

## Socio-economic status and utilization of healthcare facilities in rural Ekiti, Nigeria

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### Abstract

People especially women and children die everyday due to the poor standard of living and low level of utilization of health care facilities in most rural communities and as such, this study seeks to examine the influence of socio-economic status on healthcare facilities utilization and to ascertain the quality of healthcare facilities available in the rural communities. A descriptive research design was employed for the study, using both quantitative and qualitative methods of data collection. The sample size was selected through random sampling technique and a total of 400 questionnaires were administered to the respondents out of which 357 questionnaires were retrieved. Qualitative data were analyzed through content analysis while the quantitative data were analyzed with SPSS. Chi-square and correlation analysis were used for the objectives stated in the study to explore the relationship between the variables. Theoretically, the study made use of Rational Choice Theory (RCT) and Health Belief Model. Rational Choice Theory (RCT) focuses on individual rational action that helps to explain the aggregate behaviour in the society. Health Belief Model is a major psychosocial model of health seeking behaviour (activity taken by a person who believes himself healthy for the purpose of preventing disease) or illness behaviour (activity undertaken by a person who feels ill for the purpose of gaining relief) is described by the health belief model as proposed by Rosenstock (1966) which is cited in (Cockerham, 1978; Becker, 1974) as well as in the illness behaviour proposed by mechanic (1962). The quantitative data was computer processed and analyzed with statistical package for Social Science (SPSS v18.0). Chi-square and Correlation analysis were used for the objectives stated above to explore the relationship between the variables. It also was used to involve the use of descriptive statistics such as frequency distribution tables, percentage distribution and Pearson chi-square and Pearson correlation while the qualitative data were analyzed through manual content analysis to identify the impact of TBAs on maternal and child health. The outcome of the study indicates that Most of the respondents (95.8%) agreed that they had utilized health facility while 4.2% of the respondents had not utilized health facility. The correlation findings  $R = - 0.221 (0.000)$  illustrated that there was a negative significant relationship of 0.000 between education and utilization of health facility.

**Keywords:** Health Facility, Utilization, Socio-economic, Maternal health, Child Health, Antenatal, Postnatal.  
**Word Count:** 523

## INTRODUCTION

All over the world, debates abound on the roles that socio-economic status of people play in influencing their level of pathology, health seeking behaviour, information about and/or utilization of health care facilities to aid their general health condition. This dialectic is particularly worrisome especially in sub-Saharan Africa where almost 70 percent of the population are of low social economic status, reside in rural community and are confined into the informal of the economy.

According to National Open University (2007), the decision to utilize health services involves several stages which include; visibility and recognition of symptoms, the extent to which the symptoms are perceived as dangerous, the amount of tolerance for the symptoms, and basic needs that lead to denial. Several factors including cultural, social, gender, economic and geographic are predisposing factors in the utilization of health services. The need for utilizing health services is borne out of the assumption that only special institutions charged with the responsibility of providing healthcare can provide relevant therapeutic services to people who have health problems.

Socioeconomic status is a multidimensional concept; among the dimensions typically associated with socioeconomic status (SES) are occupational status, educational achievement, income, poverty, and wealth etc (Krieger et al., 2003b). In many societies whether rich or poor, those of greater privilege tend to enjoy better health than their counterpart. According to Abodunrin et al. (2010), the choice of health facilities for healthcare by an individual is largely determined by his/her taste, satisfaction with service and the perceived quality of care provided, the choice is however limited by factors such as availability, accessibility, affordability of services of the health facilities, cultural beliefs, the situation per time (i.e. urgency of care needed) and whether the kinds of services provided meet the need of the user. They further opined that the choice is also influenced by the users' understanding of the functions of the different levels of health facilities which ultimately result in the appropriate (or otherwise) utilization of health services. In Nigeria, healthcare system comprises both public and private health facilities. In the public sector, the facilities are in three levels (primary, secondary and tertiary) which corresponds to the three tiers of the government.

Several factors have been identified for poor utilization of modern health facilities and especially the primary health centre (PHC), these include proximity, clients'/patients' affordability, staff attitude, availability of equipments and qualified personnel. Ordinarily, a person would not use a product that does not meet his need unless he has no choice. Meeting these needs go beyond the goods and services alone but also include environmental conditions that are conducive. There seem to be higher use of private health facilities attributed mostly to issues of easy access, shorter waiting time, longer or flexible opening hours, better availability of staff and drugs, better attitude and more confidentiality in socially stigmatized diseases. Notwithstanding, the demand for public health facilities is tremendously high as compared to that of private health facilities especially in rural areas of the country.

Bunor (2004), in his study of health care utilization in Ghana discovered that the dimensions of distance to services, such as travel time, waiting time, appointment time with doctors, nature of the means of transport and cost have effect on the utilization of health facilities. Poverty and illiteracy can also affect the use of health services. Most of the people may lack enabling resources, and because of high rate of illiteracy, they might not perceive the need for health service use, especially rural people, resulting in the use of unscientifically tested traditional medicine, some of which have negative health implications. However in Nigeria, Caldwell (1990) found out that educated women benefited more from available public health-care services than the uneducated mothers. Also in a study of child nutrition in Philippines, Barrera (1990) found that access to healthcare services benefited children of educated mothers more than children of mothers with less schooling. In contrast, Rosenzweig and Schulz (1982) view female schooling and health-care services as partial substitute for information regarding knowledge of diseases, treatment of illness and childcare practices and hypothesize that the effect of education on child health becomes less important as access to public health –care services improves. Salako (1995) added that treatment sources people seek when symptoms occur include, socio-cultural factors like beliefs and household decision making to seek care, social networks, gender and economic status.

The control of disease is related to the amount and quality of knowledge available about the disease. Human values, attitudes, economic conditions and the cultural environment are factors that affect pattern of morbidity as well as pattern of healthcare. In the course of this study, attention is focused on how socio-economic status affects the utilization of healthcare facilities.

### Statement of problem

In many societies, socio-economic position of individuals influences the aggregate of the social and economic privileges and opportunities available or deniable to an individual. Even in some societies or communities where the social wealth

e.g. healthcare facilities are fairly equitably distributed, the socio economic positions of individuals sometimes debar the individuals from effective utilization of such facilities. This, mostly, is either because the individual cannot afford the utilization of such public facilities or do not have adequate information that can enhance their utilization of such public facilities. Both of these problems are actually by-products of the socio economic status in which the individual is placed in the society.

Almost everywhere in the world, the people of low socio-economic status are vulnerable to a lot of health hazards some of which can actually be preventable and curable even with the existing healthcare facilities in their immediate communities. Unfortunately a lot of mortality are recorded and are continued to be recorded against the people of low socio economic status consequence of their deficient utilization of the existing healthcare facilities in their immediate community. Many of these people continue to suffer in silence, sometimes, when adequate medical facilities through orthodox and other health service providers are in place. These prompted this research to examine what factors can explain this seemingly attitude and behaviour of people across socio-economic status towards the utilization of healthcare facilities particularly in rural areas.

The situation is even worse in rural areas where adequate facilities and information may not be on ground for people to access. Even in some communities with relatively adequate facilities, there is lack of information, this itself a function of social status being occupied by the individuals, is a determinant factor in the utilization of healthcare facilities particularly in rural areas. This may explain the submission of Buonor (2002) that there exists a higher mortality rate in the rural areas than in the urban areas.

In most of the previous studies on the utilization of medical services and on the distribution of major diseases in Nigeria, general statements about the attitudes of the people to modern medicine as well as the ecological variation in the distribution of the diseases have been made. There seem to be lack of detailed studies of the patterns of utilization of health services as well as spatial patterns of diseases in both urban and rural areas.

There is therefore the need of this type of study so that the medical needs of the population can be effectively determined. This will go a long way in enhancing optimal allocation of scarce resources in developing countries (like Nigeria). This study thus aims at discovering how socioeconomic status of people of Igboora community affect their utilization of healthcare facilities and whether or not the present hospital locations are meaningful in relation to people's healthcare needs and their accessibility to the facilities.

### Research questions

Sequel to the objectives stated above, the following shall be the questions that this research work seeks to answer:

1. What is the proximity of existing and functioning healthcare facilities in Igboora community?
2. What is the relationship between income level and people's utilization of healthcare facilities in Igboora community?
3. What is the quality of healthcare facilities in Igboora community?
4. What are people's perceptions towards the utilization of healthcare facilities in Igboora community?
5. How do cultural values influence people's utilization of healthcare facilities in Igboora community?

### Research objectives

The general objective of this study is to examine the influence of socio-economic status on people's utilization of healthcare facilities in Igboora community, Ibarapa central local government area of Oyo state of Nigeria.

The following shall however be the specific objectives of the study;

1. To document the proximity of healthcare facilities to the people of Igboora community.
2. To ascertain the quality of healthcare facilities available and functioning in Igboora community.
3. To examine the influence of cultural values of people on their utilization of healthcare facilities in Igboora community.
4. To examine the influence of socioeconomic status on healthcare utilization.

### Statement of hypotheses

This work is set to examine the relationship between socio-economic status and utilization of health care facilities in Igboora community. In realizing this objective, the following null hypotheses shall be tested:

1. There is no significant relationship between people's educational attainment and their utilization of healthcare facilities in Igboora community.
2. There is no significant relationship between income and people's utilization of healthcare facilities in Igboora community.
3. There is no significant relationship between occupational location and people's utilization of healthcare facilities in Igboora community

### Justification of study

Various works have actually studied the relationship between socio-economic status and utilization of healthcare facilities. However, much if not all of these works to the researcher's best of knowledge, were focused on urban sample, little or no attention was given to the rural communities. This is in prejudice to the fact that the rural community accounts for almost 70% of the experience in sub-Sahara Africa, particularly in Nigeria. Scholar's (Gester and Meade, 1988; Cunningham and Cornelius, 1995; love and Lindquist, 1995) have pointed out the fact that residents of urban areas utilize medical services more than their rural counterparts; and that distance to regular sources of healthcare also determine the use of those services. There is the need to examine people's accessibility to and the utilization of healthcare services and this type of study will assist in shedding more light on factors which underlie under - utilization of healthcare facilities in rural areas and suggest ways of improving the situation.

This work is therefore significant as it will attempt an analytical examination of the experience of the inter-play of the socioeconomic status and utilization of healthcare facilities in a typical rural setting of Igboora so as to update scientific knowledge on the relationship between socioeconomic status and healthcare facilities across all regions. It is also important as it will assess spatial allocation of healthcare facilities in rural community and to understand how socioeconomic status can be predictive of people's utilization of existing facilities in rural areas.

## LITERATURE REVIEW

### Sectors of health care

In looking at any complex society, Kleinman (1980) cited by Agbonlahor (1995), suggests that one can identify three overlapping sectors of healthcare: 1 the popular sector, (2) the folk sector and (3) the professional sector. Each sector has its own way of explaining and treating illhealth; defining who the healer is and who the patient is and outlining how the patient and healer should interact in their therapeutic encounter.

The popular sector consists of the non-professional (layman's) domain or society, where ill health is first recognized, defined and healthcare activities initiated. This section also covers all the therapeutic options that people utilize without consulting a qualified medical practitioner. Such option includes self-medication and advice/treatment given by non-specialists.

Traditional medicine is also identified as belonging to the folk sector, which is not usually recognized as part of the official medical system. Healers here occupy an intermediate position between the popular and professional sector.

Finally, Kleinman (1980) equates modern scientific medicine with the professional sector. This category will include not only physicians of various types and specialities but also the recognized para-medical professional such as nurses, midwives and physiotherapists. For a long time in most countries, Allopathy was practically the only legally sanctioned healing profession.

Kleinman's classification is quite apt and adequately captures the arrangement in Nigeria. Patronage of any sector is usually informed by a multiplicity of factors. Going by Wikipedia assertion, health is one of the fundamental human rights and national governments have a responsibility for the health of their people and to ensure adequate and standard health services. Basic human right principle holds that healthcare must be affordable and accessible to all, irrespective of race, gender, income, geography and religion (Mekonnen, 2009). Healthcare provision in Nigeria is a concurrent responsibility of the three tiers of government in the country. The Nigerian healthcare sector can be divided into two namely: the private healthcare and the public healthcare sector. The private incorporates clinics and hospitals, which are owned and managed by private medical practitioners, trained midwives and non-governmental organizations like missions while the public healthcare sector is government owned.

The public sector health care facilities, which constitute about 80 percent of all facilities in Nigeria are owned and managed by the three tiers of government, this is so because health is on the concurrent list in the Nigerian constitution

(Erinosho,1998). The federal government formulates broad policy in collaboration with the states, mobilizes funds from external sources for healthcare programmes and tackles epidemics and other special programmes. State governments manage and fund secondary healthcare institutions and tertiary in some cases as well as assist in the implementation of the primary healthcare programmes in their respective areas of operation while the local government authorities are vested with the provision of the primary health care. The following level of healthcare exists in Nigeria:

**Primary Healthcare;** the provision of health care at this level is largely the responsibility of the local governments with the support of state ministries of health and within the overall national health policy. Private medical practitioners also provide health care at this level

**Secondary Healthcare:** this level of health care provides specialized services to patients' referred from the primary health care level through out-patient and in-patient services of hospitals for general medical, surgical, pediatric patients and community health services. Secondary health care is available at the district, divisional and zonal level of the states. Adequate supportive services such as laboratory, diagnostic, blood bank, rehabilitation and physiotherapy are also provided.

**Tertiary Healthcare;** this level consist of highly specialized services provided by teaching hospitals and other specialist hospitals which provides care for specific diseases such as orthopaedic, eye, psychiatric, maternity and paediatric cases ([www.motherlandnigeria.com/health](http://www.motherlandnigeria.com/health)).

### **African concept of disease/health**

The African recognizes the environment as swarming with millions of micro organisms called germs, but he contends that if germs cause diseases in relation to their population, the whole human race together with animals and the vegetable kingdoms would have been exterminated before now thus the germ theory fails to account for some disease (Aja, 1999). Preternatural and mystical forces could also cause diseases as far as the Africans are concerned. Here, diseases and ill health are attributed to the interference of supernatural forces such as witchcraft or the evil machination of enemies (Oke, 1990).

In traditional medicine, attempt is therefore made to determine both physical and metaphysical causes of diseases, consequently, the traditional healer appeals to scientific and metaphysical means in an attempt to achieve a comprehensive cure of any malady. Through observation, he diagnosis ordinary diseases and through divination he probes into the causes and cure of obscure maladies (Aja, 1999) in a similar vein, Onu (1999) sees illness as not only a highly personal affair but also that which arouses a wide variety of feelings in the sick person as well as in people close to him: as they engage in a search for treatment which becomes an immediate problem. As already indicated, the choices of therapy are determined by several factors, for a simple and easy to cure ailments, natural causes are imputed but for the more complex, serious and prolong illnesses, natural and non natural causes are evoked. It thus becomes useful to regard illness as a complex phenomenon, one that derives its definition from the patient himself and those around him.

In order to explain the circumstances of our illness, we often draw from our cultural experiences for example, among the Yoruba people of Nigeria, inspite of the eradication of smallpox, the annual epidemic(such as measles) what causes high mortality and morbidity among children are often associated with the " god of smallpox" (Igbona or Sopona in Yoruba language). The implication of this is that parent of children suffering from measles would likely combine western and traditional remedies which may lead to complications (Akinsola, 1993).

### **Cultural perception of health**

Medical knowledge has permeated all human societies, in view of this, Ndeti (cited by Agbonlahor, 1995) stresses that it would be seen inconceivable for any society, no matter its rung on the developmental ladder, not to have a body of empirically tested knowledge of medical sciences. The mere fact that people have domiciled in a particular environment for a long period of time is indications that they have to a certain extent acquired enough homeopathic adaptation to enable them survive. Facts have shown that every human society regards health as treasure, which is why in different societies; there are indigenous beliefs and practices associated with health promotion, diseases and treatment as well as a variety of concepts regarding the causation of disease.

Thomas Lambo (1995) of Nigeria and P.M Yap (1951) of Hong Kong (cited by Erinosho, 1998) pioneered work on the cultural dimension of health and ill health among the peoples in non-industrial societies. According to them, health and disease are to some extent shaped by culture, the concept of disease is rooted in magic and religion because most people in non-western societies attribute the incidence of diseases to witchcraft, sorcery and mystical forces because of

the widespread belief in all of these forces. Second, what is regarded as disease in some societies may be seen as normal condition in other societies due to cultural factors, in other words, Lambo and Yap, among other workers, found that no uniform notions exist for the various disorders across all human societies. What Lambo and yap were trying to say is that normality is determined to a large extent by socio-cultural in the sense that behaviour pattern, which are regarded as normal in one society, may be seen as being abnormal in another, for instance obesity, which Euro-American women regard as an abnormal condition and which is symptomatic of rejection because the sacred concept of beauty is to be 'twiggy', it is therefore not unusual for seemingly obese Euro-American women to develop negative concept, which in turn pushes them into the arms of psychiatric help-giving agents. This is in contrast to obese women who are highly regarded in some traditional African societies. Here, seemingly obese women are sexually attractive and sought after by men as in the case of Cross River and River states in Nigeria, where women are deliberately kept in homes where they are 'fattened' prior to formal betrothal ( Erinosh, 1998)

Recent reports (cited in health sociology, 1998) also highlight many harmful traditional practices which affects the health of girl-children and women. Two of such practices are early marriage and female circumcision, which is now commonly referred to as female genital mutilation (FGM). The latter is the removal of a part or the whole of the female genitalia through surgery that is performed by untrained or formally trained practitioners (IAC Nigeria 1997) the consequences of FGM include bleeding, destruction of blood vessels in the female genital area, circumcised girl-children and women risk urinary tract infections, disease of the kidney, infertility, the spread of AIDs and infections across the fallopian tube. Similarly, miscarriages, vesigo-vaginal fistulae or recto-vaginal fistulae are linked to early marriage and FGM (IAC 1997). These practices also undermine the psychological wellbeing of women across twenty-six countries in Africa.

Cultural beliefs and practices can be identified in four overlapping groups namely;

- (1) Beneficial, which can be supported and adapted into health teaching.
- (2) harmless, with no specific value and should be best left alone.
- (3) Uncertain, which means difficult to assess as different interpretation may be possible and therefore needs to be observed and considered further and
- (4) Harmful, which should be tackled by health education with persuasion and convincing demonstration. Using the Yoruba concept of diseases, Oke (1995), notes that the Yoruba identify these major causes of diseases, namely natural, preternatural and mystical, natural causes falls within the range of scientific explanation of disease causation (germ theory) whereas in the second and third categories, diseases and ill health are attributed to the interference of supernatural forces such as witchcraft or evil machination of enemies.

Culture plays a major role in how illness and diseases are perceived in Nigeria as reflected in the work of Jane John-Nwankwo (2009) in a study she carried out to determine the effect of culture on health among the Igbo in Nigeria and arrived at the following conclusion

"Some areas of conflict between cultural practices and the healthcare delivery system include the following:

- The strong belief that one's illness is caused by one's enemies prevents people from seeking healthcare delivery, because it is believed to be useless in such cases. Many people die because of this belief
- The smuggling in of herbal preparation into the hospitals usually affects real assessment of the success of the treatment plan, usually, nurses make it a routine to search patients' surroundings to make sure that there are no hidden preparations.
- Some people do not want to be blamed for not going to the hospital, so they go, but cheek their medications, and throw them away when the nurse leaves the room, fake recovery after a few two or three days from admission, and go home. This could either be from believing in a non-scientific origin of the illness, or other personal beliefs.

Every culture has a way of ascertaining the causes, nature and treatment of diseases. Because of cultural diversities, one expects variation in disease diagnosis and treatment in each cultural setting. Traditional medicine does not require the use of such instruments as required by the modern medicine for diagnosis, however, there are traditional ways of knowing the state of health of the people (Jegede, 2011). Many researchers have come up with the idea that culture plays a very important role in the nature and management of health care services. For instance, in the pre-industrial era of the history of man, different communities had developed different methods to meet their health needs (Oke, 1995; Jegede, 1998; Owumi 2005). Oke (1995) stressed the point that among the Yoruba of the south-western Nigeria the perception of illness or disease centers on three etiological factors, these are the natural, preternatural and mystical perception. This perception of illness causation according to oke, often influence the choice of healthcare of people. He went on to reveal that one's choice of particular healthcare service is a function of one's belief and attitude about the effectiveness of a particular healthcare. In the same vein, Owumi (1993) in his study among the Okpe people, reveal the fact that the belief in witchcraft is well developed and entrenched in the culture of the Okpe people in delta state of Nigeria.

## Physical access and utilization of health facilities

According to Lekan and Sanni (2010), there is a general consensus among researchers investigating the relationship between distance and utilization of healthcare facilities, according to him, this relationship is that fewer people are willing to patronize a particular facility as the distance from it increases. Empirical investigations revealed the existence of other factors, in addition to distance, as influencing the patronage pattern of healthcare facilities. For instance, Adejuyigbe (1973) demonstrated that attendance at each medical centre in Ife region is a function of both type of service available there and the distance from other center providing similar services. Okafor (1977) analyzed the spatial distribution and efficiency of hospital facilities in the old Bendel (now Edo and Delta) State. He found that there were discrepancies between the population distribution and the distribution of hospital facilities. Olajuyin et al. (1997) investigated the effect of location on the utilization of healthcare facilities in Irewole Local Government Area of Osun State, Nigeria. They found that healthcare facilities were unevenly distributed among the settlements and that the distance was a paramount factor. Ajala et al. (2005) studied accessibility to healthcare facilities as a panacea for sustainable rural development in Osun State, Nigeria.

Based on data available on the year 2001, they employed the use of comparative values of three indices, viz: population ratio per medical officer; population ratio per nurse/mid-wife; and population ratio per hospital bed space. They noted that serious inequalities exist in the provision of healthcare facilities and services by both the public and private sectors, and that the existing distribution pattern is more in favour of urban areas.

Accessibility of health services has been shown to be an important determinant of utilization of health services in developing countries (Mekonnen and Mekonnen, 2002). It is often stated and more frequently assumed that the dispersed settlement of a rural population results in isolation and a substantial physical separation from modern sector health services (Ciocco and Altman, 1954; Girt, 1971). A variety of programmes have been developed under private and government sponsors to alleviate this perceived shortage (Kane et al. 1975; Poller and Parrish, 1974) the most generally applicable measure of their success lies in the change of utilization patterns that occurs after they are instituted. A study that was carried out by Sheldon (1981) in three rural areas of Guatemala, shows that a vast majority of persons have a reasonably good access to health service, even taking bad roads and slow travel times into account. Furthermore, the ministry of health has strategically located its facilities in congruence with rural market centre, which virtually the entire population visits regularly. Analysis of one thousand eight hundred (1800) actual patients' visits however, shows that most of the patients cover only short distances. The most plausible explanation is simply that the health post which are understaffed by poorly trained personnel and badly under-equipped, do not dispense treatment adequately and therefore people are not highly motivated to use them. Improvements in the level of utilization depend on improvement in the quality of delivered services and not in building more health posts or overcoming supposed cultural barriers.

In consonance with this, Kane et al. (1978) submits that, an increase in utilization of an existing service or a new service is the result of two interacting forces; the tapping of previously unmet demand and the redirection of existing demand. To the individual providing the service the presence of an adequate market may be the answer enough but for those who would understand the casual relationships, the distinction is an important one. In developing countries, distance is only one variable that may interact more or less strongly with others to influence utilization, most people will not travel further than 5 kilometres to basic preventive and curative care (Muller et al., 1993). In a study of the effect of distance from home on attendance at a small rural health centre in Papua New Guinea he found that attendance decreased markedly with distance. There was a 50% decrease of the number of patients at a 3.5 kilometers distance. Okafor (1984) is of the view that inaccessibility to general hospitals is mostly a rural problem and represents one of the 'syndromes of deprivation' to which rural areas are subjected by policy makers. He notes that local government areas which score low on other indices of socioeconomic development are mostly affected by inaccessibility to general hospitals and deplors the current paternalistic strategy of imitating everything in the developed world and warns that unless we change this approach, our efforts will continue to achieve only very little success. This is supported by Alubo (1990) who stresses that a vast majority of Nigerians residing in the rural areas lack health access. He remarks that access to healthcare facilities in post-colonial Nigeria is shaped by one's occupational status and that even within this framework, one's position and role play a large part in influencing the place and kind of treatment one gets. It would appear from the foregoing that there are a number of ways by which policy makers can limit the utilization of health resources. The first of this is discernible in the manner of allocation of resources as between the rural and urban areas. Sometimes, this can be so skewed in favour of the urban areas as to make health services virtually inaccessible to the rural populace. Other methods are through the introduction of exorbitant hospital fees, the provision of subsidized rates for government workforce only, and lastly, health policies that are at variance with the epidemiological conditions of a particular area.

Wilson et al. (1997) gathered from their study of the maternity home waiting concept at Nsawam in Ghana that

distance from the hospital was, among others, one of the reasons for the poor utilization of healthcare facilities. Also, in the Jasikan district in Ghana, distance decay played a major role in health service utilization (Institute of development studies, 1978). Some factors interfere with distance decay; these include socio-economic status (Bailey and Phillips, 1990), quality of care provided and the nature of the illness. In rural Nigeria for instance, people are willing to travel further for more specialized services or better quality care (stock, 1983). Buor (2003) found that distance is the most important factor that influences the utilization of healthcare in the Ahafo-Ano south district of Ghana. The inadequacies in the access to healthcare facilities have reduced the life expectancy of rural inhabitant and increased infant mortality (Ajala et al., 2005) they further asserted that rural people often waste a lot of time getting to the nearest available healthcare centre of which they have to trek a long distance on many occasions because they are often faced with the problem of reliable means of transportation.

In an article "Accessibility and Utilization of health services in Ghana" it was stated that the main features of accessibility and utilization in Ghana are ; long distances to health care centres, an urban-bias in the distribution of health services, inadequate budgetary allocation to the health sector, high transport cost, poor road from homes to some facilities, especially in rural areas, long hours spent in travelling to health centre and long hours of waiting and the considerable time mothers spend in caring for the health need of their children. Time accessibility; the influence of time on utilization can be examined in three perspectives, namely travel time, waiting time at the hospital and waiting time in respect to appointments. In developing countries, travel time and waiting time at the facility are more important in examining utilization. Waiting time for appointment is not a regular feature of the health system in the developing countries. Dimensions of distance to services, such as travel time, waiting time, appointment time with a doctor, nature of the means of transport and cost, have effects on revealed accessibility, i.e. utilization distance generally has an inverse relationship with utilization (Jolly and king, 1966; Meise et al., 1996)

One basic fact that researchers fail to unearth is that, in developing countries, time, as a barrier to utilization would be influenced by the season of the year and the nature of patients' business activities. During the farming season, it would be expected that the rural farmers would not like to waste much time travelling long distance for healthcare, whilst a very busy entrepreneur may not sacrifice too much time for health care during peak seasons like Christmas. He may prefer using intervening alternatives (accessibility and utilization of health services in Ghana, 2004). The poor nature of roads, especially in the rural areas could also discourage health services use, most of the rural area roads are not in good condition during the raining d, this leads to either very high transport cost or non use of vehicles

In sub-Saharan African countries most people are living under the poverty line and with low financial accessibility. A study conducted in south Africa on utilization of maternal health service shows that lack of financial resources for transport and distance to health facilities were the greatest barrier, (Tlebere et al., 2007) inability to pay long distances from health facilities to residential areas, combined with high transport cost contributed to low utilization of PMTCT services. Okafor (1982) has argued that the idea of travel cost has serious implication for the location and use of health care services. Most potential users do not want to spend much money on transport as observed by Owumi and Jegede (1991). They found that health facilities in the rural areas of former Bendel state (now Edo and Delta states) were under-utilized due to the effect of location. They were located far away from users' resident. Also most of the health facilities were not accessible due to poor road networks and poor transportation systems. However, greater access to health care after child birth has been related to lower rates of infant and child mortality in such developing countries as Nigeria (Orubuloye and Caldwell, 1975, Orubuloye and Oni, 1960, India (smucker et al., 1980).

### **Determinant of health care service utilisation**

Health determinants can be described as those factors that raises or lowers the level of health in a population or individual, determinant helps to predict trends in health and to explain why some people are healthy and others are not. They are the key to the prevention of disease, illness and injury ( ALWH, 2004, PHAC, 2004, BlueShield, 2005). The factors determining the health behaviours may be seen in various contexts: physical, socio-economic, cultural and political, therefore, the utilization of a health care system, public or private, formal or non-formal, may depend on socio-demographic factors, social structures, level of education, cultural beliefs and practices, gender discrimination, status of women, economic and political systems environmental conditions, and the disease pattern and health care system itself (shaikh and Hatcher, 2004).

Odebiyi (1980) established in her study that among the people of Ibadan, there are different perceptions of disease from different demographic and socio-economic status. She observed that this differential perception of disease within different socio-economic grouping influences their methods of treatment and consequently, the method of healthcare to utilize. It is difficult to identify which determinant are the most influential in the decision to utilize healthcare as culture,



economic, accessibility, finances, belief, gender, social roles all play a part in the decision to utilize a choice of healthcare. Therefore a look at few of this determinant of healthcare utilization will be discussed

Cultural determinants consist of societal beliefs, knowledge and the value systems adopted to evaluate human behaviour. Social organization, the relationships among the people, their occupation and environment affect exposure to disease and the need for healthcare (Mugnai, 1970; Ingelfringer, 1971). Kasl and Cobb (1996) and Rosenstock (1974) have provided excellent reviews of the work related to health behaviour. It is generally agreed that health-related behaviour is a function of the perception of threat and the "attractiveness of value of the behaviour" the intensity of the threat is dependent on three factors; the importance of health to the individual; perceived susceptibility and the resulting seriousness of the attack.

Zola (1964) has shown that health behaviour is determined by five interdependent factors viz; awareness of symptoms, social values related to the disease, recognition of the disease, perceived pay-offs resulting from an ameliorative action; and the presence of "critical incident"

For freidson (1973), whether or not the health services is a function of the situation; the amount and quality of knowledge about the potential disease; perceived symptoms; perceived need for medical care; and social or laic {layman's} approval.

According to bourdillion (1990), an important factor affecting choice between different forms of treatment is their relative availability. It is no good hoping for a cure from some form of treatment, which is out of one's reach. Consequently, people more readily adopt a view of illness, which is compatible with forms of treatment available to them. A person who lives in a community to which certain types of treatment are not available or are only occasionally available, is likely to accept the prevailing belief in alternative forms of treatment. There are a number of factors which make certain forms of treatment more or less available.

It is important to note that culture shapes not only illness treatment but also illness recognition, perception of illness severity and confidence in the efficacy of specific treatment for specific illnesses. For example, in many cultures, dementia in elderly is viewed as a normal process of ageing; thus it does not necessitate medical treatment, however, in united state, dementia is considered an illness requiring professional medical care (Ikels, 2002). As such, variance in healthcare utilization can result due to cultural knowledge and understanding of illness. If an individual is a member of a culture that considers the self as heteronomous, they are likely to have their course of treatment determined by people within their social network (Kleinman, 1980; Ikels, 2002). Conversely, if a culture considers the individual as autonomous, the decisions for treatment are more likely to be made by the individual. In those cultures that consider the self as heteronomous, an ill individual's treatment may be delayed as persons within their social network discuss treatment options (Janzen, 1978). Yet, even in cultures that stress autonomy, the individual may consult social networks for illness advice. Social networks can provide an impetus for health care utilization but may also press an individual to abstain from accessing health services.

The socio-economic status of a country will most likely reflect the health situation, generally, the better the economy indicators, the better the health condition. According to Daniel Buor (2005), in Ghana and some other developing countries in Africa, the low expenditure on health has affected the provision of physical and consumable health facilities. Low wages makes quality care inaccessible to a greater proportion of the population. Evans et al. (1994) argue that economic condition relate to environment, lifestyle and access to health services. Nowadays, it is possible to say every person could expect to live a long and healthy life, we could say its economic value is huge and health gains had the economic consequences of widespread economic growth and an escape of ill-health traps in poverty (World Health Organization, 1999) Economic factor is seen as affecting the availability of treatment, when the cost of treatment rises above what an individual can pay or above what he considers appropriate for the perceived seriousness of the illness, then that form of treatment effectively becomes unavailable to such a person. Users charges is a factor that discourage people from using health care facilities, According to Jegede (2010) over the years this has been the advantages of traditional medicine over modern medicine. While in traditional medicine, the charges are very moderate and low in most cases, and user have access to credit facilities with traditional healers being members of the same community, the reverse is the case in the modern medicine, while the physician sees him/herself as a professional, charges usually follow standardized rates as regulated by the medical council or the government or agency in charge of such health facility.

Anderson et al. (1956), Roth (1969) and Anderson et al. (1963) cited in health sociology (2006) have highlighted the role of economic factors in the utilization of health services, family income is an important determinant of the pattern of use of health care institution because family unit take cost of care into consideration before their members seek care among the available channels of care. Patients may also opt for costly services if they are convinced that they will receive prompt attention and/or have access to services, which they cannot afford. This assertion was also supported by

a study carried out by World Bank (1990) "Nigerians prefer to use the more costly cosmopolitan private health care providers than those within the public sector because it is believed that quality care is provided by the former". On the other hand, non-literate patients are more likely to use traditional healer partly because of the perceived cost of care of cosmopolitan services, which they believe they cannot afford. Yet there is indication that cost of care, which is rendered by traditional healers, is not necessarily lower in real terms than that provided by the cosmopolitan in view of the fact that patients expend large sum of money on variety of items, which are used for rituals in the therapeutic regimen prescribed by the healers (Erinosh, 2006)

The utilization of medical facility is also affected by other socioeconomic variables of patients. Okafor (1983) observed that civil servant utilize hospital services more than farmers, traders and craftsmen, and suggests that such differential utilization can be accounted for by time factor. He elaborates this by noting that while visits to hospital by civil servants are not accompanied by loss of income, the same cannot be said of those that are self employed. The implication of such finding for health shopping is a tendency for unemployed persons and those not in government services to seek medical services at later stage of illness.

Simon (1972) summarized the determinants of health behaviour, in his opinion, individual or group health activity will not take place without the foresight of an undesirable state; knowledge regarding what to do to forestall such a state; and taking preventive action. Knowing what to do but not doing it is irrelevant. If one knows what to do to maintain the desired health status, but lacks the resources to take the relevant action, the knowledge and related beliefs are useless.

Education and demand for health care are in general positively related (Grossman, 1972; 1875). The educated are more cautious and conscious of their health and tend to use health service more; illiterates' persons with high income are likely to use health facilities than the educated in the same income category. Of greater impact in determining the use of health facilities is the education of mothers (Caldwell 1983; Caldwell, 1986; Caldwell, 1989; Swenson et al., 1993; Mensch et al., 1985; Raghupathy, 1996; Wong et al., 1987). Educated women tend to use health facilities more than the uneducated and the level of education of a woman and the number of living children also determine her use of pre-natal and antenatal services.

Education is a catalyst in terms of acceptance of modern health care services (Jegede, 2011). Formally educated Nigerians maybe more likely to utilize cosmopolitan western style health care services than those who are non-literate at the onset of, and during ill health. Although those with formal western education are also not obsessed with magico-religious factors in their concept of diseases, nevertheless, they may resort to primordial beliefs when they or their kin suffer from chronic and emotional disorders (Erinosh, 2006). In this context, both the literate and the non-literate think alike and usually seek help from traditional healers, work from Erinosh (1977d) also indicate that student in their penultimate and final years in medical schools in Nigeria share the viewpoint that mental illness maybe attributed to bewitchment. The choice of traditional healers among non-literate patients is impelled by the conviction that they (i.e. these healers) are efficient and their medicines are efficacious.

Secondly, Erinosh also states, non-literate Nigerians prefer to seek treatment in the compounds of traditional healers rather than in the premises of cosmopolitan western-style health care facilities largely because they find formalities like queuing for cards , registration, physical examination etc in the latter cumbersome, strange and seemingly alienating. This is in contrast to formally educated patients who find the environment of the cosmopolitan western-style healthcare facilities attractive, conducive and acceptable.

Findings from numerous studies on infant and child mortality conducted in developing countries over the last decade show a nearly universal and positive association between maternal education and child survival- a relation which persisted in many societies even when the household's socio-economic status has been held constant ( as cited in African culture and health. Pp 63, Jegede, 2010). As a result, the study of the pathways through which females schooling exercises its positive power leverage has become of increasing interest to researchers in recent years (Cleland and Ginnekan, 1988, 1989; Barrera, 1990, Singaribum et al., 1986). Education modifies beliefs about disease causation and cure and thus influences receptivity to modern health care services. Schooling enhances peoples' knowledge of modern health care services, improves their ability to communicate with modern health care providers, increases the value they place on good health, results in heightened demand for modern health care services as noted by Caldwell (1979), Schultz (1940) and Caldwell and Caldwell (1988)

According to a study carried out by Jegede among the Yoruba in Akinyele community, he arrived at the conclusion that formal education modifies peoples' cognition and beliefs about disease causation and treatment, while health education provides a catalyst effect on the part of illiterates and thereby neutralizes the effects of formal education in places where public health is properly put in place. This view was also supported in a study of the differential effect of mother's education on mortality of boys and girls in India, Bourne and Walker (1991) found that improved mother's education reduced mortality at all ages below five years for both sexes. In their own argument, Rozensweig and Schultz

(1982) indicated that female education and health care services are partial substitutes for information regarding knowledge of disease, treatment of illness and child care practices. They however, posited that the effect of formal education becomes less important as access to public health care services improves.

Gender, broadly defined as the array of societal beliefs, norms, customs and practices that defines masculine and feminine attributes and behaviors, often acts as a filter leading to patterns of inclusion in access to basic needs and services, including those related to health. It also affects the ability to protect oneself from disease, violence and fear Lincoln Chen et al (2003). Gender is a social determinant of health; gender inequality accelerates the spread of Hiv/Aids and limits successful utilization of prevention of mother to child transmission (PMTCT) services (Mekonnen, 2009). In a study conducted by Jegede (2011) among a Yoruba community, he found out that "Being patrilineal society's younger mothers do not take absolute decisions on matters affecting their marriage and children. The role of elderly women and especially aged women (mostly mother-in-laws) is very important. Childcare is usually supervised by the aged women in the extended family and younger women look up to them for advice. As a result, their experiences become very important and it is highly cherished by many. According to Jegede, most of the time, they rely on home remedies to solve minor problems; they argue that it is not all the time that you will go to the hospital. In those days, our grandparents used to single-handedly handle their wards medical problems without much recourse to any external help.

Women's status vis-à-vis men's status may affect infant and child welfare in several ways, first, women who are more involved in decision making are generally more likely to use modern health care services than those who are not usually involved, second, women who have equal opportunity in decision making and control autonomy in the household is supported by the evidence that, the greater the resources a woman brings into marriage (in comparison with those of her husband including her education and income), the more significant her role in the family (Widayatun, 1991). He maintained that "relative to child health (mortality) between men and women may depend partly on their levels of education and income" for Blumberg (1976) women's income is the most important aspect of their freedom in decision making, life options and control over resources.

According to Jegede (2000), women are constrained to make unilateral decisions about their children; they are expected to get approval from their husbands even where they (women) are highly educated and have high economic status. Since the father is regarded as the head of the family, even if the mother is providing for the family as the case in some household, it is expected that the father should take the final decisions about their family including the number of children they have. Hence, decision making process at the household level reduced the power of women to make independent decisions on any matter relating to their children. Generally, one cannot separate a mother's economic status from societal value which makes women to be submissive to their husbands who are traditionally or culturally regarded as the "bread winners". Even with free immunization service, mothers still need to obtain permission from their husbands before taking their children for immunization. Nevertheless this is the product of the cultural norm of patriarchal society, where men's cultural domination is jealously guarded (African culture and health, 2010).

The above view is also supported by Chen et al. (2003) in a study carried out, they were of the opinion that two significant factors tend to delay women's decision to seek treatment when ill; their workload in the home, and their care giving roles with small children or other family member who are sick. Other factors that affect women's access to health services include the need for permission from their husbands or senior member of the household to seek treatment and restrictions upon physical mobility outside the home. In addition, gender differences in decision-making may also affect access to health facilities, for instance, in a study carried out in Tanzania found that while men made independent decision to seek voluntary counseling and testing for (VCT) services for HIV/AIDS, women felt compelled to discuss testing with their partners before accessing the service.

Generally women use health facilities more than men, which relates to higher morbidity and a lower threshold to consult a physician (Kohn and White, 1976). Gender disparities also impact negatively on the use of health services. Ojanuga and Gilbert (1992) in a work on women's access to health care in developing countries established the premise that myriad socio-cultural factors negatively impinge upon the physical wellbeing and accessibility of appropriate health care facilities of women. In developing nations, women's roles affect their use of health services, since men who monopolize family decisions are strong determinants of health care utilization (Santow, 1995). In developed world, women tend to receive more health services, more extensive diagnosis services, and more follow-up consultations (Verbrugge and Steiner, 1981). In a study of sex differences in the use of health care services in Manitoba, Canada, Mustard, et al. (1998) found that women used health services more than men. This was also supported by another study on differential use of medical care by sex in Ohio; Sindelar (1982) concludes that women use health services more than men. The result of her studies indicated that 10% of men and 17 percent of women entered the hospital per year and whereas women spend 128 dollars per year on the average on doctor's care, men spend 78 dollars.

## Factors influencing the use of maternal health services

According to the World Health Organization (WHO), current estimates of maternal mortality ratios are at more than 1000 per 100,000 live births in most African countries. In developing countries, specifically in sub-Saharan countries, many women do not have access to skilled personnel during childbirth (WHO, 2005).

Millions of women in developing countries experience life threatening and other serious health problems related to pregnancy or childbirth. Complications of pregnancy and childbirth cause more deaths and disability than any other reproductive health problems (EC/UNFPA, 2000). The situation is worse in developing countries like Nigeria due to inadequate access to modern health services and poor utilization. Despite the government's serious commitment to deliver health facilities to the doorsteps of common people through innovative approaches, such as Essential Service Package (ESP), the utilization of health services is still far below any acceptable standard. One of the public health challenges in developing countries such as Nigeria is, therefore, to identify vulnerable groups and to provide them with needed preventive and curative health services. Factors influencing maternal health services utilization operate at various levels - individual, household, community and state. Depending on the indicator of maternal health services, the relevant determinants vary. Thus, as several authors have aptly noted, the determinants of maternal health care service utilization vary across and within cultures (Navaneetham *et al.*, 2008).

Given the demonstrated health benefits of institutional deliveries, it is necessary to understand the range of factors associated with the decision to seek care during delivery, and to understand the role that the community has in influencing this decision. In Nigeria, the choice to deliver outside hospital settings could be motivated by varying factors such as economic, social, physical, cultural, or institutional (Ahmed *et al.* 2005). These factors can be grouped into Socio-cultural, social demographical and socio-economical factors.

Socio-cultural factors are factors associated with the traditions, norms and values of people that affect the way and manner in which they seek medical help on health related problems. The community beliefs and norms are reflected in an individual's health decisions; behavior is influenced by how a person thinks the community views his or her actions. (Rutenberg and Watkins, 1997) For example, traditional beliefs about childbirth, coupled with misconceptions and fears of medical institutions, have led many women to maintain reliance on home births in India (Basu, 1990). Results from a study in Benin found that women giving birth unassisted were silently admired, (Sargent, 1990) and in West Africa childbirth is considered a woman's battle (Diallo, 1991). Culture incorporates belief-system that underlies the perception and interpretation of diseases and illness in societies. Erinosh (1998), argued that, unlike in the western societies where the concept of disease is largely based on the germ theory, hence patients perceive disease in terms of organic malfunction, which can be effectively, diagnosed using scientific and clinical techniques and the acceptance of a scientific notion of disease therefore oblige patients to use modern orthodox or western-style health care service. In Africa and most developing countries that is not the case.

However, this notion of disease or illness contrasts with the dominant belief-system in most non-western societies where diseases and sickness are attributed to witchcraft, sorcery and mystical forces; hence illness and diseases are perceived, evaluated and acted upon in line with these beliefs that is why they seek medical help from assorted traditional healers. Patients that want to use traditional medicines or the services of traditional healers at the onset of ill health, and more importantly due to the attitude of relating diseases and sickness to magico-religious factors the people in such communities or societies appear to have greater confidence in the therapeutic skills of traditional healers (Erinosh, 1977; Igun, 1988).

The role of traditional and religious beliefs as well as the perception of women with regards to comparative efficacy of the medical versus traditional birth attendants may also be contributory to failure to have skilled attendants at birth. As Addai (2000) pointed out, modern (medical) and indigenous maternal health care services coexist in most African communities, particularly in rural areas, and women may have to choose between the two options. Some previous studies had reported that many Nigerian women, particularly those in rural areas, rate the services of the traditional birth attendants (TBAs) as being of higher quality than that of medical healthcare practitioners, particularly with regards to interpersonal communications and relationships (Fatusi and Ijadunola, 2003). TBAs have been reported to be more considerate and to provide more compassionate care. Women in rural Guatemala have similarly been reported as being less likely to deliver in medical settings because of lack of social support provided by health-care professionals compared with traditional midwives (Glei and Goldman, 2000). Furthermore, Falkingham (2003) reported that despite the fact that medical services were accessible and free of charge, women in Tajikistan prefer to deliver at home because they perceive available medical services to be of low quality and unsafe.

These are some of the prevailing traditional beliefs and practices among most of the communities in some part of Nigeria that hinder the full utilization of modern health facility in general and maternal health care services in particular.

This fact was clearly revealed by Jibo (2004), who studied women in Shekar Maidaki village in Kano state where he found that the two main reasons for non-utilization of maternity care services amongst the women are spousal inhibition and access to experience traditional birth.

According to Raju (2000) some of the socio-cultural practices and superstitious beliefs and practices relating to the concept of causality in which illness and other misfortunes are attributed to evil spirits are wide spread among many ethnic groups in Nigeria. Traditional perception of events may tie followers to the use of traditional medicine and encourage use of formal system only when the traditional option fails. As a result women in many communities in Nigeria seek medical treatment only as a last resort, after first attempting to appease these evil spirits. The traditional beliefs obviously have negative effects on the use of modern health care delivery. Also women under utilize maternal health care services due to their poverty, illiteracy, general backwardness and adherence to superstitious belief concerning illness and diseases.

Early marriage is an act of giving young girls below maturity age in marriage. This practice is more common in the northern part of Nigeria where girls are married off before they are physically and psychologically mature to manage motherhood. The age at which childbearing begins influences the number of children a woman bears throughout her reproductive life. Similarly, early childbearing, particularly among teenagers (those under 20 years of age) has negative demographic, socio-economic, and socio-cultural consequences. Teenage mothers are more likely to suffer from severe complications during delivery, which result in higher morbidity and mortality for both themselves and their children. (NDHS, 2003)

In addition to the fact that a high proportion of teenage girls are married out to much older men, sometimes as early as 9 or 10 years of age, based on religious/cultural beliefs, cultural norms restrict women from readily seeking health-related assistance in pregnancy and childbirth. As Wall (1998) noted, "*Kunya*, or 'shame' plays an extremely important role in *Hausa* childbirth, particularly in the first pregnancy. The newly pregnant girl should not draw attention to her gravid state, and all mention of the pregnancy should be avoided in conversation and action. This social pressure to remain 'modest' may well prevent her from asking questions about childbirth, and creates a major barrier to her seeking skilled assistance for delivering in hospital. As Wall further note, the pregnant girl's "mother, other relatives, and a local midwife usually stay with her during labor, but her *kunya* and her fear may be so great that she does not say anything until labor is well advanced." If there is nobody immediately available, it is unlikely that the girl in labor will send for someone, as "*kunya*" will prevent her from saying anything. Moreover in the cultural context of the Hausas, delivering her first child alone - unattended to by anyone - is viewed with pride.

The beneficial effects of improved socioeconomic status on maternal mortality are not direct, but are mediated by the interplay of such factors as improved health and reproductive behavior, improved health status, and improved access to health services, as well as by various other unknown mechanisms (Thaddeus and Maine, 1990). In Nigeria, for example, delay in seeking medical care, usually by women in the lower socioeconomic class, has consistently been cited by hospital-based investigators as the most important intermediate risk factor in maternal mortality. However, to date the components of this delay have not been characterized. We need to know whether this delay is due to the patient, to the health-care system, or to difficulties with transportation. It is also possible that all of these factors are equally important, that there is an interaction between them, or that a weighting can be given to them to highlight their relative importance. This information will be relevant as it will enable government and other agencies to plan a rational program of combating the problem of maternal mortality at the community level.

Another socio cultural factor to be considered is large family size which is an important predisposing factor for utilization of health care. This relates to the perception of women's fundamental role, which is child bearing and child-rearing. These cultural values are shared by both men and women, although it is interesting to note that among western educated/ working class women they desire fewer children than their male partners, doubtless because they have other aspirations and are more conscious of the burden of reproduction and child care. Recent studies in Northern Nigeria suggest that it is often men rather than women who make the decision to have more children, that is, men's views are more influential than women's views in making family decisions (WHO, 1996).

Similar findings were revealed by studies among some of the major ethnic groups in Borno State by Gazali, (1996), Waziri, (2004) and among the Hausa of Kano state by Adamu (2001) in Kano. In their studies they indicated that men, because of their position in a patriarchal society, make it difficult for the women to regulate and control birth rate or in short adopt family planning without the consent of their husbands who usually oppose the idea. For instance, among some of the major ethnic groups in Borno state, particularly the Kanuri, Shuwa and Ba'aru, large family symbolise higher status for members of the family. Politically, it makes the family more relevant and religiously, it gives them the satisfaction of fulfilling an obligation – to marry and reproduce, so that the *umma*-(followers of Prophet Mohammed) will increase (Gazali, 1996; Waziri, 2004).

Furthermore, according to Royston, (1989) in many developing countries there is still pressure on women to bear many children despite the risks associated with the cultural demand. The reasons for this among others are gender identities, that is, what it means to be a man or woman in a particular society that are shaped and defined by patterns and expectations of reproductive behaviour. Family Care International, (1991) reported that, for women in many parts of the world, the surest route to social and economic security is to bear many children, preferably sons. Furthermore, fear of infertility, of divorce or of polygamous marriage also acts as pressures on women to bear more children. In short, the pressures to bear many children relate to economic and social security as well as gender identity. Women from large families underutilize various health care services because of too many demands on their time. Larger families also cause resource constraints, which have a negative effect on health care utilization (Wong *et al.*, 1987). The way this cultural practice serves as an impediment to utilization of MHC facility usually occurs when one has many children which consequently might cause resource constraint as rightly pointed out by Mckinlay (1972) who wrote; 'Women with a large number of children under-utilize available health services because too many demands on their time force them to forgo health care'. *Purdah* system as another cultural factor accounts for low utilization of health care facilities, by constraining on women's movement outside the home, which limits access to health services. Related to this is the issue of decision-making as it relates to health care utilization. A woman must ask her husband's permission to seek treatment when even an obstetric complication arises. Prevention of Maternal Mortality Network (1992) cited a case of a woman with obstructed labour, who lived ten minutes walk from hospital but who could not leave the house because her husband was away on a business trip. By the time he returned and gave permission for her to be taken to hospital, she had developed vesico vaginal fistula (VVF) and the baby was dead in the uterus.

According to Oxaal and Baden (1996), women's mobility in times of obstetric emergency may be further limited by social restriction on their movement. For example, in some part of South Asia, the seclusion of females has often resulted in their limited mobility to leave their homes; their ability to access maternal health care services even if they exist in the vicinity is thus severely curtailed. They went on to reveal that in Northern Nigeria, particularly among the Muslims and among Malian population of Accra, Ghana, women live in *purdah*, in family compounds surrounded by high walls which they are not allowed to leave. A woman must ask her husband's permission to seek treatment when an obstetric complication arises.

Wall (1998), found that the factors contributing to the problems of maternal morbidity among the Hausa of Northern Nigeria are Islamic culture, a perceived social need for women's reproductive capacities to be under strict male control, and the practice of *purdah* (wife seclusion) which restrict women's movement and therefore access to medical care.

Furthermore, the male-dominated structure of most Nigerian family places women in an inferior status, creating a situation of inequality in respect to rights over most facets of life including the right to health care. Women's lack of autonomy and cultural restrictions are serious barrier to women's access to the needed care in Maternal Health Care clinics and hospitals (WHO (1989), Matsumura and Gubhaju (2001) and (Nasir and White, 2003).

## Traditional Medicine

Traditional medicine, which is often preferred as a first source of health care is a cultural practice that is common among most of the Nigerian ethnic groups. For instance, according to Odebiyi (1989) among the rural Yoruba in Ile-Ife almost all sicknesses are first treated traditionally before modern medical treatment. In addition, the health status of most African societies can only be understood in the light of a given socio-cultural background of folk medicine and the environment of formal health system. Traditional Dominance traditional beliefs and practices highly enhance traditional healing systems. Although there is variation in the health practices within these systems in the respective societies, it tends to be the major source of health provider. In spite of the spread of formal health systems as well as the expansion of health services, one reason why women bypass the formal system in favour of folk medicine is seen in their negative attitude towards the former, which, in many cases, results from bad experiences as reported by many of them. The situation occurs especially in relation to childbirth, when it becomes so complicated that the traditional midwife cannot handle. The woman is therefore transferred to a clinic, when, in most cases, it is too late. The resulting death/complications are consequently associated with the service providers at the clinic, hence the negative attitude towards it. In addition, the reason why they bypass the modern formal health institution for the traditional providers, is because of socio-cultural belief among most people/societies in the third world countries which favours traditional medication as against modern orthodox health care system - with its personnel's (doctors, nurses and midwives) derived from different socio-cultural background, religion and tradition; the services they provide are associated with foreign alien culture of the west etc (El-Safty, 2001).

Furthermore, Ried (1982), in her work '*Patient/healers interaction in Sukuma Medicine*' in *African Healing Systems*

cited by El-Safty (2001), argued that in the first place, traditional healers are part of the culture of the society or community, characterised by social proximity to the clients (as such, a strong affinity exists between patients and healers) in comparison to the formal health system which represent an impersonal and 'alien' approach to health care. She sums up the relationship in her study in Tanzania this way: Traditional health practitioners are people oriented with a personal approach; most modern health practitioners are western oriented with impersonal approach (Ried, 1982)

In addition, what strengthens the role of tradition medicine in this type of societies is seen in the clients' perception of causation in illness. In this type of society, causation is rooted in the interpersonal world of tradition, magic, and the supernatural, while in the 'scientific-modern medicine' it is rooted in the non-personal observable, and manipulative laws of nature. Traditional healers, therefore, interacts with the client through the channel of a shared belief system which is strongly rooted in their culture, and shapes the way of thinking of both the healer and the patient.

### **Religion and rituals during labour**

Many studies have shown that the use of modern health services is often influenced by individual perceptions of the efficacy of modern health services and the religious beliefs of the individual woman (Adetunji, 1991). According to Baley (1997) and Mekonnen (2002) there is a significant variation in the utilization of maternal health care by religion. Furthermore, Addai, (1998) and Mekonnen (1998) in their study in Ethiopia revealed that religion has emerged as an important predictor of maternal care utilization in rural Ethiopia.

In Borno state it is common among the Muslim ethnic groups for religious rituals to be performed in order to assist a woman in labour. Mallams and their grown up students (*Almarjirais*) will come and read the Holy Quran to the woman for protection against all evils relating to pregnancy and childbirth. And after that, a drink of Quranic verses particularly *Ayatul Kursiyu* are written on plate and washed and given to her to drink for safe delivery (Waziri, 2004; El-Nafaty, 1998). Adamu (2001) also revealed similar rituals among the Hausa people of Kano state in Northern Nigeria. Consequently, women tend to remain in the house instead of going to the health facilities for delivery because of the psychological satisfaction and assurance of nothing wrong will happened derived from the rituals.

### **Socio-demographic factors**

Many studies have further indicated the role of some socio-demographic factors in the utilization of health services; factors such as maternal age (Adersen et al., 1963; Morris, 1967; Reide, 2002), ethnicity (Zborowski, 1952), Education (Erinosho, 1977), Gender factors (The Prevention of Maternal Mortality Network 1992; Erinosho, 1998) and socio-economic status (Mckinley, 1972). All of these factors influence the patterns of utilization of health services in most human societies.

### **Maternal age and age at first marriage**

These are important variables in understanding the level of utilization of health facility in general and maternal health care services in particular among pregnant woman and nursing mothers because the age at which a woman first gets married influences the length of time she is exposed to the risk of pregnancy during her childbearing age.(NDHS 2003). Maternal age has been found to be positively associated with awareness and utilization of maternal health care service in many societies. Even though, it has been documented that awareness and utilization of maternal health care vary in sub-Saharan Africa and Latin America with age between the young and the old, it is well recognized that women's current age plays an important role in the utilization of medical services (Fosu, 1994). Mother's age may sometimes serve as a proxy for the women's accumulated knowledge of health care services, which may have a positive influence on the use of health services. On the other hand, because of development of modern medicine and improvement in educational opportunities for women in recent years, younger women might have an enhanced knowledge of modern health care services and place more value upon modern medicine. Whereas some previous Nigerian studies had reported a significant relationship between age and maternal services utilization (Ikeako *et al.*, 2006; Adeoye *et al.*, 2005).

### **Education**

It is well recognized that mother's education has a positive impact on health care utilization. In a study in Peru using DHS data, Elo (1992) found quantitatively important and statistically significant effect of mother's education on the use of

prenatal care and delivery assistance. In another study, Becker and colleagues (Becker *et al.*, 1993) found mother's education to be the most consistent and important determinant of the use of child and maternal health services. Several other studies also found a strong positive impact of mother's education on the utilization of health care services (Fosu, 1994; Costello *et al.*, 1996). It is 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. Mother's education may also act as a proxy variable of a number of background variables representing women's higher socioeconomic status, thus enabling her to seek proper medical care whenever she perceives it necessary. The most consistently found determinant of use of reproductive health services has been a woman's level of education (Magadi *et al.*, 2000; Nuwaha and Amootikaguna, 1999). Obermeyer (1993) believes that increased education influences service use by increasing female decision making power, increasing awareness of health services, changing marriage patterns, and creating shifts in household dynamics.

Royston (1998) argued that educated women may have more understanding of the physiology of reproduction and be less disposed to accept the complications and risk of not attending antenatal clinics, than illiterate or uneducated woman. Education has been described as a 'medication against fatalism'. In addition to that, educated women may also be less likely to accept dangerous practices aimed at alleviating complications in pregnancy. Amongst the Hausa people of Northern Nigeria, for example *girishi* cuts are a traditional surgical operation to treat obstructed labor by cutting the vagina with an un-sterilized blade. Whilst it is commonly performed on uneducated women, educated women rarely accept the practice (Royston, 1989). Uneducated women are less likely to seek the help of professional health services because they are probably less aware of what is available, and probably find the culture of modern health care facility more alienating and frightening.

### Parity

The order of birth (in terms of number of children given birth to) has been used as an explanatory variable in many studies and it is generally believed that care during delivery would be higher for the first order births and is expected to decline as order of birth increases (Elo, 1992). Furthermore, if a woman ever had a stillbirth in a previous pregnancy, the use of maternal care services would be higher because of known risk involve in childbirth (Bhatia and Cleland, 1995). The absence of a statistically significant association between the child's rank of birth and maternal services utilization among Nigerian women is surprising. Previous studies have found a strong negative association between parity and maternal services utilization (Mekonnen, 2003; van Eijk *et al.*, 2006).

Several studies have found a strong association between birth order and use of health care services (Elo, 1992). Because of perceived risk associated with first pregnancy, a woman is more likely to seek maternal health care services for first order than higher-order births. Having more children may also cause resource constraints, which have a negative effect on health care utilization (Wong *et al.*, 1987). Women with a large number of children underutilize available health services because too many demands on their time force them to forgo health care (McKinlay, 1972).

### Accessibility and Distance

The most important variable associated with utilization of MCH services is the physical accessibility of these services (Abbas and Walker, 1986). Several other studies also found that physical proximity of health care services, especially in the developing countries, plays an important role in utilization of these services (Airey, 1989; Paul, 1991). In a study in Bangladesh, Rahaman and colleagues (1982) found that geographical distance is one of the most important determinants of health care service utilization in rural areas.

Most literatures indicate that there is positive relationship between distance and utilization of health facility in general. Erinosh (1998) in one of his studies on 'the relationship between spatial location and use of health facilities' revealed that patients who reside near health facility are more likely to utilize the facility than those who are residing far away, because of travel time and transportation costs. Stephenson and Matthews (2004) also revealed that distance needed to travel to the nearest health facility in Mumbai, India, among migrants, was cited a serious problem that prevent women from receiving prenatal care and delivering in a medical institution.

### Residence (locality)

Erinosh (1998), Adeyemi (2000), Pearce (1980; 2001) UNFPA (2002 and 2004), Sabitu (2004) and Mekonnen and Mekonnen (2002), all indicated that there are differences in utilization of health care facilities and Maternal Health Care



services between urban and rural areas. That is, utilization of health facility is generally influenced by residence (locality). There is high level of utilization of health facility among urban women as compared to their rural counterparts, due to availability of health facilities in the urban areas compared to rural areas, where in most cases the facilities are not available. A base-line study on Household in Borno state by Waziri (2004) revealed among others that 73% of the urban-based facilities provide antenatal care (ANC), and only 27% of rural based facilities provide antenatal (ANC) service. Similarly 65% of the facilities in urban areas provide Post natal care (PNC) and only 23% of the facilities in rural areas provide post natal care services.

According to Erinosh (1998f), in most third world countries, urban women tend to benefit from increased knowledge and access to Maternal Health Care services compared to their rural counterpart, because health facilities are more accessible in urban areas and the various health promotion programs are urban based and disseminated by urban based mass media outlets to the advantage of urban residents. Pate (2001) also found that residence is closely linked to the availability and utilization of health services in general and maternal health care in particular. That whether one resides in rural or urban areas will have implications for access to and utilization of health facilities. Similarly, NDHS (2003) clearly indicated that there are clear differences in attendance of antenatal care clinic (ANC) by residence; women residing in urban areas are much more likely to receive ANC than their rural counterparts.

### **Income**

It is well known that increased income has a positive effect on the utilization of modern health care services (Elo, 1992; Fosu, 1994). Husband's occupation can be considered a proxy of family income, as well as social status. Differences in attitudes to modern health care services by occupational groups depict occupation as a predisposing factor. Alternatively, viewing occupation as proxy to income, which enables acquisition of more and better health care, depicts it as an enabling factor (Fiedler, 1981).

### **Cost**

Cost has often been shown to be a barrier to service use (Bloom et al., 1999) and also influences the source from which care is sought. Evidence from elsewhere have shown that access to services and cost are serious barriers to service utilization among the poor (Onah et al., 2006; Amooti-Kaguna and Nuwaha, 2000). As Fotso et al.(2008) surmised, it is not enough to increase the availability of services, making such services affordable to the poor is a necessity.

According to Gazali and Mahamoud (2012), some factors serve as barriers which are mostly with structural and personnel problems associated with health institutions that inhibit patients from patronizing health facilities. Some of these factors are; availability of facility, the standard and quality of facility, public perception of public health system, general cost associated with health facility in terms of transportation, medication, and feeding. Others are low enumeration, lack of good accommodation for doctors and nurse, lack of training opportunities, unwillingness of authority to sponsor training, and delay in promotion.

Previous studies have focused largely on the barriers and facilitators in the decision to seek health care. Studies of health care use have highlighted a range of potential influences on a woman's propensity to seek care. Demographic factors that have been shown to increase the likelihood of health service use are low parities, (Magadi *et al.*, 2000; Kavitha and Audinarayana, 1997), younger maternal age, women's employment in skilled work outside the home, Addai, 1998 and high levels of husbands' education Nuwaha and Amootikaguna(1999).

Socioeconomic factors, however, have been shown to be of greater importance in determining health service use than demographic factors (Obemeyer, 1991). Socio economic indicators such as urban residence, (Addai, 1998) household living conditions, (Bloom et al, 1999) household income, Kavitha and Audinarayana, 1997 and occupational status Nuwaha and Amootikaguna, 1999) have also proven to be strong predictors of a woman's likelihood of using reproductive health services.

Both demographic and socioeconomic determinants of use of reproductive health care are mediated by cultural influences on health-seeking behavior that shape the way individuals perceive their own health and the health services available (Basu, 1990; Rutenberg and Watkins, 1997). Thus, although demographic and socioeconomic factors are key determinants of health service use, the individual's cultural environment provides a strong influence on the extent to which these factors can lead to the use of health services.

## Pathways to utilization of maternal health services in Nigeria

In the meantime, Maternal Health Service providers can be categorized into three parts as thus; Traditional, Orthodox and Alternative. This is due to their methods of operations.

**Traditional Maternal Health Service Providers:** A Traditional birth attendants (TBA), as defined by the United Nations, is a person who assists mothers during childbirth and acquired her skills by delivering babies herself or through apprenticeship to other TBAs. Throughout history, TBAs have been the main human resource for women during childbirth. Their role varies across cultures and times, but, even today, they attend the majority of deliveries in rural areas of developing countries. There is little doubt that they have a significant role when it comes to cultural competence, consolation, empathy, and psychosocial support at birth, all of which are important benefits for the mother and also for the newborn child. The WHO observes that TBAs can potentially improve maternal and newborn health at community level and, while the role of TBAs in caring for pregnant women and conducting deliveries is acknowledged, it is noted that they are generally not trained to deal with complications. TBAs and village midwives have been employed in many interventions to reduce maternal mortality and improve pregnancy outcomes in developing countries, with mixed results.

**Orthodox Maternal Health Service Providers:** The orthodox health service is known as Hospital based services. There are three common approaches to hospital-based antenatal care available for pregnant patients in Nigeria

- Public antenatal clinics
- Semi-private antenatal clinics
- Private consultant-led obstetric care

### Public

Public antenatal clinics are available for all pregnant women in developed and few in developing countries. These clinics are booked directly with the maternity hospital chosen by the patient or on the advice of their General Practitioner. Patients are seen for an initial visit at the hospital, during which a range of blood tests are obtained and the patient's history and physical examination findings are reviewed for any signs of high risk pregnancy. An initial ultrasound scan is usually scheduled to establish how far along the pregnancy is and to confirm an accurate due date. Some hospitals also provide another ultrasound scan at about 20 weeks' pregnancy to confirm the health of the baby. Subsequent visits are often shared between the antenatal clinic in the hospital and the patient's General Practitioner. When the time for delivery of the baby arrives, the maternity hospital midwife working at that time usually delivers the baby, and the postnatal stay is usually in a public ward. Patients generally are not charged fees for any public services in some developed countries and low charge fees in some developed and developing countries.

### Semi-private

In Ireland Semi-private antenatal care is available in most of their maternity hospitals. The main difference between public and semi-private care is that patients are usually seen by one of a group of registrars or consultant obstetricians for most of their antenatal visits at the maternity hospital. Similar blood tests and an initial dating ultrasound scan are provided, as with public antenatal care. Some hospitals also provide another ultrasound scan at about 20 weeks' pregnancy to confirm the health of the baby. When the time for delivery of the baby arrives, the maternity hospital midwife working at that time usually delivers the baby. The postnatal stay is often in a semi-private room or private room, depending on whether private insurance, such as VHI or BUPA, is held. A reduced fee is charged by the hospital for providing this degree of medical attention.

### Private

Private obstetric care differs significantly from public and semi-private care in that patients are seen for all visits by a specific consultant obstetrician, and the delivery is under the immediate supervision of that consultant. As well as the usual initial blood tests and dating ultrasound scan, further ultrasound scans are usually performed at subsequent antenatal visits, often including a detailed ultrasound scan at about 20 weeks' pregnancy to confirm the baby's health and late in pregnancy to confirm the baby's growth. Because the same consultant is responsible for all aspects of

obstetric care, patient's generally having more options for individualizing their care and expressing their own personal choices at delivery. Postnatal stay is generally in a private room, when available and depending on whether private insurance, such as VHI or BUPA, is held. Fees for private antenatal care are arranged directly between each consultant and their private patients.

### **Faith Based Maternal Health Service Providers**

Faith and religion play a vital role in the lives and cultures of most people throughout the world. Religious values and practices are often deeply entwined in the fabric of daily lives, apart from the fact that the leaders of churches, mosques, temples and other religious communities play a powerful role in shaping attitudes, opinions and behavior, they also contribute to the healthcare infrastructure services, the empowerment of women, reduction in maternal mortality, and assistance in humanitarian crises. Indeed, about 70 per cent of people identify themselves as members of a religious or spiritual community. Religious values and practices are often deeply entwined in the fabric of daily lives, and the leaders of churches, mosques, temples and other religious communities play a powerful role in shaping attitudes, opinions and behaviour.

Faith-based organizations, sometimes referred to as FBOs, also have a long history of making a difference in people's lives by delivering crucial social services. Faith-based service delivery networks continue to identify and reach out to those in need, often during the most difficult times and in the most remote areas. According to the Woodrow Wilson Center's Global Health Initiative in coordination with the Maternal Health Task Force and the United Nations Population Fund (UNFPA), Faith-based organizations (FBOs) are often at the frontline of healthcare in developing countries and have networks in the most remote regions. Their close links to communities provide them with an opportunity to promote behaviour change and address other cultural factors contributing to maternal mortality rates such as early marriage and family planning.

In line with government health strategies and scripture related to health messages, Safe Motherhood Sermon Guides (Christian and Muslim) have been developed to provide religious and community leaders with the appropriate information relating to issues surrounding pregnancy and newborn child health to educate their constituents. According to a study by the Pew Charitable Trusts (Pew-Templeton Global Religious Futures Project 2010), the vast majority of people in sub-Saharan Africa identify themselves as adherents of Christianity or Islam, the world's two largest religions. Other evidence indicates that approximately 75% of Africans trust their religious leaders (Ferrett, 2005). These findings indicate that leveraging the influence of religious leaders and promoting faith-based or faith-inspired health services could be an effective means of addressing the challenges in maternal and child health in Africa, where a growing proportion of maternal and child deaths occur.

For centuries, FBOs have played a key role in the global effort to promote health and well-being, especially among the most disadvantaged populations. Owing to insufficient local resources, FBOs originally concentrated on building hospitals and clinics and training healthcare workers to improve access to affordable health and rehabilitation services. The scope of FBO-run activities has expanded over time and FBOs are now considered important providers of health care, particularly in low-resource settings. The World Development Report called for the greater use of nongovernmental organizations (NGOs), particularly FBOs, to improve service quality and fill existing gaps in healthcare services (Gill and Carlough, 2008). This call was repeated in a 2006 assessment of the impact of religion and religious entities on achieving universal access to services in the context of the HIV epidemic in Zambia and Lesotho (WHO, 2006). This assessment—carried out by the African Religious Health Assets Programme at the Universities of Cape Town, Witwatersrand, and KwaZulu Natal—stressed the need for greater appreciation of the contribution FBOs can make in the fight against HIV/ AIDS in high-prevalence countries (WHO, 2006), a sentiment that should be expanded to include maternal and child health services.

In 2009, an international consultation on NGO mapping standards co-hosted by the WHO and the Washington-based Center for Interfaith Action on Global Poverty (WHO, 2010) concluded that FBOs need to be more actively engaged in the collection, management, and dissemination of health facility data to increase their visibility to government partners, donor agencies, and their own communities. Mariana *et al.* (2011) as public health specialists in maternal and newborn health, agree that such activity would be an important step towards increasing the evidence base of the contribution FBOs make to maternal and newborn health, particularly in Africa. The WHO estimates that 30–70% of the sprawling healthcare infrastructure across the African continent is owned or run by FBOs, with percentages varying within this range in different countries (WHO, 2009). The first census in Africa on the not-for-profit healthcare sector conducted by Uganda in 2001 (Ministry of health in collaboration with Uganda Catholic, 2001), for example, showed that 70% of all private not-for-profit health facilities in Uganda are owned by autonomous diocese and parishes. A multi-country study

carried out in 2003–2005 by the Ecumenical Pharmaceutical Network in collaboration with the WHO (Banda *et al*, 2003) similarly found that approximately 40% of the healthcare infrastructure across sub-Saharan Africa is operated by FBOs, and that faith-based drug supply organizations are fundamental to the provision of essential medicines to rural and remote areas, particularly when bottlenecks occur in the management and procurement of government supplies.

## THEORETICAL FRAMEWORK

### Rational Choice Theory (RCT)

The central explanation of this theory is a focus on individual rational action that helps to explain the aggregate behaviour in the society. According to the main proponent of this theory, James Coleman (1990), the main task of sociologists is to focus on social system, but that such macro phenomena must be explained by examining the factors internal to them, which centers on behaviour of individuals at the micro level. He identified reasons for this argument. First, he argued that data are usually gathered at the individual level and aggregated or composed to yield the system level. Second, that the individual level is the point where interventions are ordinarily made to create social change in the society. Further, Coleman's rational choice orientation posits that a person acts purposively towards a goal, with the goal and the actions shaped by values or preferences. In other words, every person considers utilization of healthcare facility a rationalized choice, and perhaps the best available alternative course of action to achieve their pressing needs. The collection of the aggregate rational action helps to explain the macro social system.

Although rational choice theory recognizes that in the real world, people do not always behave rationally, but this makes little difference in the position of the theory. According to Coleman (1990) the implicit assumption is that the theoretical predictions will be substantively the same whether the actors act precisely according to rationality as conceived or deviate in the way that have been observed. Hence, given the theoretical orientation, it follows that the focus in terms of the micro-macro issue is the micro to macro linkage, or how the combination of individual actions bring about the behaviour of the system (Ritzer, 1996). While the theory is interested in micro-macro analysis, it is also interested in the macro-micro linkages, or how the system constrains the orientations of actors. On the whole, the argument of rational choice theory is the rational construction of social system from the lowest level of individual. That is knowledge of macro level is best understood from primacy of micro level. In other words, to gain adequate understanding of the utilization of healthcare facility in Nigeria, it is highly essential to understand the perception of individuals to the healthcare facility on available.

### Health Belief Model (HBM)

A major psychosocial model of health seeking behaviour (activity taken by a person who believes himself healthy for the purpose of preventing disease) or illness behaviour (activity undertaken by a person who feels ill for the purpose of gaining relief) is described by the health belief model as proposed by Rosenstock (1966) which is cited in Cockerham, 1978; Becker, 1974 as well as in the illness behaviour proposed by mechanic (1962)

Health belief model is the theory commonly used in health promotion and health education (National Cancer Institute (NCI), 2002). The Health Belief Model (HBM) is a tool that scientists use to try and predict health behaviors. It is also a psychological model that to explain and predict health behavior of an individual and this is done by focusing on the attitudes and beliefs of an individual. This theory was originally developed in the 1950s by social psychologists that were working in U.S then, and later updated in the 1980s. The model is a conceptual framework developed and used to understand health behaviour and possible reasons for non-compliance with recommended health action (Becker and Rosenstock, 1984) It is based on the theory that a person's willingness to change her health behaviors is primarily due to some factors. The following four perceptions serves as the main constructs of the model; perceived seriousness, perceived susceptibility, perceived benefits and perceived barriers. Each of these perceptions, individually or in combination, can be used to explain health behaviour. Other constructs have been added to health belief model recently; thus the model has been expanded to include cues to action, motivating factors, and self-efficacy.

**Perceived Seriousness:** Refers to the probability that a person will change his/her health behaviors to avoid a consequence depending on how serious he or she considers the consequence to be. The construct of perceived seriousness speaks to an individual's belief about the seriousness or severity of a disease.

**Perceived Susceptibility:** Refers to the personal risk or susceptibility which is one of the more powerful perceptions in prompting people to adopt healthier behaviour that is People will not change their health behaviors unless they believe that they are at risk. The greater the perceived risk, the greater the likelihood of engaging in behaviour to decrease the risk.

**Perceived Benefits:** the construct of perceived benefit is a person's opinion of the value or usefulness of a new behaviour in decreasing the risk of developing a disease tends to adopt healthier behaviors when they believe the new behaviour will decrease their chances of developing a disease. It is difficult to convince people to change behaviour if there is not something in it for them.

**Perceived Barriers:** One of the major reasons people does not change their health behaviors is that they think that doing so is going to be hard. Sometimes it is not just a matter of physical difficulty, but social difficulty as well. Changing ones health behaviors can cost effort, money, and time. Since change is not something that comes easily to most people, this construct of health belief model addresses the issue of the barrier to change. This is an individual own evaluation of the obstacle in the way of new behaviour. In order for a new behaviour to be adopted, a person needs to believe that the benefits of the new behaviour outweigh the consequences of continuing the old behaviour .This enables barriers to be overcome and the behaviour to be adopted.

The Health Belief Model, however, is realistic. It recognizes the fact that sometimes wants to change a health behavior is not enough to actually make someone do it. It also and incorporates three more elements into its estimations about what it actually takes to get an individual to make the leap. These three elements are mediating factors, cues to action and self efficacy.

**Modifying variables:** the four major constructs of perceptions are modifying by other variables, such as culture education level, past experiences, skills and innovation to name a few.

**Cues to action:** In addition to the four beliefs of perception and modifying variables, HBM suggests that behaviour is also influenced by cues to action. Cues to action are external events that prompt a desire to make a health change. It is something that helps move someone from wanting to make a health change to actually making the change. They are events, people, or things that move people to change their behaviour.

**Self efficacy:** In 1988, self efficacy was added to the original four benefits of HBM (Rosestock et al., 1988). Self efficacy looks at a person's belief in his or her ability to make a health related change. It is the belief in one's ability to do something (Bandura, 1977). People do not try to do something new unless they think they can do it. The faith in an individual's ability to do something has an enormous impact on their actual ability to do it. Thinking that one will fail will almost make such failure to happen. If someone believes a new behaviour is useful (perceived benefit), but does not think he or she is capable of doing it (perceived barrier), chances are that it will not be tried. In fact, in recent years, self efficacy has been found to be one of the most important factors in an individual's ability to successfully use.

## METHODOLOGY

The research is about the utilization of healthcare facilities in Igboora community. The purpose is to ascertain whether socioeconomic status affect the utilization of the various healthcare facilities located in Igboora. In view of this, the section shall be broken down into Research Design, Sample Design, Methods of Data Collection and Methods of Data Analysis.

### Research Design

The nature of the work necessitated the use of descriptive survey, in view of this; the researcher made use of focus group discussion and questionnaire as methods of gathering required data for the study.

The focus group discussion was organized in three different centres, each group membership were purposely selected based on their socioeconomic status, and the services of 2 research assistant were engaged for easy coordination and moderation of the focus group discussion.

Qualitative data that were generated through this focus group discussion was later quantified and coded to form integral part of the questionnaires

## Study Area

Oyo state is an inland state in the south-western Nigeria, with its capital in Ibadan. It is bounded in the north by Kwara state, in the east by Osun state, in the south by Ogun state and in the west partly by Ogun state and partly by the republic of Benin. The state is divided into twenty-three local government.

Igboora is a town in Oyo state south western Nigeria, situated 80km (50 mi) north of Lagos. As of 2004, the population of the town was 92,719 people. The unusually large number of twin birth has earned the town the nickname twin capital of the world. The town today is the location of the newly established Oyo state college of agriculture (since 2006). The college of Agriculture has contributed significantly to the socio-economic and demographic development of the town.

## Sampling Population

The target population for this study were the resident of Igboora community, Ibarapa central local government which has a population of 92,719. The community was chosen as relevant to this study because many residents of Igboora community were observably experiencing a relatively degree of upward social mobility occasioned by the newly established Oyo State College of Agriculture in the area. Besides, it was expected that desired and appropriate information and support which would lead to the attainment of objectives of this work were gotten from the community, as the researcher had reliable contacts in the community.

## Sample Size

The sample size is the number of staff selected as representative of the population. The composition of the sample size included forty staffs from each of the ten wards in the community. This summed up to total of 400 which forms the sample size.

## Sample Techniques

The sample technique that was used in drawing the sample in this work is cluster, purposive and Random sampling techniques. These techniques are selected based on their appropriateness considering the nature of this work. Therefore, the representatives in the Focus Group discussion and the questionnaire were clustered equally (40) across all the ten wards in the community. The purposive sampling ensured that sample members were residents above the age of 18, that is, they were adults, whose socio-economic status was objectively observed. In each of the wards also, the random sampling technique was used to give choosable residents of the community equal chance of being selected. The sample size of 400 was arrived at using the Yarmane's formula below:

$$n = \frac{N}{1 + N(e)^2}$$

Where:

n = sample size

N = Total Population (92,719)

e = Level of Significance (0.05)<sup>2</sup>

$$= \frac{92,719}{1 + 92,719 (0.05)^2}$$

$$= \frac{92,719}{1 + 231.7975}$$

$$= \frac{92,719}{232.7975}$$

$$= 398$$

$$= 400$$

## Data Collection

The data for this work was sourced through qualitative and quantitative means; the qualitative source was through the focus group discussion in three different locations in Igboora Township. The quantitative included responses to questionnaires. The questions were both open ended and close ended; the close ended nature of the question was to facilitate easy interpretation while the open ended question was to permit the respondents to express their opinions without being restricted to a particular option. The validity and reliability of the questionnaires and interview instruments was standardized through the erudite supervision of the supervisor of this work.

The secondary data however, was gotten from the internet, relevant textbooks, journal materials and articles on socio economic status and utilization of health care facilities.

## Data Analysis

In this work, the researchers main point of investigation were the hypotheses put forward, these hypotheses were formulated to enable the researcher attain the objectives of this study. The inferential statistical analysis was employed to interpret the data gathered. Inferential statistics had various methods but for this work, the Chi-square and the correlation methods were used in analysing the hypotheses stated earlier on.

The descriptive method of data analysis was also used for thorough detail analysis of the responses to the questionnaire. The descriptive method that was used include the mean/average, the range and simple percentage.

## Ethical Consideration

According to Babbie (1998), ethical principle comprises the consideration for voluntary participation, anonymity, and confidentiality. These principles were strictly observed in the course of this study. Consent of the prospective respondents was sought and obtained before the study instruments were used on them including recording their voices on electronic devices. Every respondent was made to know the intent and value of the study in order to sustain their confidence. Furthermore, they were made to know that they are free to back out of the study at any point in time. In all, information to be obtained from the respondents as well as their identities will be kept anonymous and strictly confidential

## DATA PRESENTATION AND ANALYSIS

### FINDINGS

Findings are presented in line with the study objectives. Necessary inferences are drawn from some of the findings in light of theoretical framework of the study, while observed similarities and differences between the present study and extant literature are reconciled using appropriate sociological explanation.

### Socio-economic and demographic characteristics of the respondents

Table 1 shows the socio-economic and demographic characteristics of 357 of respondents on socio-economic status and utilization of healthcare facilities in Igboora community Oyo state, Nigeria.

**Table 1.** Socio-economic and demographic characteristics of the respondents

AGE (Years)	FREQUENCY (NO)	PERCENTAGE (%)
≤ 20	55	15.4
21 – 30	73	20.4
31 - 40	93	26.1
41 – 50	108	30.3
51 and above	28	7.8
<b>Total</b>	<b>357</b>	<b>100.0</b>

Continuation of table 1

<b>SEX</b>	<b>FREQUENCY (NO)</b>	<b>PERCENTAGE (%)</b>
Male	180	50.4
Female	177	49.6
<b>Total</b>	<b>357</b>	<b>100.0</b>
<b>EDUCATIONAL LEVEL</b>		
No formal schooling	22	6.2
Primary school.	6	1.7
Secondary school	58	16.2
Post Secondary (Diploma, FCE)	65	18.2
Degree	133	31.7
Post Graduate	93	26.1
Tertiary school	<b>357</b>	<b>100.0</b>
<b>Total</b>		
<b>MARITAL STATUS</b>	<b>FREQUENCY (NO)</b>	<b>PERCENTAGE (%)</b>
Single Never Married	154	43.1
Married /Living together	179	50.1
Widowed	11	3.1
Separated/Divorced	13	3.6
<b>Total</b>	<b>357</b>	<b>100.0</b>
<b>ETHNIC GROUP</b>	<b>FREQUENCY (NO)</b>	<b>PERCENTAGE (%)</b>
Yoruba	243	68.1
Igbo	72	20.2
Hausa	25	7.0
Others	17	4.8
<b>Total</b>	<b>357</b>	<b>100.0</b>
<b>RELIGION</b>	<b>FREQUENCY (NO)</b>	<b>PERCENTAGE (%)</b>
Christianity	223	62.5
Muslim	125	35.0
Traditional	9	2.5
<b>Total</b>	<b>357</b>	<b>100.0</b>
<b>OCCUPATION</b>	<b>FREQUENCY (NO)</b>	<b>PERCENTAGE (%)</b>
Employed	159	44.5
Unemployed	102	28.6
Self Employed	82	23.0
Retied	6	1.7
Student	8	2.2
<b>Total</b>	<b>357</b>	<b>100.0</b>
<b>MONTHLY INCOME</b>	<b>FREQUENCY (NO)</b>	<b>PERCENTAGE (%)</b>
≤ 10,000	32	9.0
11,000 – 20,000	72	20.2
21,000 – 30,000	56	15.7
31,000 – 40,000	54	15.1
41,000 and Above	143	40.1
<b>Total</b>	<b>357</b>	<b>100.0</b>

Source: Fieldwork: 2012

Table 1 above shows the socio-economic and demographic characteristics of 357 of respondents on socio-economic status and utilization of healthcare facilities in Igboora community Oyo state, Nigeria. For the age distribution, the data shows that the respondents age range between 15-60 years which is the reproductive age. While majority of the respondents between ages 31-30 years and 41-50 years (26.1% and 30.3%) constitute the highest, meaning that in the study area, respondents are indifferent to the utilization of health facilities. Those below age 20 years constitute (15.4%) while the respondents between ages range 21-30 years were 20.4%. The result on the age distribution shows significant relationship between fertility pattern of respondents and the use of health facilities. Utilization of health facilities is greater among the productive aged women than among the old and teenaged women. This result is in agreement with other studies; Harrison et al (1985) revealed the influence of age on health facility utilization. The result shows that the use of health facilities is higher at the extreme age of reproductive life. The risk of dying from diseases and childbirth related cause is high for adolescent girls (Shane 2006).

Data on educational attainment of the respondents revealed that most of them had formal education where the largest proportion (23.2%) had post secondary school education followed by 20.2% with degree education. Furthermore, 13.4% had no formal primary education while 19.9% had primary education. Those with Postgraduate education were 8.4%. This shows that many respondents in the selected areas had acquired formal education.

The marital distribution of the respondents shows that married people were more likely to health facilities than other category of respondents. Majority of the respondents (72.3%) were married. This signifies that married people with the



support of their spouse are more likely to utilize health care facilities as compared to the separated/divorced (3.1%) and widows (3.4%), which lack the resources to support them not to talk of utilizing health facilities. The single never married were 21.3%. The majority of the respondents (68.1%) were Yoruba, followed by Igbo (20.2%), Hausa (7.0%) and 4.8% were from other ethnic groups in Nigeria. This finding was expected because the study was conducted in the Yoruba speaking community. The proportion of the Yoruba respondents utilizing health facilities was higher compared to other ethnic groups. The highest number of the respondents (62.5%) identified with Christianity followed by Islamic (35.0%) religion while 2.5% of the respondents practiced traditional religion.

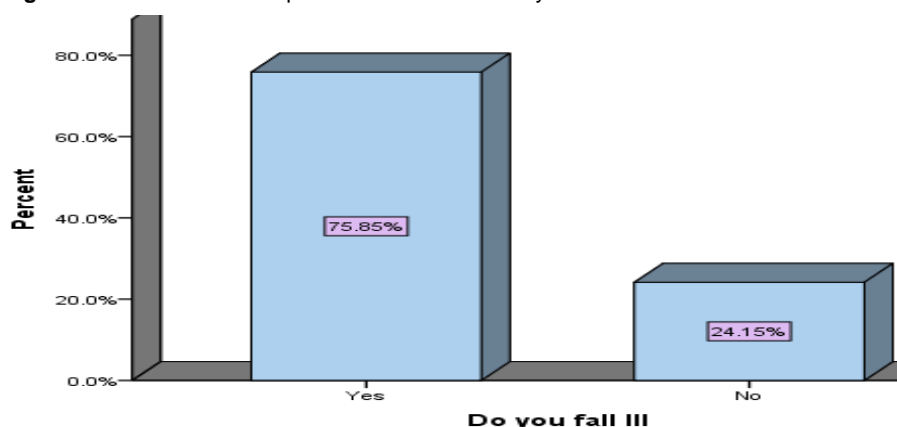
On the respondents' occupational status, the table indicates that 28.6.0% of the respondents were not working; 28.6% were employed, which is the highest while self-employed were 23.0%.

The respondents' monthly income ranged from  $\leq$  ₦10, 000 to over ₦41,000. About 27.5% of the respondents earned ₦10, 000 and below while 5.0%, which is the lowest percentage of respondents earned above N41, 000. However, 29.7% of the respondents which is the highest, percentage earned between ₦11, 000 – ₦20, 000 while 21.3% earned between ₦21, 000 - ₦30, 000. 16.5% earned between ₦31, 000 – ₦40, 000.

### Respondents utilization of health facilities and the proximity of healthcare facilities to people in Igboora community

Citizens' health, an indicator of the health status of a nation is very crucial and researchers have therefore attempted to identify factors that affect or influence the utilisation of one health facility to another. Factors such as demographic and socio-economic variable were found to be important determinant of utilization of health facilities (Caldwell, 1979; Gyimah, 2002). Despite this, people's socio-cultural beliefs and perception about diseases and health care, also influence the type of health facilities to be adopted. Therefore, the study examines the socio-economic status and utilization of health care facilities.

**Figure 1.** Distribution of respondents on whether they fall ill or not

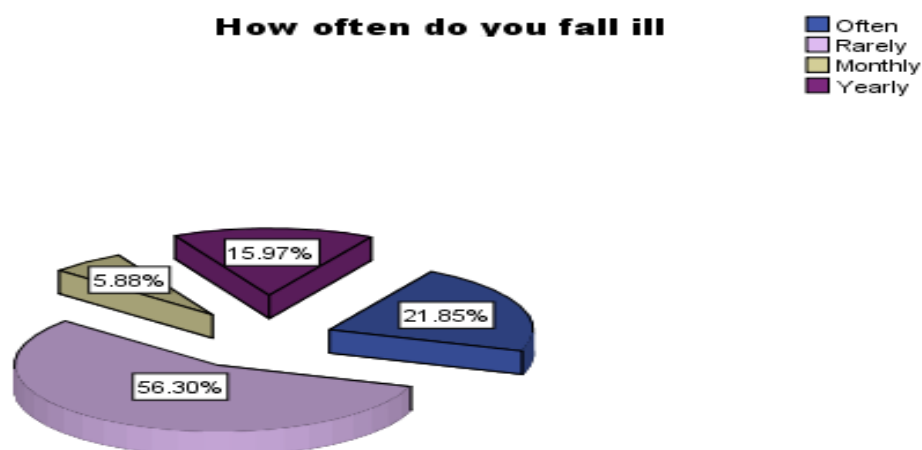


The chart above indicates that majority of the respondents (75.8%) used to fall ill why 24.2% said they do not use to fall ill. To corroborate the findings above, a respondent in the FDG session on whether they use to fall sick or not asserted that;

*“Anybody can fall sick at anytime. It depends on the nature of your job and the environment you are living. Since human body is not a stone, there are times that the body would be weak and required some rest. My own sickness is body pain because my job requires more energy and if I don’t care of my health, I use to fall sick and stay way from work a week” (FGD/Male/June 17, 2012).*

Literatures also support that African recognizes the environment as swarming with millions of micro organisms called germs, but it is contended that if germs cause diseases in relation to their population, the whole human race together with animals and the vegetable kingdoms would have been exterminated before now thus the germ theory fails to account for some disease (Aja, 1999). Preternatural and mystical forces could also cause diseases as far as the Africans are concerned. Here, diseases and ill health are attributed to the interference of supernatural forces such as witchcraft or the evil machination of enemies (Oke, 1990)

Figure 2. Distribution of respondents on frequency of illness



The chart above indicates that 56.3% of the respondents rarely fall ill; 21.9% of them showed that they often fall ill; those that suffered monthly illness were 5.9% while yearly illness is 16.0%. The result of the data showcases that some illness used to reoccur on a yearly basis. This could be as result of accident, which affects part of the body such as legs or hands and relapses yearly at the period of the incidence.

Table 2. Distribution of respondents on proximity of health facilities

<b>Do you know of any functioning healthcare facility</b>	<b>Frequency</b>	<b>Percentage %</b>
Yes	310	86.8
No	47	13.2
<b>Total</b>	<b>357</b>	<b>100.00</b>
<b>Is the healthcare facility easily accessible to you and your family member</b>	<b>Frequency</b>	<b>Percentage %</b>
Yes	248	69.5
No	109	30.5
<b>Total</b>	<b>357</b>	<b>100.00</b>
<b>What is the distance of the nearest healthcare facility to your house</b>	<b>Frequency</b>	<b>Percentage %</b>
1-3km	137	38.4
3-5km	74	20.7
7-9km	68	19.0
Above 10km	78	21.8
<b>Total</b>	<b>357</b>	<b>100.0</b>
<b>Does distance influence your decision to utilize health care facilities</b>	<b>Frequency</b>	<b>Percentage %</b>
Yes	160	44.8
No	197	55.2
<b>Total</b>	<b>357</b>	<b>100.0</b>

Health facility is very crucial and researchers have therefore attempted to identify factors that affect this. Factors such as people's demographic and socio-economic variable were indicated to be important determinant of utilization of health facilities. Nutrition deficiencies, illness, particularly malaria, diarrhea and acute respiratory infection as well as vaccine preventable diseases have been discovered to affect peoples' health in Africa (Caldwell 1979, Gyimah 2002). Despite this, peoples' perception about health care facilities, also affect the utilization of health facility. Therefore, this study examines the socio-economic status and the utilization of health facilities.

The table above shows the frequencies and percentages of respondents that had knowledge about functioning health facility. 310, which is 86.8% of the respondents agreed that they knew of functioning health facility while 13.2% of the respondents had never heard about functioning health facility. The result signifies that people in Igboora are well informed about health facility.

The highest percentage of the respondents that heard about health facility and had access to it were 69.5% while 30.5% of them did not have access to health facility. Furthermore, on the closeness of the health facilities to the respondents, 38.4% of the respondents indicated that they were close to the health facilities by 1-3 kilometres; those who were close to health facilities by 3-5 kilometres were 20.7%; 19.0% of the respondents were far from the functioning

health facilities by 7-9 kilometres and 2.8% of them went beyond 10 kilometres before they could have access to health facilities. In the same vein, 44.8% of the respondents were of the view that the distance between them and the health facility influenced the level of utilization of such health facilities while 55.2% indicated that they were not hampered from by the distance of the health faculties from utilizing them.

In confirmation of the above findings, some literatures indicate that the most important variable associated with utilization of health services is the physical accessibility of these services (Abbas and Walker, 1986). Several other studies also found that physical proximity of health care services, especially in the developing countries, plays an important role in utilization of these services (Airey, 1989 Paul, 1991). In a study in Bangladesh, Rahaman and colleagues (1982) found that geographical distance is one of the most important determinants of health care service utilization in rural areas.

Most literatures indicate that there is positive relationship between distance and utilization of health facility in general. Erinoshio (1998) in one of his studies on 'the relationship between spatial location and use of health facilities' revealed that patients who reside near health facility are more likely to utilize the facility than those who are resFGDng far away, because of travel time and transportation costs. Stephenson and Matthews (2004) also revealed that distance needed to travel to the nearest health facility in Mumbai, India, among migrants, was cited a serious problem that prevent women from receiving prenatal care and delivering in a medical institution.

### Cultural value in the utilization of healthcare facility

Thomas Lambo (1995) of Nigeria and P.M Yap (1951) of Hong Kong (cited by Erinoshio, 1998) pioneered work on the cultural dimension of health and ill health among the peoples in non-industrial societies. According to them, health and disease are to some extent shaped by culture, the concept of disease is rooted in magic and religion because most people in non-western societies attribute the incidence of diseases to witchcraft, sorcery and mystical forces because of the widespread belief in all of these forces. Therefore, this section explores the cultural value in the utilization of healthcare facility.

**Figure 3.** Distribution of respondents on the causes of illness

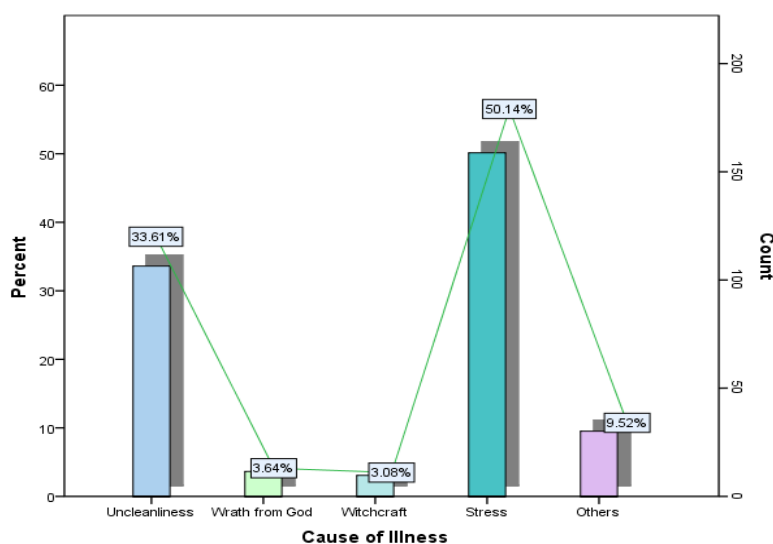


Figure 3 above shows the respondents' responses on the causes of illness. Here, it is indicated that 33.6% of the respondents were of the view that uncleanness was the cause of illness; some of the respondents (3.6%) believed that illness is cause by wrath from God against unclean attitude of mankind. Culturally, people especially in Yoruba community believe strongly in witchcraft as a cause many diseases and bad occurrences. On this note, 3.6% of the respondents indicated that witchcraft causes illness. Those that believed that stress is the cause of illness were 50.1%, which is the highest percentage while others sources were 9.5%.

To corroborate the above result, a 42 year old woman in the FGD session indicates that;

*“The herbalists or pastors are capable of addressing the spiritual issues that people may have as regards illness. For cases of witchcraft, for example, only the spiritualist can address this problem. There are some problems/complications that can only be addressed by the spiritualists especially those involving witchcraft. For instances, a woman was taken to a spiritualist from my family three months ago by one of our relatives because she got married for over 14 years with no child. When they tried to understand the cause, it was the mother-in-law that was behind the scene in which no hospital can understand. As I am talking to you now, the woman is pregnant”*

Culture plays a major role in how illness and diseases are perceived in Nigeria as reflected in the work of Jane John-Nwankwo (2009) in a study she carried out to determine the effect of culture on health among the Igbo in Nigeria

**Table 3.** Distribution of respondents on the possible source of medical care they are likely to utilize

Health condition	Hospital/clinics %	Traditional Healing %	Faith/spiritual Healing %	Pharmacy/ Patent medicine store %	Hawkers of modern drugs %	Hawkers of native drugs %	Total %
Diarrhea	83.2	6.4	2.5	5.0	1.7	1.1	100.0
Malaria fever	62.7	4.8	5.9	19.9	2.8	3.9	100.0
Yellow fever	86.0	5.0	3.4	4.8	0.0	0.8	100.0
Typhoid fever	83.2	6.2	4.2	2.2	1.1	3.1	100.0
Antenatal care	90.5	4.2	5.3	0.0	0.0	0.0	100.0
Prolonged abdominal pains	76.8	12.0	8.1	1.7	0.6	0.8	100.0
Illness suspected to be induced by witchcraft	1.1	31.9	66.7	0	0	0.3	100.0

**Source:** survey, 2012

A closer examination of the table above indicates that the majority of the respondents were likely to utilize hospital/clinics for most of illness aside the illness indices by witchcraft. On the illness suspected to be induced by witchcraft 66.7% of the respondents were likely to make use of faith/spiritual healing home such as churches and mosques. Furthermore, some illnesses such as diarrhea, malaria fever, yellow fever, typhoid fever, etc were likely to be taken care at the hospitals and clinics.

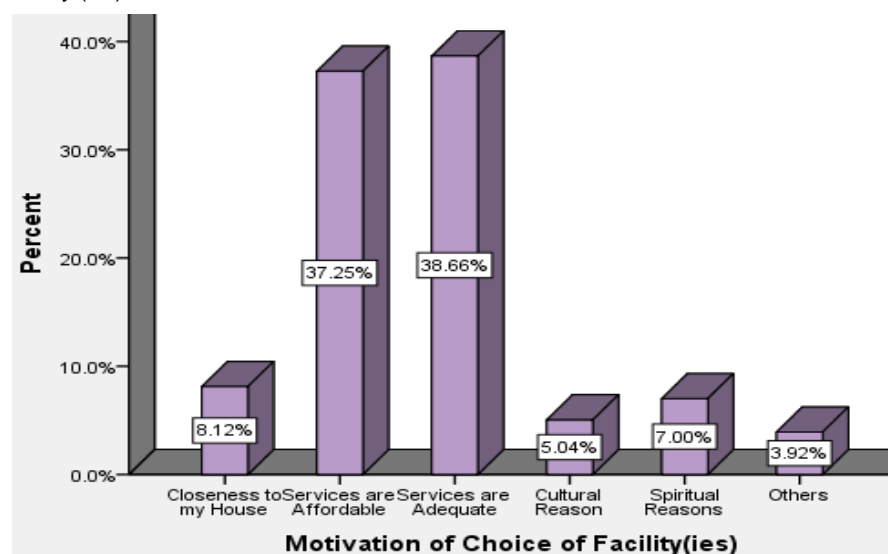
To support the above result, a 55 years old man in the FGD session indicates that;

*Though, I believe in the efficacy of the medicine and care given at hospitals, but herbal concoction is the best therapy for curing some illnesses I perceived as not ordinary, I take it to church pastor. He has been there for me and God is using him for us.*

Odebiyi (1980) established in her study that among the people of Ibadan, there are different perceptions of disease from different demographic and socio-economic status. She observed that this differential perception of disease within different socio-economic grouping influences their methods of treatment and consequently, the method of healthcare to utilize. It is difficult to identify which determinant are the most influential in the decision to utilize healthcare as culture, economic, accessibility, finances, belief, gender, social roles all play a part in the decision to utilize a choice of healthcare. Therefore a look at few of this determinant of healthcare utilization will be discussed. According to bourdillion (1990), an important factor affecting choice between different forms of treatment is their relative availability. It is no good hoping for a cure from some form of treatment, which is out of one's reach. Consequently, people more readily adopt a view of illness, which is compatible with forms of treatment available to them.

It is important to note that culture shapes not only illness treatment but also illness recognition, perception of illness severity and confidence in the efficacy of specific treatment for specific illnesses. For example, in many cultures, dementia in elderly is viewed as a normal process of ageing; thus it does not necessitate medical treatment, however, in united state, dementia is considered an illness requiring professional medical care (Ikels, 2002). As such, variance in healthcare utilization can result due to cultural knowledge and understanding of illness. If an individual is a member of a culture that considers the self as heteronomous, they are likely to have their course of treatment determined by people within their social network (Kleinman, 1980; Ikels, 2002). Conversely, if a culture considers the individual as autonomous, the decisions for treatment are more likely to be made by the individual. In those cultures that consider the self as heteronomous, an ill individual's treatment may be delayed as persons within their social network discuss treatment options (Janzen, 1978).

**Figure 4.** Distribution of respondents on what motivated them for their choice of health facility (ies)



Source: fieldwork, 2012

The pie charts above shows the result of the reasons why the respondents chose the place for the illness treatment. The highest percentage (38.7%) of the respondents indicated that they chose where they attend basically because of adequacy of the services rendered for them. 37.3% of the them attended their choice health facility because the service is affordable to them than any other facility. 8.1% chose the health facility because is very close to their houses. Also, 5.0% and 7.0 of the respondents indicated cultural reason and spiritual reasons for using a particular health facility respectively as the reason for using their preferred health facilities while those that used the health facilities due to other reasons were 3.9%.

The above finding is corroborated by a 42 years old pregnant woman in the FGD session who states that; *“It is good for pregnant women to patronise both hospital and church. To my own knowledge, hospital does not handle any spiritual issue. As for me, I make use of church for prayer and hospital for immunization and medical check-up.*

### FGD/Pregnant women

Another women in the FGD session also indicated that availability of health facilities influences the usage. This is stated below;

*“People prefer home delivery with the availability of TBA or delivery in the TBAs centres instead of doctors because they have no money to spend at Health Centres because if any woman wants to deliver in UCH now, she must prepare up to ₦20,000 if not more without complication but if it by caesarean, it will cost nothing less than ₦50,000 unlike TBAs that collect just ₦1,000 or less” (FGD/37 years/ women)*

To affirm the above finding, some literatures show that proximity to health facility aids the utilization of such a health facility. Erinosh (1998), Adeyemi (2000), Pearce (1980; 2001) UNFPA (2002 and 2004), Sabitu (2004) and Mekonnen and Mekonnen (2002), all indicated that there are differences in utilization of health care facilities and Maternal Health Care services between urban and rural areas. That is, utilization of health facility is generally influenced by residence (locality). There is high level of utilization of health facility among urban women as compared to their rural counterparts, due to availability of health facilities in the urban areas compared to rural areas, where in most cases the facilities are not available. A base-line study on Household in Borno state by Waziri (2004) revealed among others that 73% of the urban-based facilities provide antenatal care (ANC), and only 27% of rural based facilities provide antenatal (ANC) service. Similarly 65% of the facilities in urban areas provide Post natal care (PNC) and only 23% of the facilities in rural areas provide post natal care services.

## Socio-economic status and utilization of healthcare facility

The socio-economic status of a country will most likely reflect the health situation, generally, the better the economy indicators, the better the health condition. According to Daniel Buor (2005), in Ghana and some other developing countries in Africa, the low expenditure on health has affected the provision of physical and consumable health facilities. Low wages makes quality care inaccessible to a greater proportion of the population.

Economic factor is seen as affecting the availability of treatment, when the cost of treatment rises above what an individual can pay or above what he considers appropriate for the perceived seriousness of the illness, then that form of treatment effectively becomes unavailable to such a person.

This section will explore the impact of socio-economic status on utilization of health facility

**Table 4.** Distribution of respondents on proximity of health facilities

<b>How often do you visit your healthcare centre?</b>	<b>Frequency</b>	<b>Percentage %</b>
Regularly	75	21.0
Rarely	237	66.4
Never	45	12.6
<b>Total</b>	<b>357</b>	<b>100.00</b>
<b>Do you set money aside in case you or any member of your family falls ill?</b>	<b>Frequency</b>	<b>Percentage %</b>
Yes	119	33.3
No	238	66.7
<b>Total</b>	<b>357</b>	<b>100.00</b>
<b>Do you think the healthcare facility in your vicinity is standard?</b>	<b>Frequency</b>	<b>Percentage %</b>
Standard	100	28.0
Fairly standard	212	59.4
Not standard	45	12.6
<b>Total</b>	<b>357</b>	<b>100.0</b>
<b>Does your income serve as a determinant of the healthcare facility you use?</b>	<b>Frequency</b>	<b>Percentage %</b>
<b>What is the distance of the nearest healthcare facility to your house?</b>	<b>Frequency</b>	
Yes	160	44.8
No	197	55.2
<b>Total</b>	<b>357</b>	<b>100.0</b>
<b>Who takes care of your medical bills?</b>	<b>Frequency</b>	<b>Percentage %</b>
Spouse	82	23
Family member	115	32.2
Employer	80	22.4
Others	80	22.4
<b>Total</b>	<b>357</b>	<b>100.0</b>

Source: survey, 2012

An examination of what motivates the choice of the respondents on the health facility utilized, 21.0% of them regularly visited healthcare centre; 66.2% of the respondents rarely visited while majority, which is more than average while 12.6% of them never visited healthcare centre. Maybe those who did not visit healthcare centre were utilizing other health facilities such as TBAs, church and the like.

Furthermore, on whether the respondents set aside money for any eventuality, 33.3% of the respondents indicated that they set money aside for any occurrence while 66.7%.

In corroboration to the above result, one of the FGD participants indicated that;

*"It is difficult to patronize health centres when there is no money. I know that the health centre cannot be reached in case there is a problem but we don't pray for that. The TBAs are really trying and are more caring than the health workers. The TBAs collect small amount of money from us and they make sure that we are well. Even, many at times, we don't pay they and they still give us necessary care"*

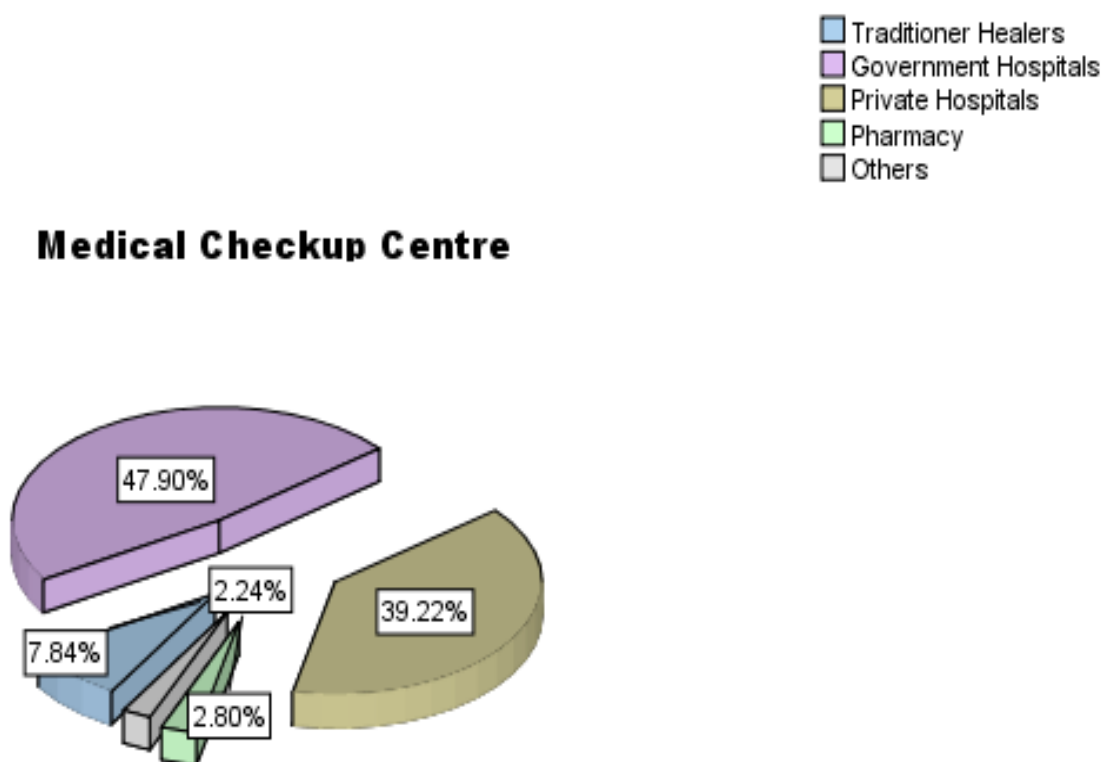
Majority of the respondents did not have money set aside for any future occurrence health wisely. This may be as a result of low level of income of poverty, which is endemic in Nigeria. As it is indicated in a literature, it is well known that increased income has a positive effect on the utilization of modern health care services (Elo, 1992; Fosu, 1994).

Moreover, to determine the standard of the health facilities around the respondents' vicinity, it is deduced that 28.0% of the respondents were of the view that the healthcare facilities around them were of standard; 59.4% of them indicated

that healthcare available around them is of fair standard while 12.6% showed that the available healthcare facilities are not of standard.

An examination on who took care of the respondents' medical bills, the data findings shows that 23.0% of the respondents' medical bills were taken care of by their spouse; family members took care of medical bills of 32.2% of the respondents. These people might be the dependants. 22.4% of the respondents' bills were taken care of by their employers; this is peculiar to the civil servants and some private employees that utilized National Health Insurance Scheme (NHIS).

**Figure 5.** Distribution of respondents on the centres visit for medical check up



Source: survey, 2012

In examining the centres where the respondents patronized for medical check up, the chart above indicated that the highest percentage of the respondents (47.9%), patronized government hospitals followed by private hospitals with 39.2% while 7.8% of the respondents visited Traditional healers/herbalist home, those that patronized Pharmacy was 2.8% and 2.2% of them visited others. Despite the high level of awareness about maternal and child high mortality rate, people still made use of TBAs' facilities. The reason for this is not far fetched; public health care facilities that are supposed to provide basic prevention and health promotion services that include immunization, health education, promotion of adequate nutrition and management of malaria, diarrhea, acute respiratory infection and other common illness are expensive, which makes the respondents make use of the available health facilities such as TBAs (Simpson 2004).

In supporting the above, literature indicates that users charges is a factor that discourage people from using health care facilities, According to Jegede (2010) over the years this has been the advantages of traditional medicine over modern medicine. While in traditional medicine, the charges are very moderate and low in most cases, and user have access to credit facilities with traditional healers being members of the same community, the reverse is the case in the modern medicine, while the physician sees him/herself as a professional, charges usually follow standardized rates as regulated by the medical council or the government or agency in charge of such health facility.

### Quality of healthcare facility

This seeks to examine the quality of healthcare facility in Igboora, Oyo State.

**Table 5.** Distribution of respondents on quality of health facilities patronized

<b>What is your view of the healthcare facility you patronize</b>	<b>Frequency</b>	<b>Percentage %</b>
Standard	110	30.8
Average standard	196	54.9
Below standard	51	14.3
<b>Are the practitioners qualified to handle ailment</b>	<b>Frequency</b>	<b>Percentage %</b>
Yes	276	77.3
No	81	22.7
<b>Total</b>	<b>357</b>	<b>100.00</b>
<b>Do you know if other healthcare facilities are better than the one in your vicinity?</b>	<b>Frequency</b>	<b>Percentage %</b>
Yes	136	38.1
No	221	61.9
<b>Total</b>	<b>357</b>	<b>100.0</b>
<b>Does the medication you are given work for you?</b>	<b>Frequency</b>	<b>Percentage %</b>
Yes	296	82.9
No	61	17.1
<b>Total</b>	<b>357</b>	<b>100.0</b>

**Source:** survey, 2012

Seeking the views of the respondents on the standard level of health facility patronized, it is deduced that 30.8% of the respondents were of the view that the healthcare facilities patronized were of standard; 54.9% of them indicated that healthcare facilities used are of average standard while 14.3% showed that the available healthcare facilities are below standard. Furthermore, an examination on qualification of the health practitioners handling ailment; majority, 77.3% of the respondents indicated that they were qualified while 22.7% in indicated no that they were not qualified.

Also, on whether the medication given at the health centres worked for them, 82.9% of the respondents indicated that it worked while 17.1% said no.

This was supported during the FGD by a 32 years old pregnant woman:

*“My husband preferred government hospital because of the belief that is well equipped with trained personnel and referral can easily be made to teaching hospital in case of any complication than other birth attendants such as TBAs”*

This section presents the results and interpretation of hypotheses that were designed to guide the study. Appropriate statistical tools such as chi-square and correlation were used in the process of testing the hypothesis. Each hypothesis was stated in both null and alternative forms to accommodate any possible outcome. Cross tabulation of variables like, Educational Qualification, Income and Occupation is presented for clarity of analysis.

### **Socio-demographic characteristics of the respondents and socio-cultural factors influencing utilization of health facilities**

This section will discuss the socio-demographic characteristics of the respondents and socio-cultural factors influencing utilization of health facility.

#### **HYPOTHESIS ONE**

##### **Alternative hypothesis H<sub>1</sub>:**

There is a significant relationship between people’s educational attainment and their utilization of healthcare facilities in Igboora community.

##### **Null hypothesis H<sub>0</sub>:**

Socio-cultural factors influencing utilization of people’s perceptions towards the utilization of healthcare facilities in Igboora community



**Table 6.** Distribution of Respondents Educational Level and Utilization of Health Facility

Educational Status	Have You Ever Used Any Health Facility Before		
	Yes	No	Total
No Formal Education	21 39.6%	32 60.4%	53 100.0%
Primary	45 65.2%	24 34.8%	69 100.0%
Secondary	36 67.9%	17 32.1%	53 100.0%
Post Secondary (Diploma, FCE)	59 72.8%	22 27.2%	81 100.0%
Degree	52 75.0%	18 25.0%	72 100.0%
Post Graduate	23 79.3%	6 20.7%	29 100.0%
Total	238 66.7%	119 30.8%	357 100.0%

$X^2 = 23.271$ ;  $df = 5$ ; Asymp. Sig. 2-sided = 0.000;  $P < 0.05$ ;  $R = -0.221$ ; Asymp. Sig = 0.000

Source: Fieldwork, 2012

Examining the relationship between the utilization of health facility and educational qualification, a closer examination of the table above indicates that there is strong correlation between respondent's educational qualification and the utilization of health facility.

The 2008 NDHS indicates that people with no education did not receive healthcare from trained personnel.

Table 4.7.1 shows that 39.6% of the respondents with no formal education had utilized health facility while 60.4% of them had never utilized health facility. Among those with primary school level, 65.2% said yes while 34.8% indicated that they had not utilized health facility. Respondents from secondary postgraduate level are all knowledgeable about the utilization of health facility. The result signifies that there is significant relationship between education and utilization of health facility. Hence, it can be deduced that the higher the level of respondent's education, the higher the utilization of health facility and vice-versa.

Furthermore, the correlation findings  $R = -0.221$  (0.000) illustrated that there was a negative significant relationship of -0.221. Hence, there was relationship between educational qualification and the utilization of health facility. The findings from the chi-square test coupled with the support of the findings obtained from the correlation result indicate that even when there was an association between the respondents with higher education and the awareness of health facility, it also pointed out that there was relationship between higher education and utilization of the use of health facility. respondents with higher educational qualification will have knowledge of utilization of seeking best health facilities in taking care of themselves and children and will get such utilization from 'significant others'

The findings above confirmed some literatures on the relationship between education and utilization of health facility. According to Grossman (1972), education and demand for health care are in general positively related. The educated are more cautious and conscious of their health and tend to use health service more. Of greater impact in determining the use of health facilities is the education of mothers (Caldwell, 1983; Caldwell, 1986; Caldwell, 1989; Swenson et al 1993; mensch et al., 1985; Raghupathy, 1996; Wong et al., 1987). Educated women tend to use health facilities more than the uneducated and the level of education of a woman and the number of living children also determine her use of pre-natal and antenatal services. Education is a catalyst in terms of acceptance of modern health care services (Jegade, 2011).

Erinoshio also states, non-literate Nigerians prefer to seek treatment in the compounds of traditional healers rather than in the premises of cosmopolitan western-style health care facilities largely because they find formalities like queuing for cards, registration, physical examination etc in the latter cumbersome, strange and seemingly alienating. This is in contrast to formally educated patients who find the environment of the cosmopolitan western-style healthcare facilities attractive, conducive and acceptable.

Education modifies beliefs about disease causation and cure and thus influences receptivity to modern health care services. Schooling enhances peoples' knowledge of modern health care services, improves their ability to communicate with modern health care providers, increases the value they place on good health, results in heightened demand for modern health care services as noted by Caldwell (1979), Schultz (1940) and Caldwell and Caldwell (1988)

## The relationship between income level and people's utilization of healthcare facilities in Igboora community

### HYPOTHESIS TWO

#### Alternative hypothesis $H_1$ :

There is significant relationship between income and people's utilization of healthcare facilities in Igboora community.

#### Null hypothesis $H_0$ :

There is no significant relationship between income and people's utilization of healthcare facilities in Igboora community

**Table 7.** Distribution of Respondents Income and Utilization of Antenatal Facility

Income	Have You Ever Used Any Health Facility Before		Total
	Yes	No	
N10,000 and below	58 42.0%	80 58.0%	138 100.0%
N11,000 - N20,000	77 74.8%	26 25.2%	103 100.0%
N21,000 - N30,000	50 90.9%	5 9.1%	55 100.0%
N31,000 - N40,000	39 86.7%	6 13.3%	45 100.0%
N41,000 and Above	13 81.3%	3 18.8%	16 100.0%
Total	237 66.4%	120 33.6%	357 100.0%

$\chi^2 = 64.624$ ;  $df = 4$ ; Asymp. Sig. 2-sided = 0.000;  $P < 0.05$ ;  $R = -0.360$ ; Asymp. Sig = 0.000  
**Source:** Fieldwork, (2012)

Table above shows the distribution of respondents by income and utilization of health facility. The result shows that among 138 of the respondents with monthly income of less than N 10,000, 42.0% of them made use of health facility while 58.0% of the respondents did not make use of it. Among the respondents with income between N11, 000-N20, 000, 74.8% of them made use of antenatal care facility while only 25.2% did not use it. Those that earned between N21,000 - N30,000 and N31,000 – N40,000 and made use of health facility were 90.9% and 86.7% respectively. By taking a critical look at the relationship between income and the utilization of health facility, it reveals that the low income earner have lower propensity to utilize healthcare facility. This may not be unconnected with their inability to pay, thus affecting the use and access to healthcare facility. An individual ability to use a particular health facility depends on his/her family income level (NDHS 2008). Thus, if there are sufficient resources available to a family, it has great influence on their use of healthcare facility as at when necessary.

This indicates that the lower the income, the lower the used of health facilities. The findings show that respondents with higher income will not have difficulty in making use health facility as those with lower income.

Moreover, the correlation result  $R = -0.360$  (0.000) also points out that there was a weak negative significant relationship of -0.360, which shows that there was a relationship between monthly income and the responses of the respondents that they had used health facilities in taken care of their health status during illness though there was a very weak negative significant relationship between the two variables. Although, this explains that monthly income can partially influence respondents to utilize health facilities, though, from the findings, respondents who earn lower income would find it difficulty to have used health facility as regards to their health and that of their family members for economic reason. Conversely, respondents with higher income appreciated ever used of health facility due to the fact that they can afford to go to modern health centres no matter the distance to their environment or community instead of remaining untaken care of during illness.

It is well known that increased income has a positive effect on the utilization of modern health care facility (Elo, 1992; Fosu, 1994). Husband's occupation can be considered a proxy of family income, as well as social status. Anderson et al (1956), Roth (1969), and Anderson et al (1963) cited in health sociology (2006) have highlighted the role of economic

factors in the utilization of health services, family income is an important determinant of the pattern of use of health care institution because family unit take cost of care into consideration before their members seek care among the available channels of care.

### The influence of cultural values of people on their utilization of healthcare facilities in Igboora community

#### HYPOTHESIS THREE

##### Alternative hypothesis H<sub>1</sub>:

There is a significant relationship between occupational location and people's utilization of healthcare facilities in Igboora community

##### Null hypothesis H<sub>0</sub>:

There is no significant relationship between occupational location and people's utilization of healthcare facilities in Igboora community

**Table 8.** Distribution of Respondents Occupational Status and Choice of Health facility Use

Occupational Status	Have You Ever Used Any Health Facility Before		Total
	Yes	No	
Employed	104 70.7%	43 29.3%	147 100.0%
Unemployed	66 55.5%	53 44.5%	119 100.0%
Self Employed	57 77.0%	17 23.0%	74 100.0%
Retired	3 33.3%	6 66.7%	9 100.0%
Student	7 87.5%	1 12.5%	8 100.0%
Total	237 66.4%	120 33.6%	357 100.0%

$\chi^2 = 17.377$ ;  $df = 4$ ; Asymp. Sig. 2-sided = 0.002;  $P < 0.05$ ;  $R = -0.004$ ; Asymp. Sig = 0.051  
Source: Fieldwork, (2012).

The table 8 above shows that 66.4% of the total respondents responded that they used health facility while 33.6% of the total respondents did not utilize health facility. 70.7% of the respondents that were employed did use health facility while 29.3% of the employed respondents did not make use of health facility. Furthermore, unemployed respondents that utilized health facility were 55.5% while those who did not make use of health facility were 44.5%. Also, 77.0% of the respondents that were self-employed made use of health facility while those who did not make use of health facility were 23.0%. The respondents who are retirees that utilized health facility were 33.3% while 66.7% of them said that they did not make use of health facility.

Differences in attitudes to modern health care facility by occupational groups depict occupation as a predisposing factor. Alternatively, viewing occupation as proxy to income, which enables acquisition of more and better health care, depicts it as an enabling factor (Fiedler, 1981). Occupation has been found to be positively associated with utilization of healthcare facility in many societies..

However, the chi-square result ( $\chi^2 = 517.377$  (0.002)) shows that there was no association between occupation of the respondents and those saying that they made use of health facility, the correlation result  $R = -0.004$  (0.051) shows that there is also relationship between the occupation of the respondents and utilization of health facility. This depicts that the occupations of the respondents had influence on whether the respondents made use of health facility or not.

To support the findings above, there was a study in rural Malawi to determine the factors on the individual, community, and health facility level that influence choice health facility, it was noted that cost of facility, educational level and lack of available facility among others were major issues. They confirm several issues that are common themes thought to affect women's choice in delivery location. In the first place, while many women attend ANC, not all of these women deliver at the health facility. Also, they noted that women feel that the nurses and health staff give them very little time,

that there is a socio-economic and cultural gap between the health worker and the client, and that there is little privacy Bullough, (2000).

## CONCLUSION

The study has been able to provide a strong relationship between socio-economic status and the utilization of health facility. From clear and meaningful understanding of the subject matter, the synthesis of Health Belief Model was employed in presenting the relationship between the dependent and independent variables.

Socio-economic status in a household has been identified as the most important predictor in the utilization of health facility which invariably dictate place of delivery. The study shows that respondents of low socio-economic status patronized TBAs and faith based organisations more frequently than government hospital. This indicates that more funds should be allocated to the health sector in order to improve the facilities and facility rendered.

The importance of patriarchal natures of virtually every developing country in which Nigeria is not an exception has also been reiterated by this study. The men initiate and control decision making in the household, the type of health facilities to be utilized, when and where to seek such facility is solely determined by the husband as the head of the family.

In all, the study has been able to reveal the importance of cultural, socio-economic status of the women and community as well as how availability and accessibility affect the use of healthcare and has equally reinforced the need for the intensification of awareness that is geared toward attitudinal change for better health of the people and mothers at large.

## RECOMMENDATIONS

In light of the literature review and study evidence, in order to reduce the rate of health mortality and achieve considerable improvement in the health and well being of Igboora people, the following recommendations are suggested:

1. There should be adequate public enlightenment with the involvement of traditional institution on the use of healthcare facilities. It is believe that this awareness will have long lasting effects on the perception and attitude of people towards utilization of health facility which invariably will reduce both health morbidity and mortality.
2. The health system must be strengthened, equipped with adequate facilities so that they are able to offer a continuum care from conception, through pregnancy and delivery.
3. There should be general improvement in the socio-economic status of the population at large including availability of free and compulsory education up to at least secondary level.
4. There is need to provide a solid infrastructure for the provision of facility which is comprehensive, culturally sensitive and which respond to the needs of child bearing women and their family. Element of this infrastructure should include empowerment, training and development.
5. In order to ensure that everybody has access to health facilities, there is need to establish maternity waiting homes, health centres in those areas where access to road and transportation are unavailable.
6. There is need for more training of traditional birth attendants (TBAs) to refer women with complication promptly. Attention must also be paid to the antenatal care facility with facilities for early detection of complication
7. Female education was associated with patterns of healthcare facility use. Educational levels of women need to be improved. In the sample studied, most of the women had either none or just primary education. Education affects healthcare facility use by changing ideas about health and attitudes toward risk prevention by using the healthcare facility.

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APPENDIX I  
RESEARCH QUESTIONNAIRE

Dept. of Sociology

Serial No: -----

Date: -----

Faculty of Social Sciences  
University of Ibadan, Ibadan

Dear Respondent

I am a Post graduate student of the Department of Sociology, University of Ibadan, carrying out a study on "Socio-economic status and utilization of healthcare facilities among people of Igboora community". This questionnaire is aimed at obtaining data on this study. I will therefore appreciate your cooperation in completing it.

You do not need to write your name on it. I assure you that it is purely for an academic purpose.

Please tick or answer questions as appropriate.

Thank you.

**SECTION A: BACA KGROUND INFORMATION OF RESPONDENTS**

1. Age \_\_\_\_\_
2. Sex: a. male [ ] b. female [ ]
3. Marital Status a. Single [ ] b. married [ ] c. widow [ ]  
d. separated/divorced [ ]
4. Religion a. Muslim [ ] b. Christian [ ] c. Traditional [ ]  
d. Others \_\_\_\_\_
5. Tribe a. Hausa [ ] b. Yoruba [ ] c. Igbo [ ]  
d. others \_\_\_\_\_
6. Education a. no formal education [ ] b. primary [ ]  
c. secondary [ ] d. post secondary (Diploma, FCE) [ ] e. Degree [ ]  
f. post graduate [ ]
7. Occupational Status a. employed [ ] b. Unemployed [ ] c. Self employed d. Others \_\_\_\_\_
8. Income from all sources  
a. N5, 000- N10, 000  
b. N11, 000- N20, 000  
c. N21, 000- N30, 000  
d. N31, 000- N40, 000  
e. N41, 000 and above

**SECTION B: PROXIMITY AND UTILIAZATION OF HEALTHCARE FACILITY**

9. Do you fall ill?  
a. Yes [ ] b. No [ ]
10. How often do you fall ill? a. Often [ ] b. Rarely [ ] c. Monthly [ ] d. Yearly [ ]
11. Do you know of any functioning healthcare facility? a. Yes [ ] b. No [ ]
12. Is the healthcare facility easily accessible to you and your family member?  
a. Yes [ ] b. No [ ]
13. What is the distance of the nearest healthcare facility to your house?  
a. 1-3km [ ] b. 3-5km [ ] c. 7-9km [ ] d. Above 10km [ ]
14. Does distance influence your decision to utilize health care facilities?  
a. Yes [ ] b. No [ ]  
b.

**SECTION C: CULTURAL VALUE IN THE UTILIZATION OF HEALTHCARE FACILITY**

15. What do you think cause illness? a. uncleanness [ ] b. Wrath from God [ ] c. Witchcraft [ ] d. Stress [ ]  
e. Others (specify) \_\_\_\_\_



16. Who determines your mode of health seeking behaviour? (tick as many as possible)
- a. Family members
- b. Extended family
- c. Religion
- d. Health promotion activities
- e. Environment
- f. Friends
- g. Others \_\_\_\_\_
17. Has there been any occasion during your ailment or that of family member when you had to use drugs other from the one prescribed by your health practitioner?
- a. Yes  b. No
18. If yes, what prompted the alternate use? \_\_\_\_\_
19. Does your religious affiliation influence your choice of healthcare? a. Yes  b. No
20. Does your cultural background influence your choice of health seeking behaviour? a. Yes  b. No
21. For each of the following conditions, please indicate the possible source of medical care you are likely to utilize by ticking ( )

Health condition	Hospital/clinics	Traditional Healing	Faith/spiritual healing	Pharmacy/ Patent medicine store	Hawkers of modern drugs	Hawkers of native drugs
Diarrhea						
Malaria fever						
Yellow fever						
Typhoid fever						
Antenatal care						
Prolonged abdominal pains						
Illness suspected to be induced by witchcraft						

22. What motivated you for the choice of facility(ies) above
- a. Closeness to my house
- b. Services are affordable
- c. Services are adequate
- d. Cultural reason
- e. Spiritual reasons
- f. Others (specify) \_\_\_\_\_

#### SECTION D: SOCIOECONOMIC STATUS AND UTILIZATION OF HEALTHCARE FACILITY

23. How often do you visit your healthcare centre?
- a. Regularly  b. Rarely  c. Never
24. Do you set money aside incase you or any member of your family falls ill?
- a. Yes  b. No
25. Do you think the healthcare facility in your vicinity is standard?
- a. Standard  b. fairly standard  c. Not standard
26. Does your income serve as a determinant of the healthcare facility you use?
- a. Yes  b. No

27. Who takes care of your medical bills?
- Spouse [ ]
  - Family member [ ]
  - Employer [ ]
  - Others (specify) [ ]
28. Which of this centres do you visit for medical check up
- Traditional healers [ ]
  - Government hospitals [ ]
  - Private hospitals [ ]
  - Pharmacy [ ]
  - Others (specify) \_\_\_\_\_
29. Does your educational attainment influence your choice of healthcare facilities? a Yes [ ] b. No [ ]
30. Does your place of work have a standard hospital where you receive treatment based on your status?
- Yes [ ] b. [ ]
31. If yes, which of the following facility will you visit when ill?
- Traditional homes [ ]
  - Healing homes [ ]
  - Hospitals [ ]
  - Patent vendors [ ]
  - Other (specify) [ ]

#### SECTION E: QUALITY OF HEALTHCARE FACILITY

32. What is your view of the healthcare facility you patronize?
- Standard [ ] b. Average [ ] c. Below standard [ ]
33. Are the practitioners qualified to handle ailment?
- Yes [ ] b. No [ ]
34. Do you other healthcare facilities are better than the one in your vicinity?
- Yes [ ] b. No [ ]
35. If yes, why? \_\_\_\_\_
36. How quickly are you attended to? \_\_\_\_\_
37. Does the medication you are given work for you?
- Yes [ ] b. No [ ]

**APPENIX II****FOCUS GROUP DISCUSSION GUIDE**

## INDIVIDUAL CHARACTERISTICS

Age

Marital Status

Education

Occupation

Religion

Section B

Proximity and utilization of healthcare facilities

What do you understand by healthcare facility?

How functional and equipped are the healthcare facility in your vicinity?

How many are located in your community?

How easily accessible are they?

Does distance to these facilities serve as an impediment?

Cultural value and utilization of healthcare facilities

What is your believe about health and healthcare facility?

Does your culture frown at the use of alternative healing practices?

Does your culture agrees with the fact that disease and illness is caused by germs?

What role does culture play in seeking good health?

Who determines your choice of health seeking behaviour?

Do you believe in western medication or you will rather treat yourself with traditional means?

Does your religion permit you to visit modern healthcare centres?

Socio-economic status and utilization of healthcare facility

How affordable are the healthcare facilities in your locality?

Are they private or government owned?

What is your view about the patronage of the healthcare facility? ( is it patronized only by affluent)

Does your occupation influence your choice of healthcare?

Do you see illness as undesirable?

Which do you prefer to visit between private and public healthcare facility

Does your family income determine your patronage?