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AN EVALUATION OF SOCIO-CULTURAL FACTORS AFFECTING MATERNAL HEALTHCARE IN OKENE LOCAL GOVERNMENT AREA, KOGI STATE, NIGERIA.

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Abstract

Maternal health is globally an issue or concern because the existence of human population largely depends on it. It is in this view that this study sought to assess socio-cultural factors that influence maternal healthcare in Okene local government area of Kogi state by identifying the belief, norms, ways of life and values of the people and how it affects maternal healthcare in the study area. This research used semi structured questionnaire and focus group discussion (FGD) for data collection from 379 sample of women in the childbearing age (15-49) using the Krejcie& Morgan (1970) formula. This study found that the belief of women in traditional medicine is responsible for their patronage of traditional birth attendants which indirectly increases their health risks during pregnancy. This research also found that the people operate a patriarchal societal way of life where it is found that more than half of the respondents about 55% have to seek the consent of their husbands first in matters concerning their health. This study also recommends need for training and retraining of TBAs by encouraging them to develop more skills to assist delivery and also to make early referrals in case of complication during childbirth.

Keywords: maternal health, childbirth, healthcare, socio-cultural factors.

INTRODUCTION

Maternal health is a topical issue with enormous global and economic implication on human life particularly on population propagation (African Population and Health Research Center, (APHRC), 2017). Maternal healthcare is comprehensive as it includes educational, social, nutritional services as well as medical care during and posts pregnancy. As has been observed, some reasons have been attributed to why many pregnant and nursing mothers chose not to make use of appropriate antenatal and postnatal care. Some of these reasons can be cultural, hereditarily related to the social, economic and political developments. This implies that both the natural environment-biological-and the social environment perform powerful and critical functions in healthcare utilisation behaviour of women across most African societies.

According to Okeke et al., (2016) Women and their health have largely been influenced by the African traditional culture. Owing to the patriarchal nature of most of these African societies, diverse inequities are being perpetrated against women. ‘‘It is not just what is done to women, but what is not done for them’’ .Maternal health according to is defined as a state of total physical, mental and social wellbeing and not just the nonexistence of illness or infirmity in all issues that has to do with the reproductive age of women. Furthermore, with peculiarity to the African societies, maternal health would include the ability to “exercise reproductive rights of family planning and access to basic focused antenatal care, without the encumbrances of patriarchy, financial or geographical inhibitions impacting on her overall health’’. Maternal health care services include an extensive scope of health services mothers are given before pregnancy, during pregnancy, delivery and post-natal. Maternal health care services, therefore, comprise pre-natal care, childbirth and postnatal care.

Inadequate access to healthcare services by women in the reproductive age group still remains a challenge in developing countries which Nigeria is one of them. This situation is further aggravated by poverty , ignorance and the belief of the people which guide them either to accept or reject improved healthcare delivery system from a standard hospital. The situation is such that most births in Nigerian rural areas occur in the homes of traditional birth attendants (TBAs) which can be poorly managed and end up in complications or even death

(Ibisomi, 2017) in which Okene local government area is not an exception to this assertion. When women in labour experience life-threatening complications, they are often assessed to ensure that they are not suffering the repercussion of their disobedience to the norms, values and customs of the land. Where there is adequate accessibility to comprehensive health services, women are less likely to die in pregnancy, more likely to have healthier children and better able to balance their family and work life. Access to quality health care depicts why motherhood can be a positive and fulfilling experience, but for many women in Okene , pregnancy is associated with ill–health, complications and even death (Ojo, 2018). The health of a woman during pregnancy, childbirth and within the weeks after childbirth is essential to ensure the adequate wellbeing of the home and family especially in matters relating to childbirth, childcare, breastfeeding, home care etc.

Motherhood is a thing cherished by most women; yet this valued and precious part of life is among the most hazardous experience that women often engage in without being aware of the risk or danger they are in (UNPFA, 2012). Pregnancy and childbirth complications are leading causes of death and disability among women of reproductive age, especially in developing countries in (UNPFA, 2012).Maternal healthcare is comprehensive as it includes educational, social, nutritional services as well as medical care during and post pregnancy. However some socio-cultural factors have been attributed to why many pregnant and nursing mothers chose not to make use of appropriate antenatal and postnatal cares. This implies that the natural environment, biological, and the social environment perform powerful and critical functions in healthcare utilisation behaviour of women across most African societies. Health seeking behaviour, particularly of women is often determined by social norms of behaviour, beliefs and practices (UNFPA, 2009). Most women tend to conform to culturally defined norms when it comes to health-seeking during pregnancy and childbirth, despite the presence of formal health services, they are often bypassed for traditional providers (Alkali and Hussein, 2016). All these are closely tied to the fact that the community where the mother resides influence her attitude and behavior. The traditional perception of pregnancy in the African context is that of a natural condition, not requiring special health care because it is a normal fact of

life(Alkali et al, 2016). Secondly, women tend to be the major clients of the traditional healers because of their beliefs being passed from one generation to another; the natural outcome of this situation is pregnancy complication resulting in maternal mortality (Cooke and Tahir, 2014).

Burchett and Mayhew (2015) conducted a National baseline survey of positive and harmful traditional practice affecting Women and Girls in Nigeria. Their findings revealed that there are about 250 ethnic groups and these groups have various beliefs and practices, some of which are harmful to health. The negative effect of these practices affect between a quarter and one-fifth of women in the north, in the south-south area, it affect about 12.1% and in the middle belt it affect 10% (WID, 2000). In the north, there are several practices like massaging the womb and eating of local herbs during pregnancy and child birth (WID, 2000).

Busia (2010) also conducted a study of the overview of culture and traditional medicine in ECOWAS member states. It revealed that in some traditional Hausa communities, during labour a woman is given raw beans which have been soaked in water for hours to help speed labour, a fairly long stick is pushed into the woman's mouth to induce vomiting and help expel placenta. Most of these practices can be harmful to maternal and infant health.

Circumcision of pregnant women is a common practice among the Urhobo and Isoko of Delta State in Southern Nigeria, it is a commonly held belief among these people that a girl cannot graduate into womanhood unless she is circumcised and this circumcision must take place during the advanced stage of her first pregnancy, usually about seven months (Izugbara, 2012). This same source revealed that such practice has serious medical implications especially at child-birth, it reported that prolong labour is more common among women who have undergone these circumcision.

Nwokocha (2017) in assessing pregnancy outcome among the people in Rivers state found that pregnant women are not allowed to come out during cultural festivals as doing so will amount to severe punishment, not minding her health condition.

Also, in the northern part of the country where the purdah system is practiced, pregnant women's movements is somehow restricted to prevent them from being seen by other men asides their husbands. This has implications on their maternal health as some will frown at male health practitioners attending to

their wife during delivery (Isah, Alagh and Umar, 2014). They would rather prefer female health practitioners to attend to them.

Subsequently, the Oro festival among the Yoruba in the southern part of Nigeria is another cultural activity that impinges on women freedom of movement, especially during pregnancy (Fawole and Ijaiya 2012).

In some traditional communities, girls are engaged in marriage at their very early ages of life (12-13) and they are usually exposed to the pressure of having male children not only to belong to the husband's lineage but also to secure inheritance. Age at marriage, age at first birth (maternal age) and how many children to have are very much influenced by the social institution of marriage. Nigerian women marry young and bear on average six children (USAID, 2016). It is believed that early marriage lowers the risk of pre-marital sexuality, as such, it is widely practiced, meanwhile 'very early' marriage can put the young particularly the girl at high health risks of morbidity and mortality (Abouzahr et al, 2016).

For instance in the traditional community of Mbaise in Imo state, a woman who has 10 or more children is compensated with a cow on the 10^{th} live birth (Ityavyar, 2015). Such cultural practices can expose women/girls to the health risks of early and frequent pregnancies that can lead to high maternal morbidity and mortality.

Food taboos are prevalent in several Nigerian communities, during pregnancy and child birth; women's eating habits are guided by these local taboos, which deny the consumption of certain food that can fall within the range of protein, carbohydrate or fruits. For instance, some communities among the Yoruba prohibit the ingestion of meat, egg, beans or other protein-containing foods during pregnancy (Isah, Fleming and Ujah, 2014). Similarly in some communities of both the eastern and southern parts of Nigeria, pregnant women are discouraged from eating egg as they believe that it reduces contraction strength during labour, hence leading to difficult labour. Other forbidden foods are Okro soup and snail, for fear of excessive salivation of the infant; garden egg for fear of impaired speech in infant; fish for fear of extra digits and plantain for fear of delayed separation of the placenta; palm oil for fear of jaundice and certain fruits for fear of baldness (Salami et al, 2012; Ojo, 2013).

Such itemized foods have been proven to be of high nutritional values that are vital for pregnant women, because they enhance adequate foetal growth, improve maternal health and can help a woman to attain healthy labour (Salami et al, 2012). Absence of such food can lead to malnutrition; lack of a well-balanced diet in the body of the mother, malnutrition during pregnancy and child birth is life threatening, it can lead to anaemia which in turn can result to both maternal and infant death(Salami et al, 2012; Ojo, 2013). Olubunmi and Clarke (2015) in studying cultural practices and beliefs among women of child bearing age in Nigeria found that in most rural societies in Nigeria, there is high regard for obnoxious traditional beliefs and values that influence everyday lifestyles and contribute to maternal mortality. Amongst these beliefs and practices that affect maternal mortality are the following:

a. Food Taboos women's eating habits are still guided by food taboos which contribute to anemia and other forms of malnutrition. Among such taboos are restrictions on women from eating meat and eggs which are a vital part of their diet in pregnancy. Anemia and malnutrition can cause complications for women which can lead to maternal mortality.

b. Male Domination: With the stiff cultural and religious set up of male domination especially in rural settings, most women in northern Nigeria require the consent of their husbands before going to hospitals for child birth. In cases where their husbands are not available to consent, such women if faced with complications during child birth may not be taken to hospital and may end up bleeding to death or dying from complications of the pregnancy.

c. Female Genital Mutilation (FGM) This practice is most common among people of Northern, Western and Eastern Nigeria. It is a widely used gender bias traditional practice in Nigeria; it involves the cutting off of girls' clitoris and some other parts of the vagina. This practice aims to reduce promiscuity and enhance fidelity in marriage. Although much has been done to eradicate the practice of FGM, and increase awareness of its harmful consequences, it is still widely practiced, and a major indirect cause of maternal mortality in Nigeria. Pain, infection, and hemorrhage are immediate follow ups of FGM, meaning that FGM can be a direct cause of death. (Olubunmi et al, 2015). The associated risk of being infected with HIV and tetanus cannot be excluded. Scarring is one of the major problems

following FGM. A scar tissue stretches poorly in child labour, this narrows the vaginal passage and the stretching easily leads to perineal tears and hemorrhage during child birth, which due to inadequate emergency obstetric care are major causes of maternal deaths in rural areas of Nigeria. Similarly, Okonofua et al (2012) studied the impact of female genital cutting on first delivery in Nigeria and concluded that associations between genital cutting and obstetrical complications reflect disparities by social class and the delivery conditions rather than the effect of genital cutting.

d. ***Access to and acceptance of modern, effective family planning methods*** is both a socio-economic and cultural influence on maternal mortality. The use of modern contraceptives contributes to child spacing and reduces infant and maternal mortality (Dinyan et al, 2014). Family planning is touted as one of the most cost-effective development investments; it not only contributes to reduction in mortality but also empowers women and creates a bridge out of poverty(Envuladu, Agbo and Zoakah, 2013; Dinyan et al, 2014). Dinyan et al, 2014 described family planning in male-dominated areas as "a sensitive issue." Access to family planning services remains poor in Nigeria. According to the 2008 Nigeria DHS only 9.7 percent of married women used a modern method of contraception. Contraceptive use is lowest in northern Nigeria (Envuladu et al, 2013; Dinyan et al, 2014).

e. Also related to this is the traditional practice of inserting concoctions such as hot herbs, and *alum*, into a woman's vagina to increase vaginal firmness and increase sexual pleasure to her male partner or husband. Some of these concoctions are dangerous to the human body and are capable of causing complications during pregnancies or childbirth which can lead to maternal mortality in most rural areas in Nigeria (Dinyan et al, 2014).

f. ***Polygamy*** they also considered a cultural practice that can put a woman at greater risk of many births because family resources must be split among the wives according to their number of children which is determined by the husband. In addition, behavioural taboos are also believed to contribute to maternal complications and deaths through supernatural explanations of etiology. For example, in particular tribes in Nigeria, a pregnant woman is believed to bleed or die during pregnancy because of witchcraft, spiritual

powers, infidelity, or by being rude to her husband (Galadanci et al., 2010; Muoghalu, 2010). Families that believe in supernatural etiology will seek care from faith or traditional healers and not medical providers (Galadanci et al., 2010).

In addition, a study conducted by UNFPA (2001) reports that in developing countries, women's decision in relation to health treatment (especially among the poor) are made by the husband, the household head or the mother in law, as such, unless support comes from family, husband or friends, women often tend not to seek treatment (Galadanci et al., 2010; Muoghalu, 2010).

Ogu& Ephraim in 2015 conducted a study on the socio-cultural factors contributing to maternal mortality in Nigeria. They found that unequal gender relations, lack of education, unemployment, and underemployment led to poverty greatly disadvantaged Nigerian women and put them at greater risk of dying during pregnancy and childbirth (Ogu et al, 2015). Education, specifically education of girls, is inversely related to maternal complications and death (Debrouwere et al., 2012). Girls and women deprived of education have limited ability to make decisions in the home. They are often ill equipped to advocate for their own lives in the face of high-risk health situations. Women with more education also tend to have fewer children, use contraception, communicate better, and have greater aspirations for their children, all of which work toward reduction of risk (Okonofua,Ntiomo, & Ogu, 2012). Few women in Nigeria are employed in formal work. Many work on their husbands' farms, transporting goods, fuel, and water often balanced on their heads and for long distances. Those that are employed are paid less than their male counterparts (Okafor, 2010).

Nwosu and Adeboye in 2019 conducted a cross sectional survey on the effect of family size on maternal health in Northern Nigeria. They found that about 72% of the sampled women who were exposed to more than five births were at a higher risk of complications than those with lower family sizes. They accepted the hypothesis that the greater the number of children born to a woman the greater the risks of complication at delivery.

Clara and Ibisomi in 2019 attempted to assess the interrelationship between religious beliefs and its resultant effect on maternal health in Jigawa state. This was a household survey based majorly on the religious beliefs of the people as

pertaining to the health of women. They found that 82% of the women were Muslims and were married in polygamous marriages. Their major belief was that a woman's fecundity is a source of pride and prestige and gives her an edge over other wives seeming more like a competition. The women engage in several births thereby increasing their risks of complication at pregnancy and childbirth. Clara et al concluded that religion directly affects the women's overall way of life and her attitude to fertility thereby putting her at risks during pregnancy and childbirth.

The aim of this study is to assess socio-cultural factors that influence maternal healthcare in Okene by identifying the belief, norms, way of life and values of the people and how it affects maternal healthcare in the study area.

STUDY AREA

Okene is a local government in Kogi central senatorial district of kogi state. The headquarters is based in a Local Government Area of the same name. Okene runs along the A2 highway. It had an area of 328 km² and a population of 325,623 at the 2006 census. The predominant people are the Ebira of central Nigeria and the Yoruba; the local languages are Ebira and Yoruba (Ojo, 2014). It is located on latitude 07^0 33' ^{N} and 7^0 52'^{N} and longitude 05°56′E, 06°48′E of the Greenwich meridian (Adeoye, 2014). The Local Government is bordered by four Local Government Areas of Kogi and Edo State. It is bordered to the West by Okehi LGA, to the East by Ajaokuta LGA, to the North by Adavi LGA and to the South by Ogori- Magongo local government and Edo state. Okene local government area was created in 1976 from the then Ebira division by the administration of General Olusegun Obasanjo following the 1976 local government reform. The people of Okene local government are a part of Ebira Tao people of the central senatorial district of Kogi State. There are 11 wards in the Local Government which are Bariki, Otutu, Iruvu-cheba, Lafia/Obessa, Okene-Eba, Idoji, Agasa, Obehira-Eba, Obehira-Uvete, Abuga/Ozuja and Upogoro/Odenku wards. The major villages are: Okengwe, Obehira, Iruvu-cheba, Agasa, Otutu, Okene-Eba, Idogido, Etahi, Idozumi, Idoji, Esomi, Upogoro, Inike, Enyinare, and Iresupogo. (Adenyuma , 2020)

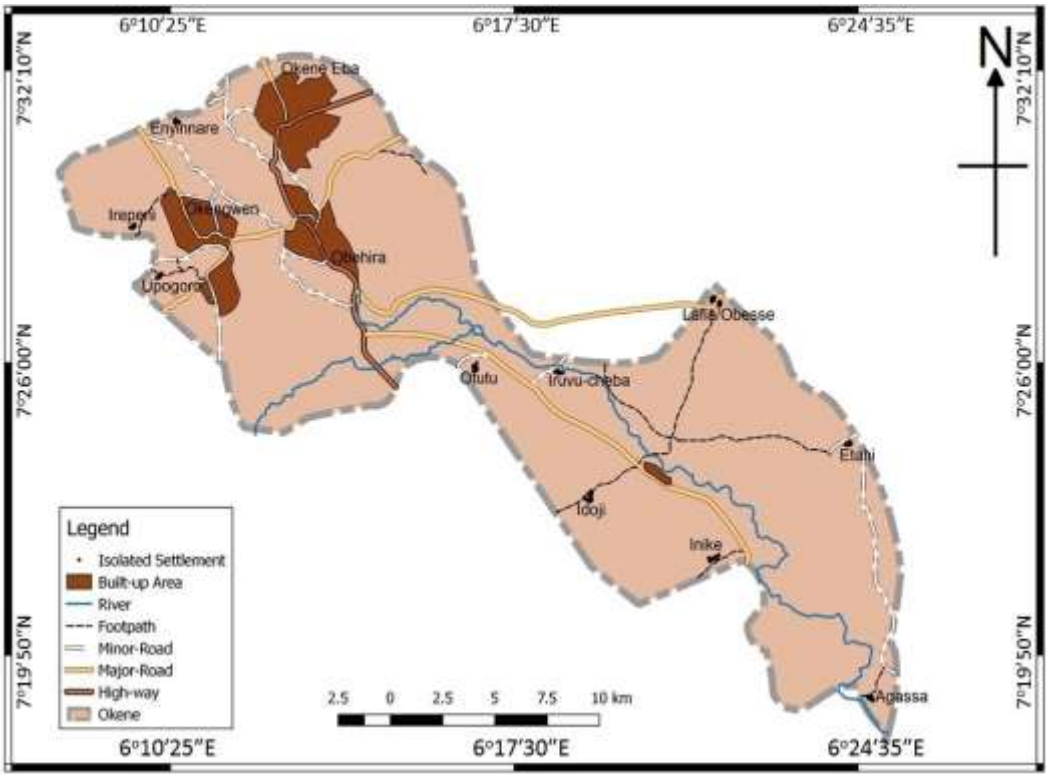


Fig.2.1 Map of the Study Area - Okene Local Government Area
Source: Kogi Ministry of Lands and Survey(KMLS 2018)

Okene land is mostly used for subsistence farming. The hill slopes and the plains are intensively cultivated by the indigenes (Ebira people) of the area. The major economic activities in Okene are Agriculture and weaving. There are many Farm produce from the state notably coffee, cocoa, palm oil, cashews, groundnuts, maize, cassava, yam, rice and melon. Mineral resources that are found there include coal, limestone, iron, petroleum and tin. The crops grown in Itakpe are mainly food crops. These include Millet, Sorghum, Maize, Yam, sweet Potato, and Guinea corn, Cocoyam, Cassava, Melon and Beniseed. The vegetation in Okene local government area is however not in its luxuriant state owing to inappropriate human use of the forest such as bush burning, clearing of land for farming purposes and grazing of animals (Ododo 2001; Adenyuma 2020).

Since the advent of colonialism, many Ebiras have moved southwards due to search for arable farming spaces and working as migrant farmers.

In early history of Ebira people, the family was headed by the father or the oldest male who acted as the provider, religious leader and the protector of the nuclear family (ireh),(Okene&Suberu2013). Other important social systems are compounds(ohuoje) which are composed of related or kindred patrilineal families (ovovu) the outer compounds and lineages (Abara), composed of several related compounds. The clan (iresu) which is a community of kindred lineages in Ebiraland is led by the Otaru (Okene *et al* 2013). Clan identities are distinguished by symbols mostly animals such as leopard, crocodile, python, or buffalo. The affairs of the community were managed by elder male members each representing related lineages. Contemporary Ebira social life has seen changes over the years even though farming is still a dominant occupation, many Ebiras exhibit behaviours such as polygamy (Okene *et al* 2013).

METHODOLOGY

The design adopted in this study is sample survey design. The population of study consisted of all married and ever married women in Okene that were within the reproductive age group (15-49). The study used a total sample of 379 households. The sample size was determined by adopting the Krejcie & Morgan, (1970) model for determining sample size of a given population, which states that is: $S = \frac{X^2 NP(1-P)}{d^2(N-1)+X^2P(1-P)}$

Where:

S = Required Sample size

X = Z value (e.g. 1.96 for 95% confidence level)

N = Population Size

P = Population proportion (expressed as decimal) (assumed to be 0.5 (50%)

d =Degree of accuracy (5%), expressed as a proportion (.05); It is margin of error.

With a total of 143,003 people in the five randomly selected wards using a table of random numbers and a total households of 10,547, a corresponding sample size of 379 households was determined using the Krejcie and Morgan formula for sample size determination. The required number of sampled respondents was systematically selected after picking the first respondent at random sampled and in a situation where a household is to be sampled and there was no woman

there within the reproductive age group the next household was sampled automatically. This study is also qualitative in nature and purposively targeted women of the reproductive age group (15-49). Five wards were purposively selected (*see table 1.1*). This was based on the fact that they were most assessable and the active healthcare centres are located there owing to the fact that the topography of Okene is hilly undulating. The appropriateness of sample size is dependent on the purpose of the research and the variability of population characteristics even though the variability is almost unknown (Bloor 2001).
Five focus group discussions were conducted with one in each of the wards respectively. Each session of the group discussions was conducted for about 30 minutes with 8-12 participants. This was done to have a collective view from the perspective of the people's culture as it relates to the women utilizing the healthcare facilities in the study area. The results of the FGD were recorded, transcribed and in an effort to portray distinct themes when the key concepts emerged common concepts were identified and when similar categories were combined, the dominant themes emerged and are presented.

Table 3.1: Population and sample size for field study

S/N	Wards	Population	Number of household	Sample household
1.	Otutu	17,918	1823	67
2.	Lafia/obese	24,551	2507	93
3.	Idoji	33,222	2216	78
4.	Obehira-Uvete	27,183	1771	63
5.	Upogoro	40,129	2230	78
	Total	**143,003**	**10,547**	**379**

Source: National Population Commission (2006)
Field survey (2019)

RESULTS

4.1 Socio-demographic characteristics of respondents.

Table 4.1 portrays the results obtained in the course of this research pertaining to the socio demographic characteristics of the respondents in terms of their age group, marital status, family type, family size, religion, educational qualification, occupation and monthly income.

Table 4.1: Socio-demographic characteristics of respondents

Items	options	total	Percent (100)
		Frequency (n = 379)	
Age group(years)	15-24	83	21.9
	25-34	160	42.2
	35-44	83	21.9
	45 & above	53	14
Marital status	Single	62	16.4
	Married	173	45.6
	Separated/Divorced	74	19.5
	Co-habiting	24	6.4
	Widow	46	12.1
Family type	Monogamy	179	47.2
	Polygamy	200	52.8
Family size	4-Jan	103	27.2
	8-May	92	24.3
	9 & above	184	48.5
Religion	Christianity	105	27.7
	Traditional	107	28.2
	Islam	167	44.1
Educational level	No formal	93	24.5
	Primary/Qur'anic	112	29.6
	Secondary	86	22.7
	Post-secondary	46	12.1
	Post graduate	42	11.1
Occupation	Civil service	84	22.2
	Others	55	14.5
	Artisan/Weaving	60	15.8
	Petty trading	180	47.5
	Total	379	100
Monthly income(N)	10,000& below	48	12.7
	10,001-20,000	96	25.3

	20,001-30000	85	22.4
	30,001-40,000	91	24
	40,001& above	59	15.6

Source: field survey, 2019

A total of 21.9% of the respondents are aged 15-24 years, 42.2% of the total respondents are aged 25-34 years, 21.9% of the total respondents are aged 35-44 years, while 14.0% of the total respondents are aged 45 years and above. The implication of this is that most of the respondents were young and majorly between the ages of 15-24 representing about 42% of the total respondents and this made them essentially adequate for the information on access to healthcare by women in the reproductive age group.

Furthermore, 16.4% of the total respondents are Single, 45.6% of the total respondents are Married, 19.5% of the total respondents are Separated/Divorced, 6.4% of the total respondents are Co-habiting, while 12.1% of the total respondents are widows implying that majority of the women (45.6%) are married effectively contributed to the theme of this research.

About 47.2% of the total respondents are in monogamy, while 52.8% of the total respondents are in polygamy implying that most of the men in marriages in the study area marry more than one more than one wife. Polygamous marriages produce more children as there is some sort of competition among the women. They see fecundity as a sign of feminine prowess and also to gain favor from their husbands thereby putting them at risks of complication and childbirth.

However, 27.2% of the total respondents are in a family size of 1-4, 24.3% of the total respondents are in a family size of 5-8, while 48.5% of the total respondents are in a family size of 9 & above. This implication of this is that majority of the respondents 48.5% have large family sizes that is not less than nine people. The desire to have large families is high among the respondents of this study which in turn increases the risks women face at pregnancy and childbirth as presented by Nwosu et al(2019).

This research found that 27.7% of the total respondents are Christians, 28.2% of the total respondents are of traditional religion, while 44.1% of the total respondents are Muslims thus making Islam the dominant religion. The religious beliefs and norms surrounding having a lot of children put the women

at a higher level of health risk and is in tandem with the findings of Clara et al in 2019.

About 24.5% of the respondents had no formal education, 29.6% of the total respondents had primary/Qur'anic school education, 22.7% of the total respondents had secondary school education, 12.1% of the total respondents had Post-secondary, while 11.1% of the total respondents had Post graduate education. The implication of this finding is that a reasonable proportion of the respondents of about 24.5% had no formal education while 29.69% had only primary education. These low literacy level deters women from realizing the enormous health benefits of seeking quality medical care. This was also revealed by Harrison (2017) where he found that widespread ignorance as a result of lack of basic education, in addition to low level of awareness he reiterated relates directly to maternal health. Most of the women under Harrison's study believed that it is only lazy women that will give birth in a health facility. Education is a distant factor which offers the possibility of affecting the magnitude of maternal mortality. As a result of lack of education many women do not know what are the danger signs and effect of prolonged labour therefore they stay in their houses without seeking medical care.

Similarly, this corroborates the findings of (Debrouwere et al, (2012), that women deprived of education have limited ability to make decisions in the home.

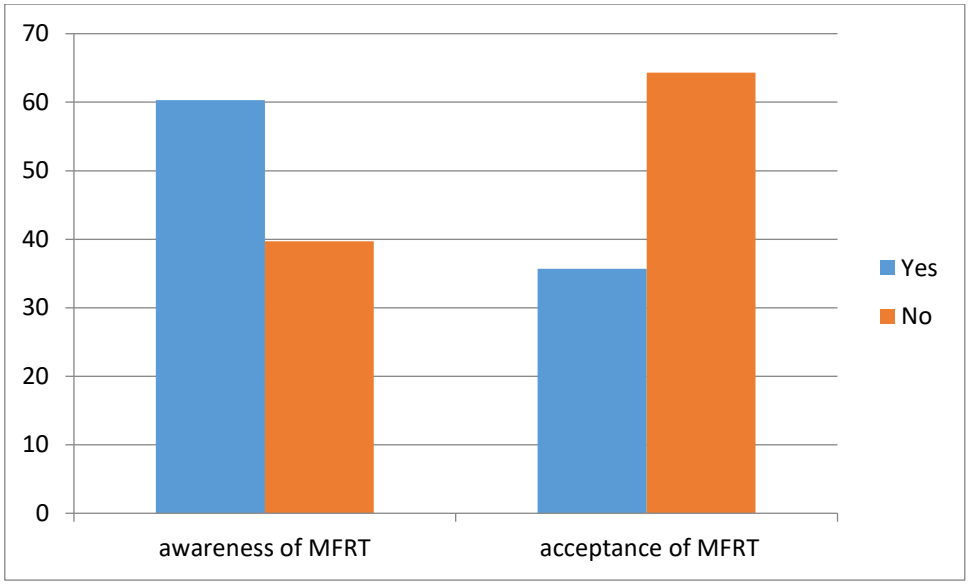
In this study, 22.2% of the respondents are civil servants, 14.5% of the respondents belong in the category of others, 15.8% of the total respondents are into Artisan/Weaving, while 47.5% of the total respondents are into Petty trading. This implies that even though majority of the women are not gainfully employed 47.5% of the respondents rather engage in petty trading to support their families.

This research found that, 12.7% of the total respondents earn N10,000 & below, 25.3% earn N10,001 – 20,000, 22.4% earn N20,001 – 30,000, 24.0% of the respondents earn N30,001 – 40,000, while 15.6% of the total respondents earn N40,001 & above. In this study about 38% of the respondents earn below N20,000 which is implies less than $2 per day similar as reported in the world population Datasheet (2008) that about 91% of Nigerians live below $2 per day. Similarly the USAID report (2016), further reported that close to 60 percent of

Nigerians live in extreme poverty, as such, insufficient money to pay for medical expenses serve as a barrier for treatment.

Percentage awareness and acceptance of modern fertility regulation techniques

Figure 4.1 shows the percentage awareness and acceptance of modern fertility regulation techniques in Okene local government area of Kogi state.



Source: Field work 2019

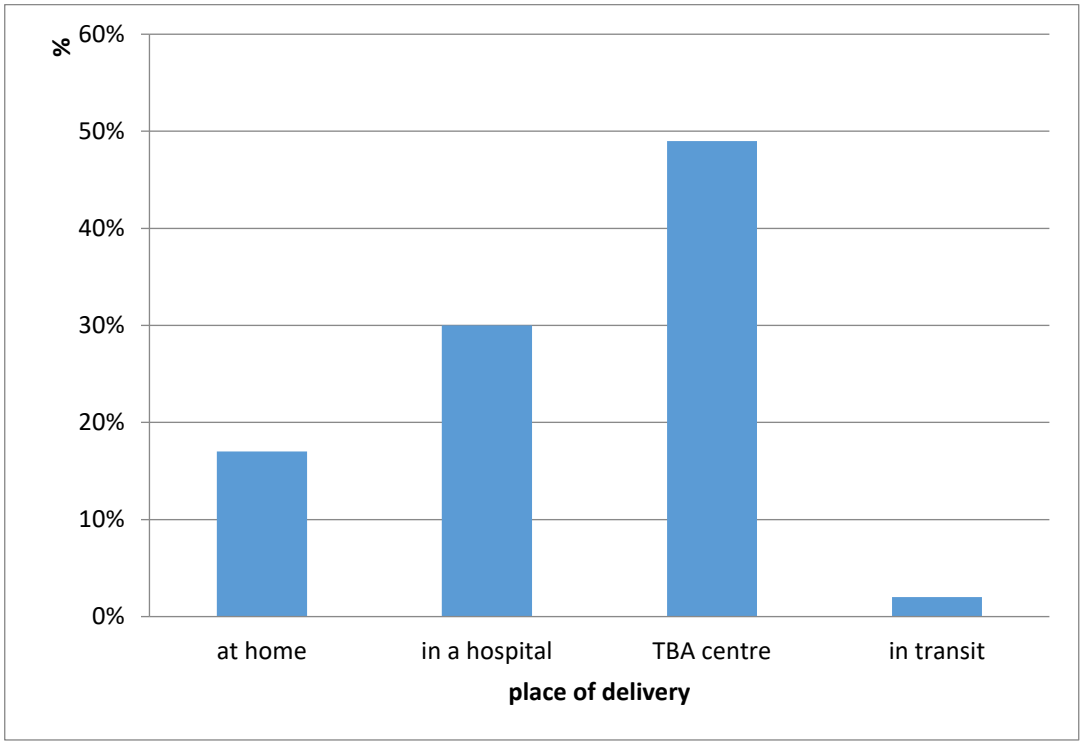
Figure 4.1 shows that in Okene 35.7% are on modern family regulation techniques while 64.3% are not on modern fertility reduction techniques. The indication of this is that there is low level of adoption of modern fertility planning technique .When asked the reason this is so during one of the FGD sessions, one of the women had this to say:

> *"It is not as if I am not aware that if I go to hospital the doctor can help me to stop my having children but I cannot do so, because in my husband's family they are not many and he married me because we are very very fertile in my lineage. He sees having many children as a sign of prestige and virility when a wife has plenty children and we don't see it as a health risk. I am already a grandmother and will keep on having children because it is God that gives children" Salamatu Osheiza, Okengwen,Okene L.G.A).*

Meanwhile Dinyan et al, 2014 reiterated that the use of modern contraceptives contributes not only to child spacing but reduces maternal mortality. Family planning according to Envuladu et al (2013) says it not only contributes to reduction in mortality but also empowers women and creates a bridge out of poverty.

Percentage distribution of preferred place of delivery of respondents

Figure 4.2 shows Percentage distribution of preferred place of delivery of respondents

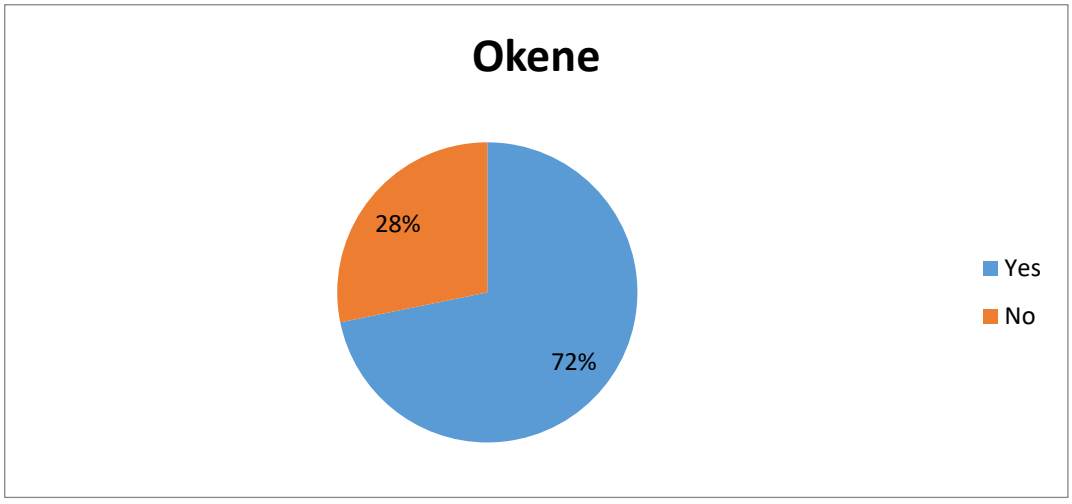


In the study area, 16.2% of the total respondents delivered at the home, 30.8% of the respondents delivered at Health care facility, while majority about 48.9% of the total respondents delivered at traditional birth attendant centre as shown in plate 1.1, and 2.1% of the total respondents delivered in transit. This implies that there is still the need to sensitize the women in Okene of the advantages and the need to deliver in a skilled healthcare facility so as to reduce the risks of pregnancy and childbirth to the barest minimum.

Plate 1.1 Traditional birth attendant's home in Okene L.G.A
Source: Field survey, 2019

BELIEF IN TRADITIONAL MEDICINE

Figure 4.3 shows the results of respondents on whether they believed in the efficacy of traditional medicine in pregnancy.



Source: Field survey, 2019

Figure 4.3 depicts the results of respondents on whether they believed in the efficacy of traditional medicine in aiding a woman in labor. Majority of the respondents 72% of respondents believed in traditional medicine. This implies that a reasonable proportion of respondents in the study area believed in traditional medicine thereby reducing the patronage of orthodox healthcare in the study area while only about 28.2% of the respondents do not believe that traditional medicine is efficient and effective in aiding labor. This agrees with APHRC 2018, which stated that an estimated that over 70% of West Africans rely on traditional medicine for treatment of both communicable and non-communicable diseases as a result of their belief that traditional medicine offers many positive aspects to healthcare. Africans believe that despite the criticisms of traditional methods and techniques by orthodox medicine, the use of herbs and roots have proven clinical success. The problem with utilizing traditional medicine lay in the belief of many that it should be the primary source of medical care.

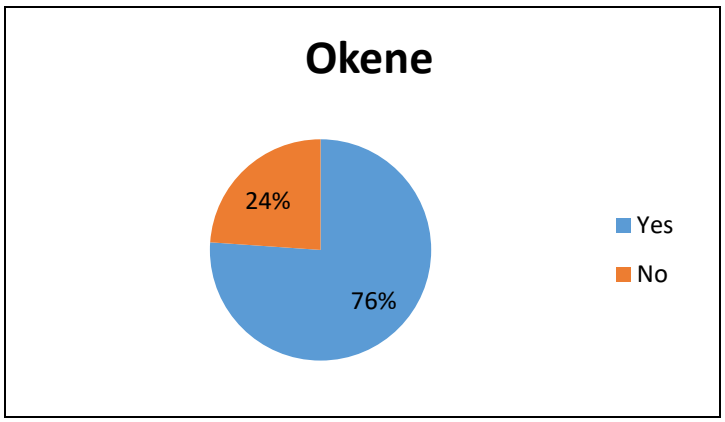
During an FGD session in Okene Local government, majority of the respondents believed that herbs and roots can aid a woman's safe delivery. One of the participants responded thus:

> *"Carrying a pregnancy is made by God because we have to reproduce our younger ones. Our forefathers survived by using herbs and roots for assisting labor. Herbs and roots will fail to work and make a woman to die while giving birth only if she has engaged in infidelity against her husband" (Ahuoiza Adomu, Okene L.G.A).*

Muoghalu,(2016) was also of the view that patronizing traditional birth attendants or believing that traditional healers are the first and last line of defense against an illness can lead to potential life threatening medical emergencies even maternal death.

Belief in food taboos

Figure 4.4 shows the results of respondents on whether they believed in food taboos that threaten a woman's health in pregnancy or a woman in labor.



Source: Field survey, 2019

Figure 4.4 depicts the results of respondents on whether they believed in food taboos that threaten a woman's health in pregnancy or a woman in labor. Majority 76% of respondents believed that food taboos exist and is applicable to women in pregnancy. Very few of the respondents about 24% in Okene do not believe that food taboos exist. This implies that people in the study area are homogenous in the belief about food taboos. This agrees with the findings of Isah et al in 2014 that Food taboos are prevalent in several Nigerian communities, during pregnancy and child birth; women's eating habits are guided by these local taboos, which deny the consumption of certain food that can fall within the range of protein, carbohydrate or fruits. When respondents were asked about their belief in food taboos one of the participants of the FGD session had this to say:

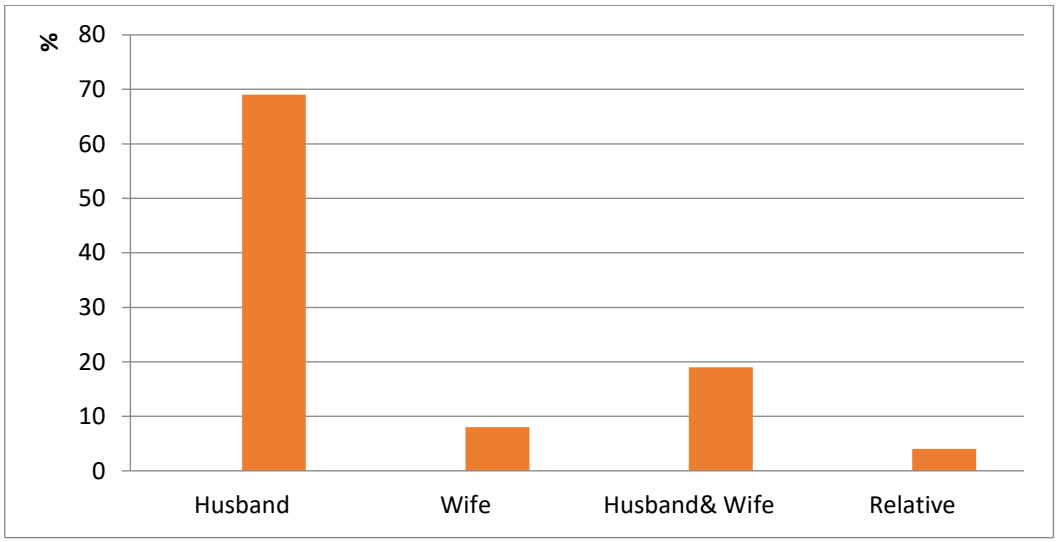
> *"Pregnant women are prohibited from eating snail in pregnancy because it is believed to make them bleed and have negative impact on the growing baby" (Habibat Usman FGD, Lokoja L.G.A)*

Meanwhile most of these foods that are prohibited are nutritious assist in the improving the immunity of the mother to infections or diseases in pregnancy and improve their overall wellbeing in Pregnancy. The WHO in (2010) found that malnutrition causes increased vulnerability to serious and chronic illness, mental retardation and early death. This was buttressed by Bhatia, (2012) saying that malnutrition affects the immune system's response to infection and interferes with the body's ability to utilize food which is a condition not conducive to longevity. It increases the risk of infection, particularly among

women of reproductive age which during pregnancy, poses a threat to maternal survival.

Who takes decision on health matters?

Figure 4.5 shows who takes decision on health matters.



Source: Field survey, 2019

Decision to seek maternal health care is very complex and distressing and a lot of women have died because decisions had not been taken promptly on whether she should go to a hospital or not. As revealed in figure 4.5, 69% of the total respondents agreed that the husband is the decision maker on health matters, 8% of the total respondents agreed that the wife is the decision maker, 19% of the total respondents agreed on husband and wife, while 4% of the total respondents agreed that they needed consent from relatives on matters concerning their health. This findings agree with the findings of the UNFPA (2001) as cited by Galadanci et al., 2010 and Muoghalu, 2010 that in developing countries, women's decision in relation to health treatment (*especially among the poor*) are made by the husband which most times doubles as the household head and as such, unless support comes from the husband or his family, women often tend not to seek treatment. In this study, a patriarchal societal way of life is evident where even in case of obstetric emergencies, some women still have to seek the consent of their husbands first, who may be far away during such moments thereby poising risks to their health.

Conclusion and Recommendation

Conclusion

Poverty is identified as one of the major barriers to accessing maternal health service by women in HC facilities. Majority of women of child bearing age in the study area are living below poverty line. They had low degrees of access maternal healthcare service in HC facility because they had no money to pay for transportation to and fro, drugs and medical service at the facility. This explains why some of the women preferred to deliver at a traditional birth attendant centre or at home because of the cost of accessing orthodox healthcare.

One factor that is basic is the high illiteracy level among women which is responsible for their limited access to maternal healthcare service in HC facility. It was discovered that the high illiteracy level among women in the study area have been responsible for their limited access to maternal healthcare service in HC. The study found that the lack of awareness on reproductive health education coupled with high illiteracy level has made it difficult for some women in this group to recognize life threatening complications during pregnancy and childbirth which would enable them access timely maternal healthcare service in HC facility.

This study also concludes that the belief of women in traditional medicine is responsible for their patronage of traditional birth attendants which indirectly increases their health risks during pregnancy.

This research found that the people operate a patriarchal societal way of life where it is found that more than half of the respondents about (55%) have to seek the consent of their husbands first in matters concerning their health.

Recommendation

i. The women should be provided with incentives such as soft loans to boost their economic capacity.
ii. This study recommends enlightenment of women in seeking orthodox medical care during pregnancy and childbirth.
iii. This study also recommends need for training and retraining of TBAs by encouraging them to develop more skills to assist delivery and also to make early referrals in case of complication during childbirth.

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