Gender Influence on Health Care Utilization among Antenatal Care Women in Nigeria.

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Introduction

Gender is a very serious factor affecting maternal health particularly in a patriarchal setting like Nigeria. Gender is a force that exacerbated poor utilization of maternal health services. The dynamics of gender roles especially in a patriarchal society affects maternal roles adversely through male domination, female dependency, low status of women and socio-economic status, cultural beliefs and practices with unpleasant implications for poor maternal health utilization which culminate in high maternal mortality and morbidity. Efforts of international and national summits on Safe Motherhood such as the International Safe Motherhood Initiative, 1987 in Kenya,   International Conference on Population and Development (ICPD), 1994, Beijing- Fourth world Conference on Women, 1995, United Nations MDGs 2000, and its local equivalent in Nigeria such as National Safe Motherhood Conference, Abuja 1990, Integrated Maternal Newborn and Child Health Strategy 2007 among others have succeeded poorly in advancing the cause of poor health status of women during the past decades.   Maternal mortality statistics remain high in Nigeria. Men decide where and when their households go for health care services, antenatal care (ANC) and delivery services. In fact maternal mortality is a very sensitive indicator of inequality and a resultant offshoot of gender role which is embedded in several patriarchal cultural practices. While the patriarchal system confers on men a superior position in the family decision-making process, the cultural setting gives recognition to men as the traditional head of the household.

The gender inequality index of Nigeria is very low with Nigeria ranking 153 out of 186 countries (UNDPHDR, 2013). Nigeria has one of the highest rates of maternal mortality in the world, ranked second globally with 37,000 cases of maternal deaths annually. While India occupied the first place with 136,000 maternal deaths and Pakistan was in the third place with 26,000 deaths. Ironically, Nigeria with only 2% of the world's population accounts for 10% of global maternal deaths. Each day 144 Nigerian women die in childbirth, which is equivalent to one death every 10 minutes. Decision to seek treatment may be influenced by a woman's socio- economic status and cultural dogmas in the household. In Nigeria, 62% of births take place at home (NPC 2009). Access to quality health care during pregnancy and delivery are vital forces in influencing maternal morbidity and mortality. Regrettably, it's the male folks that do not bear the burden of pregnancy and child birth that virtually decides the fate of their spouses including use of treatment issues.

Health care utilization is poor in Nigeria and several reasons have been adduced for non-utilization of the available health facilities by pregnant women leading to high maternal mortality. Unfortunately this dimension has been the least focused in terms of research study and available studies are yet to identify gender factors responsible for the poor scenario and the data is ever scarce. In the words of McCarthy and Maine (1992) much less research has focused on the relationship between women's status and the use of health services, a proximate determinant of maternal and child mortality. Hence the imperative towards narrowing the gap as this paper investigated the issue among men who lost their wives during pregnancy and child birth in Ado-O/Ota Local Government Area of Ogun State. The objectives of the paper are to examine gender related variables retarding maternal health utilization, and to serves as intervention tool for improving the current low usage of health care facilities by pregnant mothers thereby improving on the reduction of maternal mortality in the country.

The hypothesis considered is that cultural male- related factor (place of consultation) does not significantly affect maternal utilization of health care services.

Methodology

Data used for this paper were from a recently Covenant University sponsored study on non-medical determinants of maternal mortality. The study which was an informant based survey study was carried out in Ado-Odo/Ota Local Government Area, Ogun State Nigeria. Interviews were conducted in eleven randomly selected wards out of sixteen wards in the local government area which was purposively selected for this study. Respondents consist of husbands whose wife (or wives) has/have died during pregnancy, in the course of delivery or 42 days thereafter in the last three years preceding the survey. Informants were employed to aid in locating respondents through the assistance of health workers in hospital/clinics and traditional birth attendants who were recruited as key informants. Where the husband was not available, a close sister or head of household who is fully aware of the case was used in eliciting information on maternal death and issues related to it as contained in the research instrument. However, respondents selected were ever- married men who have resided in the place of study for over 5 years. The sample size was 360 eligible respondents. A framework for analyzing the determinants of maternal mortality and morbidity by McCarthy and Maine (1992) was used for the paper with modification.

Review of related Literature

Access to and use of modern health care services lowers maternal deaths especially during pregnant and child delivery. Among numerous factors influencing the usage of healthcare facilities, cultural engendered factors are more hash.

According to Jose et al (2009) there is no one shot intervention for decreasing maternal mortality alone, but there is consensus on the importance of a strong health system, skilled delivery attendants and women's rights for maternal health. Chukuezi (2010) opined that socio-economic and cultural factors and indeed gender discrimination contribute to high maternal mortality and morbidity in rural Nigeria.   According to Federal Ministry of Health Nigeria (2006),these factors work through the pervading high level of poverty in the country, low status of women and high prevalence of harmful traditional practices, all add up to pose great obstacles to women's access to much needed reproductive health information and services. Addai (2000) asserts that cultural perspective on the use of maternal health services suggest that medical need is determined not only by the presence of physical disease but also by cultural perception of illness. According to Shireen (2002), social norms concerning gender roles powerfully shape women's autonomy. In line with the above, Shelah et al (2001) in their study on dimensions of women autonomy and maternal health care utilization in a North Indian City ascertain the influence of women's autonomy on the use of health care during pregnancy and child birth. Rob and Amy ong Tsui (2002) found that women's health care seeking behavior to not only restricted by socio-economic barriers and lack of quality health care facilities, but also by cultural norms that limit women's role in making decisions regarding health care and impede their freedom to use available services. In Nepal, Marie and Sarah (2006) observed that low status of women hinders progress toward national health and population policy and acts as constraints to women's access to skilled health care.

In a study among the Hausa of Kano State, Adamu (2001) revealed that men make it difficult for the women to regulate and control birth rate without the consent of their husbands. While Afonja (1986) noted that the hierarchical nature of Yoruba society in Nigeria relegates women to a subordinate position in matters of family planning and otherwise, Biratu and Lindstrom (2006) found out that a husband's approval has a greater effect on prenatal care utilization than whether a wife wanted the pregnancy or a wife's level of education. In a study investigated among women from four local governments in Benue State, Nigeria, Okeshola and Ismail (2013) noted that cultural practice of the Hausa people plays a major role in determining women's choice of place of child delivery in addition to poor hospital services and nature of attendants which may violate women's privacy. In an exploratory study which focused on socio-cultural factors affecting pregnancy outcome among the Ogu speaking people of Badagry area of Lagos State, Nigeria, Ajiboye and Abimbola (2012) found that culture was very dominant in shaping their reproductive behavior. Whereas another recent study among childbearing women in Ibadan North Local Government Area of Oyo State Nigeria, Ewa et al (2012) revealed that husband's decision or preference of antenatal care(ANC) and privacy constituted the prominent factors that influenced the choice of ANC as well as place of delivery. In Pakistan, women have to seek permission from the head of household or men for visiting health facility (Fatimi 2002). In an intra-familial power dynamics and attitudes study of 317 households in two rural districts of Central Mali, Darcy White et al (2013) found that the preferences and opinions of mothers-in-law were associated with the maternal health behaviors of their daughters-in-law. Similarly, other scholars have observed that cultural beliefs, practices and taboos organized according to mainstream societal values of male superiority, supremacy and preference exacerbate difficulties of pregnancy and childbirth often leading to maternal mortality or morbidity (Aina et al.2002; Chukuezi 2010). The autonomy of women to take own decisions is positively associated with utilization of antenatal care (Pallikadavath et. al. 2004).

Results and discussions

On the whole, 64.7% of the respondents were husbands and 35.3% were related female respondents of the deceased. The highest level of education attained by majority of the respondents interviewed is secondary education (48.1%), followed by primary education (28.6%). However, respondents with no school and post secondary education account for16.1% and 7.2% respectively. When reference was made to the education of their spouses, it was observed that 50% of them had only primary education followed by those who attained secondary school (26.7%) and those who never went to school (19.7%). Nevertheless, those who attained post secondary education were the least (3.6%). Women need to be empowered through life transforming education to better their status. These figures show that males are better off than their female counter part, a strong indication of low status of women in the study area. The survey also revealed that 36.4% of the husbands preferred 1-4 children as ideal and 63.6% preferred 5 children and above. The perception showed inclination towards multiple pregnancies among the respondents. This high preference for higher family size exposed women to higher risk of pregnancy and apparently depicts the low status of women and also by extension the prevailing situation in sub-Sahara African nations.

Access to health seeking behavior of the respondents and entire household reflects domineering inclination of the husband. Places of consultation include hospital (41.4%) and PHC/Clinic (41.1%). However, consultation at homes of traditional healers, pastors, relatives and friends attracted a reasonable proportion (17.5%). This is particularly important when we consider the dangerous consequences of such practice. Decision on what contraception to use (65.6%), where to go for treatment (73.3%) and who pays the treatment costs (40%) were all under the domain of the husband who is apparently the head of the household. Issues relating to these areas mentioned above and the spacing of pregnancy is the decisions of the husbands, more so, in a patriarchal society like Nigeria. Nobody takes such decisions on behalf of the husband except if so delegated by the supreme head and breadwinner of the family/household. Economic dependence of women in the study areas cannot be overemphasized. Distance is a very important factor in the utilization of health facility. Respondents who have health facility close to their homes (< 2-3 kms) account for the least (10.3%) and those that avail the health facility at a distance of 4-5 km account for 14.5 percent. However, slightly above three-fourths of respondents (75.2%) have to travel 6 kms and beyond to

access or avail themselves the services of health facility. The distance to the closest government health centre is above 6 km and this is at variance with the maximum distance of 4 km recommended by World Health Organization. Private health clinics abound but the charges are very expensive.   The implication, among others, is that pregnant women become lethargic to access the facility for ANC, delivery and treatment. Considering the poor status of wives in sub-Sahara African countries in general and the absolute dependence on household heads, it becomes practically difficult to travel such distance without approval/assistance, coupled with the poor road networks in most rural areas.

Seeking diagnosis from modern health worker leads to better health care delivery system as it reduces the risks for the mother and child during the critical period. Assistance on diagnosis of illness during pregnancy and child delivery showed that medical personnel account for slightly above half of the respondents (51.4%) and non medical persons account for 48.6 percent respectively. This is a worrisome situation as it increases the probability of adverse pregnancy outcomes particularly as 62 percent of births take place at home in Nigeria (NPC 2009).

 While majority claimed their wives delivered at hospital (25.2%), majority of these deliveries were concentrated in the private hospital/clinics (27.2%) and PHC (6.4%). However, a worrisome figure of about 18.4% respondents' wives delivered at home and 22.8% delivered at traditional medicine homes. Therefore, non-institutional delivery accounts for 41.2 percent which is a cause for concern and a big clog in the wheel of maternal mortality reduction and achievement of Millennium Development Goal 5.

To support the above findings, a regression analysis result showed (See Appendix Table 2) that place of consultation, a gender related issue, was a predictor of delivery place. In a patriarchal society like Nigeria, it is the husband that decides where to go for consultation on any health issue or challenge confronting the household. The place of consultation suggests that antenatal mothers that seek the services of medical consultants have more likelihood of having institutional delivery. This implies that wrong place of consultation might adversely influence the choice of birth place which invariably affect maternal mortality in the study area. Given the result of the F-statistic (25.458) of the ANOVA test with the significance level of 1 percent, the study accepts the hypothesis that cultural male- related factor (place of consultation) significantly affect maternal utilization of health care services.

 Recommendations - The study suggests the following policy actions: i) empowerment and improvement on the status of women through education and paid employment in order to lessen dependency on their husbands. Once their status is enhanced it will equally encourage participation in decision making process; and ii) provision of culture-based health and population education along with intensified community enlightenment programs, targeting particularly the men in order to increase their perception about pregnancy risk and make them more responsible in terms of Safe Motherhood (SM). In addition, extensive community education will aid to

jettison cultural aspects that are not in tune with the present reality thereby maintaining the current tempo of modern health consultation.

Conclusion
To achieve MDG 4 and 5 call for regular research on the determinants of poor utilization of health facilities by women especially during pregnancy and child birth. The essence of this study is to provide data for effective intervention measures towards reduction of maternal mortality and by extension their children. The present study has affirmed the link between gender- related factors and place of consultation by pregnant women. The study reveals that gender related roles are significant to the use of maternal health facilities in the study area. The study has identified several factors that have important influence on utilization of maternal health services in the study area. Among the core gender related factors are low participation in decision-making with respect to: treatment place, payment of treatment costs, place of consultation, contraceptive use and place of birth. The study equally recommends that culturally appropriate health education especially on harmful traditional practices and benefits of (SM) should be employed as a short term measure. Transformation of status of women and empowerment should be effected for better healthcare utilization among pregnant women.

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Appendix

Table 1 Socio-demographic and gender related characteristics associated with maternal health care usage.

Variable	No	%	Variable	No	%	Variable	No	%
Gender			**Education of Respondents**			**Education of Spouse**		
Male	233	64.7	No School	58	16.1	No School	71	19.7
Female	127	35.3	Primary	103	28.6	Primary	180	50.0
Total	**360**	**100.0**	Secondary	173	48.1	Secondary	96	26.7
			Post Secondary	26	7.2	Post Secondary	13	3.6
			Total	**360**	**100.0**	**Total**	**360**	**100.0**
Family Size			**Place of Consultation**			**Decision on Contraceptive Use**		
1-2 children	30	8.3	Hospital	149	41.4	Husband	236	65.6
3-4 children	101	28.1	Clinic	148	41.1	Spouse	35	9.7
5 children and above	229	63.6	Home of Trad-tional healer, Pastor, relative/			Both	16	4.4
Total	**360**	**100.0**	Friend	63	17.5	Other	73	20.3
			Total	**360**	**100.**0	**Total**	**360**	**100.0**
Decision on Place for Treatment			**Payment of Treatment Cost**			**Distance to Health Facility**		
Husband	264	73.3	Husband	179	49.7	<2km	9	2.5
Spouse	24	6.7	Spouse	17	4.7	2-3km	28	7.8
Both	65	18.0	Both	32	8.9	4-5km	52	14.5
Relative/Friend	7	2.0	Family/Relative	90	25.0	6km & above	271	75.2
Total	**360**	**100.0**	Other	42	11.7	**Total**	**360**	**100.0**
			Total	**360**	**100.0**			
Diagnosis of Illness			**Place of Delivery of last Birth**					
Med Worker	185	51.4	At Home	66	18.4			
Husband	92	25.6	Trad-Med.Man	82	22.8			
Trad. Healer	44	12.2	Govt Hospital	91	25.2			
Pastor	10	2.8	PHC	23	6.4			
Family/relative	21	5.8	Private Clinic	98	27.2			
Other	8	2.2	**Total**	**360**	**100.0**			

Total	360	100.0		

Source: Derived from field work 2010

Table 2 Regression Analysis

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.270[a]	.073	.070	1.242

a. Predictors: (Constant), Place of consultation

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	39.253	1	39.253	25.458	.000[a]
	Residual	499.560	324	1.542		
	Total	538.813	325			

a. Predictors: (Constant), Place of consultation

b. Dependent Variable: Place of Delivery of last birth

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	3.265	.120		27.101	.000
	Place of consultation	.165	.033	.270	5.046	.000

a. Dependent Variable: Place of Delivery of last birth