) from each market. Finally, all eligible women in the selected markets were sampled until the required numbers for each of the town quarters were selected for the study.

Responses were elicited from a pre-tested 30-items semi-structured interviewer administered questionnaire from the 420 respondents. In all, only 387 properly filled questionnaires were used for the analysis. Mean was used to analyse the request one. However, in order to establish the extent to which social support determine utilisation, Muijs' (2004 cited in Cohen, Manion & Morrison (2007, p. 523) suggestion for assessing the goodness of fit of regression model using squared regression coefficient (R^2) was employed.

Results

The results of the analysis are presented according to the research questions and the summaries presented in tables to highlight the findings. Table 1 show that majority (42.9%) of the respondents were aged 25-34years followed by 35years and older age bracket (38.8%). Also, almost all the respondents were married (92.8%). Finally, 73.6% enjoys a very strong social support. Table 2 show the respondents mean score for each of the items and the overall mean score, which is the means of means. The mean of means of 3.16 indicates that extent of utilisation of maternal health services is high. The item-by-item analysis shows that out of the 25 items listed, respondents utilise 23 to a high extent. The summary of simple regression analysis displayed in table 3 shows that regression coefficient (R) = -.149, while the coefficient of determination $R^2 = .022$. This indicates that social support explained 2.2% of the variance in utilisation of maternal health services. With R^2 being less than 0.1; it shows that social support to a low extent determines utilisation of maternal health services. However, the F-ratio associated with this is 8.69 and the P-value is .003, this means that the obtained P-value is less than the stipulated 0.05 level of significance, it therefore shows that that social support significantly determines the extent of utilisation of maternal health services.

Table 1: Demographic Characteristics of Respondents

Frequency Table Age Range				
	Frequency	Percent	Valid Percent	
Valid 15-24years	71	18.3	18.3	
25-34years	166	42.9	42.9	
35years and older	150	38.8	38.8	
Total	387	100.0	100.0	

Marital Status				
	Frequency	Percent	Valid Percent	
Valid Single	28	7.2	7.2	
Married	359	92.8	92.8	
Total	387	100.0	100.0	

Social Support				
	Frequency	Percent	Valid Percent	
Valid Support	285	73.6	73.6	
No support	102	26.4	26.4	
Total	387	100.0	100.0	

(Source: Field work, 2018)

Research Question 1: What is the extent of utilisation of maternal health services?

Table 2: Mean Ratings on the Extent of Utilisation of Maternal Health Services

	N=387	Mean	Remark
1.	ANC in the first 3 months	3.31	High Extent
2.	ANC after 3 months (four or more times)	3.24	High Extent
3.	Intermittent preventive treatment of malaria in pregnancy (IPTp)	3.32	High Extent
4.	Routine screening and tests	3.45	High Extent
5.	Health education on care of the body	3.41	High Extent
6.	Health education on infant feeding	3.40	High Extent
7.	Health education on choice of place of	3.29	High Extent

delivery			
8. Routine ANC drugs	3.43	High Extent	
9. Recommended doses of tetanus toxoid injection and Vit A	3.41	High Extent	
10. Voluntary STI testing including HIV/AIDS and counselling	3.23	High Extent	
11. Child delivery services in health facility	3.45	High Extent	
12. The services of Skilled birth attendants during delivery	3.16	High Extent	
13. Assisted vaginal delivery	2.51	High Extent	
14. Caesarean section delivery	2.05	Low Extent	
15. Emergency referral services	2.45	Low Extent	
16. PNC follow up within 6wks	3.49	High Extent	
17. Exclusive breastfeeding education	3.22	High Extent	
18. Health education on care of the baby	3.43	High Extent	
19. Health promotion on nutrition	3.29	High Extent	
20. Vitamin A Supplement	3.35	High Extent	
21. Counselling on family planning	3.15	High Extent	
22. Immunization services	3.46	High Extent	
23. Health education on unsafe abortion	2.84	High Extent	
24. Health education on safer sex	2.97	High Extent	
25. At least one family planning method	2.78	High Extent	
Mean of Means	3.16	High Extent	

Research Question 2: To what extent does social support determine utilisation of maternal health services?

Table 3: Summary of Simple Regression Analysis with Social Support as Determinant of Utilisation of Maternal Health Services

	<i>B</i>	<i>SE B</i>	<i>B</i>	<i>t</i>	<i>P</i>
Constant	92.794	1.627		57.043	.000
Social Support	-3.583	1.216	-.149	-2.947	.003
R	.149				
R ²	.022				
Adj.R ²	.020				
<i>F</i>	8.69				.003

Discussion

The result showed that generally there was high extent of utilisation of MHS among childbearing women in Nnewi South East Nigeria. This is an indication that there have been increased efforts in the state to improve MHS utilisation in recent times and women are keying into it. This could be because of varied factors that determine utilisation and related to the presence of a teaching hospital and numerous hospitals in the area. Moreover, most of the women were traders and spouses that are traders too with the financial capacity to utilise care

at the hospitals. In addition, it could be attributed to Nnewi being a semi-urban town. At the rural area with poor socioeconomic position, the rate will likely be lower than was found here as it has been shown that there is a significant differential in utilisation of MHS in Nigeria between the urban and rural dwellers (NPC & ICF International, 2014; Yar'zever & Said, 2013). The findings is in accord with that of Emelumadu et al (2014) that reported a high level of utilisation of MHS among women of child bearing age in Anambra state but indicated the need to address the gaps of late ANC booking and low ANC visits. This is also supported by Ugboaja et al (2017) that reported a good rate of utilisation of SBAs among Igbo women in Southeast Nigeria. However, the finding is different from Ugboaja et al (2011) who found that utilisation is very low in Nnewi, Nigeria. This could be as a result passage of time between the two studies or due to the numerous safe motherhood awareness programmes ongoing in the country in general and Anambra in particular.

Even though the extent of utilisation is high generally, the finding records very low extent of utilisation of caesarean delivery and emergency referral services. This is not surprising because the choice of caesarean delivery is always taken as a last resort and even then some women are still sceptical to using it and could very well be the reason behind the persistently high MMR in the area even when the extent of utilisation has been found to be high (NPC & ICF, 2014). Therefore, there is need for continued health education for women to help change their preconceived erroneous ideas and beliefs about caesarean delivery and also help them understand the importance of safe motherhood not minding the type of delivery. The low extent of utilisation of emergency referral services could be attributed to the high extent of utilisation of skilled attendants during delivery as recorded in the study. This shows that delivery was handled well and only minimal cases were primed for referral as supported by Ugboaja et al (2017), although it could also mean that emergency referral services are not readily available hence the low extent of utilisation.

The result of the simple regression analysis on the extent social support determines utilisation of MHS indicated that social support to a low extent determines utilisation of MHS in Nnewi South East Nigeria. Unlike the above findings, Nwosu et al (2012) and Ugboaja et al (2011) revealed that social support determines significantly utilisation of MHS. The disparity in the findings of the two studies could be because of passage of time with which more awareness on the importance of social support to maternal health was created. This is evident in the result as a higher percentage of women have maximum support from family members (see table 1). This finding is relevant because it implies that family members have improved on their responsibility of providing adequate and effective social support network.

The test of hypothesis showed that social support significantly determines the extent of utilisation of maternal health services by women. This is in agreement with Babalola (2014) as well as Ugboaja et al (2017) that strong social support from family members highly determine utilisation of MHS. A strong support system can be essential in helping a woman obtain prenatal care as well as engage in behaviours that promote health of both the mother and the infant. Little or no social support from family and friends after delivery was predictive of higher levels of emotional distress. The individuals' ability to cope with crisis depends on the extent to which they receive social support from relatives; friends and other members of their social network (Babalola, 2014).

Conclusion

Based on the results of the study, it would be concluded that the extent of utilisation of MHS is high among women in Nnewi South East Nigeria. Also, social support to a high extent determines the utilisation of MHS among women in Nnewi South East Nigeria. This indicates that the ongoing interventions for improved utilisation of MHS are not in vain. However, women should continue to be encouraged by the ministry of health in conjunction with the health educators, through workshops and seminars among others to keep improving on effective utilisation of maternal health services. The findings also reported a low extent of family planning utilisation among the women. There is a need to create more awareness also on family planning services promoting the advantages of its utilisation and dispelling fears following its utilisation.

Finally, the study revealed that social support determines utilisation of MHS among women in Nnewi South East Nigeria. As social support to a high extent determine utilisation of MHS, therefore it would be considered important variables in any study concerning MHS utilisation and in the planning of any maternal health intervention geared at improving effective utilisation of MHS. It is recommended that government and non-governmental organisations (NGOs) should continue in embarking on programmes that could increase social support programmes like involvement in mother's group, targeting role of family members and general population. Men should also be encouraged through mass sensitization to participate in any maternal health programme to create the social support needed by the women.

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