THEORETICAL CONCEPT OF PROXIMATE DETERMINANTS OF UTILIZATION 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. Behavioural model by Andersen and Newman (2005) and the general theory of help-seeking behaviour by Mechanic (1978) were employed as theoretical framework for exploring the proximate determinants of utilisation of maternal health services. Lack of education, large family size and financial concerns among women undoubtedly contributes to the widespread self-neglect characteristic of many African women. They tend to be unmindful of their own health needs and fail to seek care. This therefore suggests that efforts to promote use of MHS should pay special attention to the needs of multiparous, lowly-educated and poor women.

Introduction

Maternal health services (MHS) constitute a large range of curative and preventative health services of particular importance to the health of women of reproductive age. It also refers to population-based services such as health communication (for example promotion of antenatal care). 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. A health facility is a private or public health establishment recognised by the government that provides health care services. Examples include local community health centres, clinics, and hospitals.

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 North LGA are being used among women of childbearing age.Utilisation of quality MHS is very crucial in reduction of maternal mortality and morbidity both directly and indirectly. Several studies carried out across the country indicated that utilisation of quality MHS is still low in Nigeria (Babalola&Fatusi, 2009; NPC & ICF International, 2014; Onah, Ikeako&Iloabachie, 2006; Yar'Zever& Said, 2013). Utilisation of MHS is a determinant of maternal and child morbidity and mortality. 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).

The extent of utilisation of MHS varies from country to country and region to region. Most maternal health services are being utilised more than others while some are underutilised. In South East Nigeria, there are variations in the utilisation of MHS. ANC attendance (99.7%) and facility delivery (97.0%) is high, while family planning services utilisation (<10.0%) is low (NPC & ICF International, 2014).Same report showed that in Anambra State, maternal mortality rate is 260-280 per 100,000; utilisation of ANC and FP services is 58% and 35% respectively while facility delivery is high (85%) and PNC services (56.1%). This report is seen in all the regions of Nigeria with worse statistics from the north (Emelumadu et al, 2014; NPC & ICF International, 2014; Ugboaja, Nwosu &Oguejiofor, 2017; Yar'Zever& Said, 2013).

Nnewi, a semi-urban town boasts of an array of primary, secondary and tertiary health facilities with the presence of a teaching hospital (Nnewi, 2014). This means that women in Nnewi LGA have a wide range of facilities to choose from in order to access MHS. The theoretical concepts adopted in this study therefore will explore the availability of services, accessibility, affordability and others. In this study, the household and individual factors such as age, marital status, family size, socioeconomic position and social support in Nnewi North LGA are considered.

Methods

Theoretical Framework

In order to anchor the research problem within a consistent body of knowledge, the three categories of individual determinants of utilisation of health services presented in the revised behavioural model by Andersen and Newman (2005) and the general theory of help-seeking behaviour by Mechanic (1978) were employed as theoretical framework for exploring the determinants of utilisation of maternal health services.

Anderson Behavioural Model

This behavioural model was proposed by Anderson and Newman in 2005. The model hypothesizes that the decision to seek medical help is a function of three sets of variables that identified the primary determinants of health care utilisation: societal, health system, and individual determinants of healthcare utilisation. Societal determinants are comprised mainly of social network factors such as support systems and family. The health system characteristics include availability, quality of care and organisational factors, while the individual determinants include predisposing characteristics, enabling and need factors for health services. Predisposing characteristics centre on the idea that some people have a greater tendency to utilise health services than others do. These characteristics exist in the individual prior to the onset of illness; and in the case of this study prior to the onset of pregnancy or childbirth. Such factors include age, marital status, educational level and occupation. These factors describe the propensity of individuals to utilise healthcare services.

Enabling factors are seen as the logistical aspects of obtaining care and supporting resources which may be resources from an individual or those that exist at the community level. Such factors

include income, having a health insurance, availability and access to vehicles. The need factor explain the reasons someone will utilise health services. The need factors are fundamental to health seeking behaviour, one should perceive a condition as susceptible and severe enough before seeking care to gain benefits. Perceived need is how people view their own general health and functional state, as well as how they experience symptoms of pregnancy, pain, and worries about their health and whether or not they judge their problems to be of sufficient importance and magnitude to seek professional help.

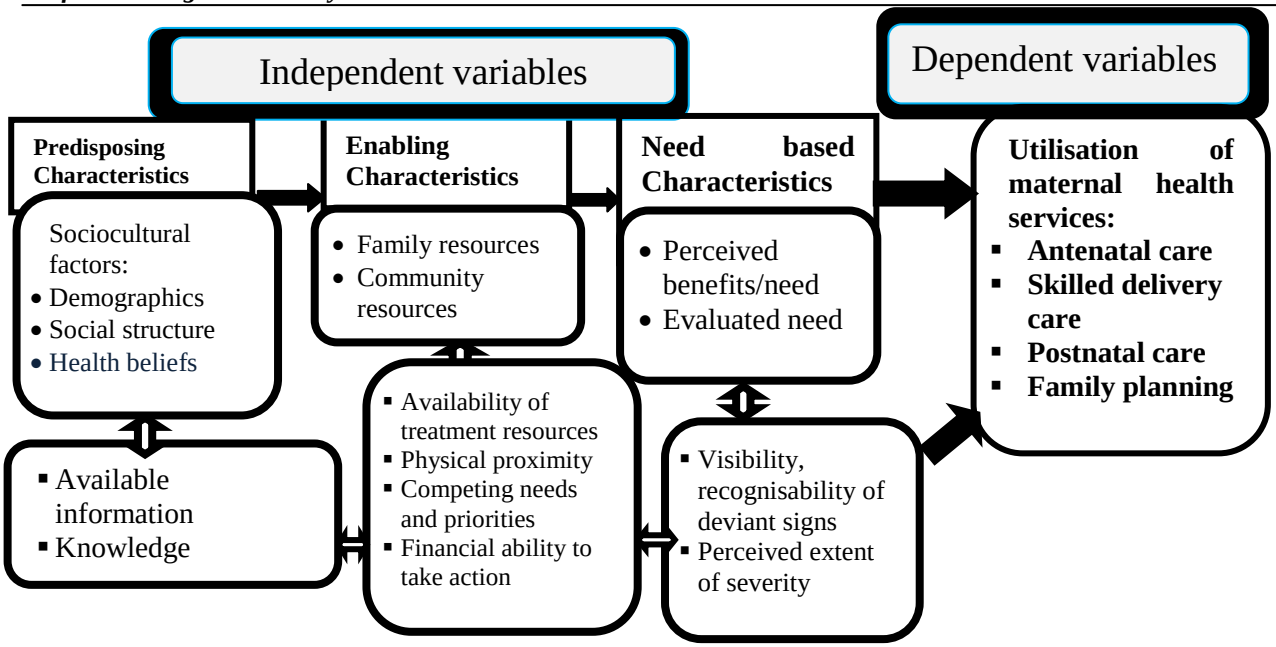
In this study, women would first of all identify the need to utilise MHS then other characteristics will then be considered. These characteristics such as age, marital status, occupation and educational level of women will determine how, whether or not and if they are going to utilise available MHS. This corresponds to the determinants being considered by the researcher in this present study.

The Mechanic General Theory of Help-Seeking Behaviour

Mechanic David in 1978 theorizes that care-seeking is a culturally and socially learned response. The theory emphasizes individual differences in help-seeking behaviour. Individuals respond to their health needs according to their perception of the situation. According to him, family members, friends and colleagues may influence this perception. He proposed ten determinants on which the decision to seek health care is based. These determinants influence the individual's decision to utilise health care service or not. It generally include her knowledge whether she comprehends that she has a problem, her perception of its severity, the extent to which symptoms disrupt family, work, or other social activities, availability of treatment resources and physical proximity, economic cost of health care seeking, knowledge and cultural assumptions.

Beyond these points, Mechanic also allowed utilisation to be influenced by the person that makes the decision for the individual. While some people cope well with illnesses (which in the present study illness could be construed as pregnancy), others find it difficult. If people experience difficulties, they are more likely to seek help from their health care providers. Women will utilise available MHS if they perceive the symptom to be severe and exceeding their degree of tolerance. For instance, among pregnant women nearing term some will go to the hospital at any slightest symptoms while others will wait till they could no longer tolerate the pains associated with labour. Also, economic cost of health care seeking plays a role in help-seeking behaviour of women. In resource constraint family, other needs competing with basic needs could lead to denial to utilise MHS. This theory also reiterates the individual and community level factors that determine health seeking behaviour being considered by the researcher.

The researcher found this theory and model relevant to the study amongst several others available because the major factors highlighted in them were used to provide insight to the various factors that determine utilisation of maternal health services. Their inter-relationship is illustrated in Figure 1 below which shows the relationship between the independent variables and how it affects the dependent variables of the study. The two were deemed relevant to the study because they examined the individual determinants of utilisation of health service namely, the predisposing, enabling and need based components as well the socio-cultural assumptions that makes the decision for individuals whether to utilise MHS or not.



(Adapted from Anderson & Newman, 2005; Mechanic, 1978)

Figure 1:Framework for analyzing determinants of MHS utilisation

Theoretical Studies

Determinants of utilisation of maternal health services.

Various factors determine utilisation of maternal health services. These factors as presented by Andersen and Newman (2005) and the general theory of help-seeking behaviour by Mechanic (1978) revolve around societal, economic, educational and cultural practices that include education (which encompasses available information, knowledge and cultural assumptions), occupation and income which takes care of the family resources, availability of treatment resources and financial ability to take action as postulated by General help-seeking theory, family size which determines the competing needs and priorities as well as social support and marital status which is part of the community resources and social structure.

Family size.

Family size directly influences the timing of first visit for antenatal care though the results are sometimes dissimilar. Late booking for ANC is more common among women who have had more than one child. Likewise, women with only one birth were more likely to use PNC services than those who had 5 or more births. In the utilisation of maternal healthcare services like ANC, delivery care and PNC in Nigeria for example, women in their first pregnancy were more likely to seek care due in part to the perception that first pregnancy is precious compared to other pregnancies; this is opined by Andersen and Newman (2005) that perception of need is not a direct reason for the utilisation of health services, but it result in the preference to make use of services.

A higher birth order decreases the utilisation of maternal health services which can be attributed to resource constraints; where the income is not much to start with as well as too many demands on their time force them to forgo health care. This is because when family needs are prioritised in a large family size, a woman of a higher birth order will most definitely take care of every other person else's need before her own. The time and cost pressures associated with larger families causes women with a large number of children to underutilize available health services.

Education.

Education is a key determinant of maternal health service utilisation as it helps in Making informed decision. Education leads to greater awareness of important maternal health indicators and enhances value for healthy life style (Fadeyi, 2007). Lack of education among women undoubtedly contributes to the widespread disregard of self, typical of many African women. They tend to be inattentive to their own illness and health needs and fail to seek care. Lack of education and its resultant ignorance among other factors often make women submissively accept the many conditions of life meted to them in the name of culture and tradition. It can be safely argued that better educated women are more aware of health problems, know more about the availability of health care services, and use this information more effectively to maintain or achieve good health status.

It was on this note that Ogbalu(2009) concluded that the low level of education together with the fact that over 60% of the population are rural –based in Nigeria that cultural norms and practices still wield a strong influence on reproductive health care especially in relation to pregnancy, delivery and child rearing. These and every other issues border on ignorance or lack of education. Women with higher level of education are more likely to utilise MHS as they have better employment opportunities, are better able to comprehend the importance of receiving prenatal care and are more likely to know where to get it. The level of a husband's education is also a determinant of utilisation, indicating that women might need to seek a husband's/partner's permission or approval before taking decisions related to care (Gabrysch& Campbell, 2009). African men are dominant decision makers, they decide and dictate most things and their wives are expected to abide by their decisions or perceived wishes. Level of education of the women often determines how women invest in health, utilise MHS, and therefore contribute significantly to delays in seeking care (Ogbalu, 2009). Educated women may be more empowered which will improve their ability for making independent decisions on their health leading to greater health care utilisation (Gabrysch& Campbell, 2009). This directly leads to a reduction in the risk of dying during pregnancy and childbirth.

Occupation and income.

The context within which women are employed influences their access to MHS. In addition, occupation can be viewed as a proxy for income. Family income is an important enabling factor as it determines the amount of funds available to an individual to cover healthcare and related costs. It is generally assumed that women who are working and earning money will have better autonomy and the financial ability to pay for services. Women engaged in low cadre occupations for example farming or clerking are less likely to utilise MHS because they do not have the financial autonomy to do so. Women whose husbands have higher status occupations are more likely to use MHS because such occupations are usually associated with greater income, which enables them to bear the costs of healthcare.

Family income is an important enabling factor as it determines the amount of funds available to cover health or health related costs. The costs of seeking healthcare may include costs for transportation, user fees (basic registration and consultation fee), medications, laboratory charges and other supplies. Women from families with limited financial resources may have difficulty paying for such costs and are likely to be deterred from using MHS (Gabrysch& Campbell, 2009). For instance, hospital births drastically declined in Nigeria following the introduction of user fees in the 1980s (Thaddeus & Maine, 1994 cited in Gabrysch& Campbell, 2009). Therefore, economic and financial status is an important consideration in the use of health services.

Sometimes, even the availability of financial power may not change the healthcare behaviour of people due to their culture of poverty. Reproductive ill health is both a cause and consequence of poverty (Family Care International, 2005). It follows that poverty endangers the health and lives of many in developing countries since the most widespread and severe poverty occurs in developing countries such as Nigeria. Poverty greatly amplifies every other risk factor for maternal mortality and morbidity from the gross female oppression to maternal under nutrition and to inadequate medical and physical infrastructure. However, women are less likely to utilise MHS when they do not have

personal control over finances suggesting that an interaction between autonomy and household income produces health services utilisation. Hence, women are more likely to utilise health services as their economic status and autonomy level increase.

Social support.

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. Social support is one of the mechanisms through which social networks are thought to affect health. Social support means having friends and other people including family to turn to when you are in need or in crisis to give you extensive focus and positive sense of self. It can be functional (emotional, instrumental, informational, appraisal) or structural (formal and informal). It enhances quality of life, provides a buffer against adverse life events, and occurs in social relationships, and the resulting sense of satisfaction and well-being. This can be support from a spouse through marriage, a group of people/friends, family, care providers, or peers (social network), assurance of worth from others and reliable support. Marriage confers some level of family and social support, security and societal respect upon women in Africa. A married woman is expected to have more access to financial support from her husband and extended family and thence has better access to healthcare which is associated with better health (Babalola, 2014). More so, newly married young women may become pregnant earlier than they would like in order to prove their fertility, or have multiple and closely spaced pregnancies until they produce a son especially where preference for male children is strong.

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.

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. 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).

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 where we have many working women, they rarely have time for themselves as they spend more time on their multiple responsibilities for the workplace and household as well as 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. 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).

Conclusion

The study identifies the proximate determinants of utilisation of MHS by exploring the revised behavioral model by Andersen and Newman (2005) and the general theory of help-seeking behaviour by Mechanic (1978). Lack of education and large family size among women undoubtedly contributes to the widespread self-neglect characteristic of many African women. They tend to be negligent to their own health needs and fail to seek care. Financial contemplations pose actual difficulties to accessing the most basic needs. This therefore suggests that efforts to promote use of MHS should pay special attention to the needs of multifarious, lowly-educated and poor women.

These have created health disparities, a common problem that must be addressed through effective systems because it undermines the economy, heightens social costs, and reduces overall well-being.

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