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Social Determinants of Health Care Service Utilization among Women in Cross River State

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Abstract

The article examines social determinants of Health care services utilization among women in Cross River State, Nigeria. Specifically, the study examine the extent to which family size spousal literacy rate and cultural beliefs have a significant effect of the health wellbeing of women of reproductive age in Central Senatorial District of Cross River State, Nigeria. The article reviewed literature relevant to the variables while the theory of planned behaviour was employed for the study. The study employed a descriptive and cross sectional survey design with a sample of 300 women. The sample was lessened to 280 after field work. The purposive and convenience sampling were employed. The instruments used were questionnaire and in-depth interviews. Data was present numerically and tabular form. Hypotheses were tested with chi-square and Linear regression statistical tools at 0.05 level of significance. From the study's analysis, findings revealed that family size, spousal literacy level and cultural beliefs are core social determinant affecting women of reproductive age in Central Senatorial District of Cross River State, Nigeria. The study recommends amongst others that government of Cross River State and beyond should make effort to ensure maximum educational attainment opportunities for girl children as well as women of reproductive age in order to expose and enlighten them on those maternal health issues and ways of prevention. It was concluded that Cost of transportation, physical accessibility, language gap, attitude of health care workers/pregnant women, belief system have a strong influence on women of reproductive age
Keywords*: cultural belief, family size, health care services, reproductive age, spousal literacy*

Introduction

In almost all developing countries of the world, determinants of good health often reflects the physical conditions and social determinants or factors that influence the social environment where people are born, live, learn, play, work, and age (Agency for Healthcare

Research and Quality (AHRQ), 2008) These factors can be seen as being physical factors due to their impact on the social health functions outcome they contribute to the quality of life of a people. These factors are good precursor to good health because they serve as complex hubs for mans' quest for good health. As man strives for survival, good health is essential to every individual, community and the society at large especially women of reproductive age. This is because a healthy society is a wealthy society. Being healthy is not just the absence of diseases and infirmity but a state of complete physical, mental and social well-being (WHO, 2000). The importance of healthy living is of concern to all stakeholders and different levels of government being that when the citizenry are in good health, it brings about positive outcome in human development. Thus, the wealth of any society can be determined by the health status of its subjects. WHO, (1999) statement stressed that women are the mainstay of families, they are key educators of children healthcare providers, care givers of young and old alike, farmers, trader and often the main, if not the sole bread winners.

Bradley, (2002) supports the above view by stating that women in most families are the providers of healthcare and the health of children depends on the health of the mothers and her knowledge and practice relating to good health: Thus the quality of health care services available to women in any society or culture, determines the state of health of her child/children during pregnancy and after and birth. Women make important and diverse contributions to socio-economic development of the family and the nation as wives, mothers, healthcare providers, counselor, etc and as such their health should be given more attention (Ihejiamaizu, 2002). Research has shown that women suffer needless death and complication during pregnancy, childbirth and after childbirth due to several activities and actions that has serious implications for women of reproductive age in our societies.

Reproductive and sexual rights were first officially recognized at the international conference on population and development (ICPD) in Cairo in 1994 (Griffin, 2010). According to World Health Organization (WHO) sexual health is defined as "a state of physical, emotional, mental, and social well –being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships. As well as the possibility of having pleasurable safe sexual experience, free of coercion, discrimination and violence. For sexual health rights of person must be respected, protected and fulfilled" (WHO, 2006). Reproductive health implies that people are able to have a satisfying and safe sex life and that they have a capability to reproduce and the freedom to decide if, when and how often to do so. Protecting and promoting the SRH rights of the youth and empowering them to make informed choices is a key to their wellbeing (Asghar, 2010).

Nigeria is the most populous country in sub Saharan Africa. It's also has a very young population (National Demographic Health Survey, 2014). The majority of the population is below the age of 25 years, with 22% of the country's population between the age of 10 -19 years. Data on SRH outcomes in Nigeria highlights the importance of focusing on adolescents. At 5 maternal deaths per 100000 live births, Nigeria accounts for roughly 14% of the global burden of maternal mortality (NDHS). National data indicates that the national adolescent fertility rate in Nigeria is 122 births per 1000 women aged 15 – 19 years. It is as high as 171 births per 1000 women aged 15 -19 years. Investing in the health of young people is essential for the economic and social development of any nation.This

study set out to investigate the social dimension or determinants of health care services among women of reproductive age in Central Senatorial District of Cross River State, Nigeria

Statement of the problem

In Cross River State, it has been observed that, health inequality abounds among women or reproductive age due the cultural and social factors. Physical, cultural and social factors such as availability of resources to meet daily needs, such as educational and job opportunities, living wages, or healthful foods, social norms and attitudes of health workers, such as discrimination, lack of social support and communication, lack of exposure to mass media and emerging technologies, such as the Internet or cell phones, socioeconomic conditions, such as concentrated poverty, Quality schools, transportation options and residential segregation may have a negative effect of women access to reproductive health services.

In Nigeria according to Ebingha, Esther and Sharon-Rose (2015), a third world country that has suffered the epidemic of poverty which is a potent factor that depletes the health status of women, it is clear, that about 60% of Nigerians live below $ 1 per day that shows the health status of its citizenry. The adverse effects of these pictures are seen in the poor maternal health in developing countries especially in Nigeria. The implications may even be worse when some family factors related with poverty are involved. WHO (2012) in Ebingha et al., (2015) x-rayed that, everyday approximately 800 women die from preventable causes related to pregnancy and childbirth, 99% of all maternal death in developing countries and they are largely unpreventable. They further noted that the maternal mortality in developing countries is 240 per 100,000 births versus 16 per 100,000 in developed countries.

In Most areas in Central Senatorial District of Cross River State, like rural communities in Obubra, Boki, Etung and Riverine Abi communities the deplorable state of health centers for Antenatal services may have contributed to high maternal mortality in the area. In these areas, where health centers exist, there is usually low manpower, obsolete facilities and equipment and poor attitude of health workers to women receiving antenatal services (Mfongang, 2016). In line with this, Obionu, (2007) observed that due to these problem, pregnancy and childbirth complications may have been seen to be harmful to women of reproductive age. This mishap may have contributed to lack of services unitization by pregnant women to the high preference of Traditional Birth Attendant Services.

As a core component of developing nations, due to high cost of services and poor communication, maternal mortality has continued to be a public health problem aside the high rate of infant mortality in the area. In line with this, WHO (2014) reports stated facts on maternal health pointing out that, 289,000 women died in 2013 of complications during pregnancy, childbirth and after childbirth. Most of these deaths can be avoided if necessary preventions are taken on human action/activities that may not be healthy. UNICEF Report (2014), further revealed that "apart from losing about 2,300 under five year old children every single day Nigeria also loses 145 women of reproductive age. This makes the country

the second largest contributor of under-five and maternal mortality rate in the world Park, (2006) contended that more than 500,000 women died during child birth each year. These is due to ignorance, illiteracy, lack of money or income, limited language access, cultural belief, poor hygiene environment, food restriction amongst others which could have been prevented during maternal care. The Millennium Development Goals (MDGS), (2014) assets that maternal health improvement could set the pace for reducing 75% maternal mortality and achievement of reproduction health accessibility universally by 2015. But so this key objective has not been achieved. And despite National and Donor effort to improve the quality of health of women of reproduction age through the years by providing family planning service, free pre-natal and neo-natal care, health education, enlightenment programmes, etc. the problem still persist. It is against this backdrop the study is carried out to investigate social dimension or determinant of health care services utilization among women of reproductive age in Central District of Cross River State, Nigeria

Study objectives

The main objective of the study is to investigate social determinants of health care service utilization among women in cross river state. Subsidiary objectives seek to:

1. Examine the effect of family size on health care services unitization among women of reproductive age
2. Evaluate the impact of spousal literacy level on health care services unitization among women of reproductive age
3. Access the impact of cultural belief on health care services utilization among women of reproductive age

Theoretical framework
Theory of Planned Behaviour

The conceptual framework adopted for this study is the 'Theory of Planned Behaviour' (TPB). This theory was formulated by Ajzen and Fishbein in 1980. It first started as the Theory of Reasoned Action (TRA) which suggests that a person's behaviour is determined by his/her intention to perform the behaviour and that the intention in turn becomes a function of his/her attitude toward the behaviour and his/her subjective norm. The Theory of Planned Behaviour on the other hand predicts deliberate behaviour. It states that behaviour achievement depends on both motivation (intention) and ability (behaviour control). According to Ajzen (1991), the Theory of Planned Behaviour is comprised of six constructs that collectively represent a person's actual control over the behaviour.

1. Attitudes - This refers to the degree to which a person has a favourable or unfavourable evaluation of the behaviour of interest. It entails a consideration of the outcomes of performing the behaviour.
2. Behavioural intention - This refers to the motivational factors that influence a given behaviour where the stronger the intention to perform the behaviour, the more likely the behaviour will be performed.

3. Subjective norms - This refers to the belief about whether most people approve or disapprove of the behaviour. It relates to a person's beliefs about whether peers and people of importance to the person think he or she should engage in the behaviour.
4. Social norms - This refers to the customary codes of behaviour in a group or people or larger cultural context. Social norms are considered normative, or standard, in a group of people.
5. Perceived behavioural control - This refers to a person's perception of the ease or difficulty of performing the behaviour of interest. Perceived behavioural control varies across situations and actions, which results in a person having varying perceptions of behavioural control depending on the situation. This construct of the theory was added later, and created the shift from the 'Theory of Reasoned Action' to the 'Theory of Planned Behaviour'.
6. Perceived power - This refers to the perceived presence of factors that may facilitate or impede performance of behaviour. Perceived power contributes to a person's perceived behavioural control over each of those factors (Ajzen, 1991).

The Theory of Planned Behaviour (TPB) explains the individual's social behaviour by considering social norms as an important variable. The study states that attitude towards behaviour; subjective norms and perceived behavioural control, together shaped an individual's behavioural intentions and behaviours (Fishbein&Ajzen, 2010). Accordingly, the theory explains that increasing knowledge on reproductive health of women alone does not help to change behaviour but campaigns that aim at attitude, perceived norms and control in making the change, have better result. Based on the above theory, secondary school students' beliefs/perception about HIV/AIDS produces favourable or unfavourable attitude towards reproductive health and this can lead to formation of a behavioural intention. Generally, the more favourable the attitude and subjective norm, and the greater the perceived control, the stronger should be the persons' intention to perform the behaviour in question (Ajzen, 1991).

In this study, women reproductive health is dependent on adequate knowledge, good attitude and adequate sources of information among spouses. If husband or spouses have good knowledge to the social defects of women reproductive lives or health, it will influence their attitude positively. Therefore, based on the above framework, it is expected that individuals in various families or women acquire and retain useful information about the importance of women reproductive health to avert the rate.

Literature review

According to ICDP program of Action (1994) the components of reproductive health include the following:
- Safe motherhood comprising prenatal care, safe delivery, essential obstetric care, perinatal and neonatal care, postnatal care and breastfeeding.
- Family planning information and services
- Prevention and management of complications of abortion
- Provision of safe abortion services where the law permits

- Prevention and management of reproductive tract infections, especially sexually transmitted infections (STIS), including HIV infection. Acquired Immunodeficiency Syndrome (AIDS).
- Promotion of healthy sexual maturation as from pre-adolescence, responsible and safe sex throughout the lifetime and gender equality.
- Elimination of harmful practices, such as female genital mutilation (FGM), premature marriage and domestic and sexual violence against women.
- Management of non-infectious conditions of the reproductive system, such as genital fistula, cervical cancer, complications of female genital mutilation and reproductive health problems associated with menopause.

The size of any family which is seen as the number of children within a given family determines the quality of control and interaction of parents with their children (Obi, 1995). Researchers on the influence of family size on maternal health reveals that the presence of large numbers of people in the family has an adverse effect on member's health especially women of reproductive age. McLeren, (2005) concluded that, having many children implies having many troubles, considering the fact that the women may not have any house help and most times the burden of having to cook, clean the house and care for children rest solely on her. The adverse effect occurs when women due to a lot of stress of managing the home face complication during pregnancy and child birth and the situation may even lead to death.

Arthur, (2006) observed that, a large family comes with so many implications such as poor healthy, low income and status, low level of education, pressure on environmental resources due to over population, poor child care and poor nutrition. Arthur, (2006) further noted that, women in small families 1-6 children (parent inclusive) visit the hospital for check-up regularly, such that most of the sickness such as malaria and other minor health challenges can be avoided with basic preventive measures thereby improving their health. But women in large family do not visit the hospitals for medications, prenatal or post-natal services due to lowincome, lesser spousal support in terms of income. This leads to poorer outcome in women's health. Blake, (2004) examined the effect of large family size on maternal health. In his study he focused on the number of children one woman has and the health outcome. To him, large family greatly influences women's health leading to high blood pressure, hypertension, lower weight children, etc. Thus the more the number of children a woman bears, the increase in hypertension, blood pressure and so on. Educational background of women affects the outcome of maternal health leading to still births and even deaths of mothers or their babies. Down through the years many studies have shown that one of the key to improve survival chances for children in developing countries is the educational level of their mothers. Surveys show that mothers who had seven or more years schooling, were subject to less risk of complication or death than those mothers who had no schooling at all.

Etobe, (2005) opines that, education enables women to conceptualize family size and reproduction as being an aspect that is separated from tradition and culture and as something which is within their control. Education gives women knowledge of the possibility and means of planning birth, the power to chart their own diet and seek Medicare. It also allow for the dissemination of knowledge regarding family planning. Lim, (1991) as cited in Etobe, (2005) observed that education increases the chance that, women

will find work that pays better and has career potential, thus enabling women to achieve good health through the degree of economic dependences. Being financially empowered women could undergo medical investigation and treatment meted out for them during pregnancy, or child birth with or without the support of their spouse.

Arthur, (2006) sees illiteracy as one of the factors that influence the health of women of reproductive age. He observed that women who are educated are likely to visit the hospital for checkup or medication and delivery while those who are uneducated don't visit the hospital but patronize the traditional birth attendant. Lack of education among women of reproductive age undoubtedly contributes to the widespread of self-neglect of many women. They tend to be inattentive to their health needs illness and fail to seek care. It is lack of education and its correlates-ignorance amongst others that often make women passive to accept the conditions of life that are meted out to them in the name of culture and tradition. On this note Nijikan, (1994) concluded that low level of education together with other factors exert a strong influence on the health of women of reproductive age especially during pregnancy, delivery and after child birth.

Baumirind, (2004) suggested that, family variables such as parents level of education have been regarded as a predicator of women of reproductive age attaining good health. A woman's educational background is part of those variables that influences her health outcome during pregnancy, childbirth, etc. He further noted that attending a higher level of education may give them access to resources such as income, information on health. Thus influencing the health outcome and reducing the risk of complication and maternal mortality. Sharma, (2004) revealed that, educated women realize the benefit of maternal health services and family planning method than the illiterate women. He also stressed that, with improved educational level of women of reproductive age, there is bound to be an improve outcome in maternal health. Ratzan, Filerman & Lasar, (2002) assert that, "a mothers educational level influences her health". Women's chances of surviving during pregnancy and childbirth usually depend on the mothers' educational level. Women's education is interrelated with many other health determinant compared with less educated women, the educated woman is more likely to marry at an older age and consequently to have her first birth later. She is more likely to use family planning and to want have fewer children-all this factors bring about a better maternal and child health

Socio-cultural norms and taboos regarding women sexual behavior are the most significant factors influencing women perception of reproductive health. Also most women own fear and shame, judgmental attitudes of services providers and disapproval from spouses and community gate-keepers influence their perception on SRH (Kennedy, Bulu, Harris, Humphregs, Malverus & Gray 2013; UNICEF, 2011). The result from a study in Pakistan showed a low level of perception amongst more than half of the husbands/caregivers (58%) and women (55%). Similarly, the qualitative findings also highlighted a low perception of ASRHR among all adolescents, teachers and few doctors and the study also indicated that 71% of adolescents and 64% of parents/caregivers, teachers, siblings/cousins and the media (Igbal, Zakar & Fiscler 2017). The view that men should be the sole decision makers on sexual issues was held by some adolescents (Yendaw, Yeboah & Bagah 2015). Another study conducted among in-school adolescents in Bangladesh to explore ASRH knowledge and perception also indicates that the boys and girls who participated in the study had better knowledge and perception about AIDS in

comparison to other issues related to women reproductive health with a possible reason that AIDS is included in the secondary school curriculum (Aktar, Sarker & Jenkins 2014).

In Nigeria studies indicated low perception of women of sexual and reproductive health for example, in a study conducted in Akwa Ibom State family planning services though available, were not well-utilized and most women who participated in the study were not worried about unplanned pregnancy and consequences of unprotected sex (Isonguyo & Adindu 2013). In another study conducted in Cross River and Kogi States, respondents had unrealistic perceptions of their own HIV risk. Among youth who are sexually active, most did not use condom at last sex during the past 12 months, or at sexual debut. And most respondents have not been tested for HIV, though they know the value of the test and where to get one. These are serious risk factors that must be addressed, along with multiple and concurrent sexual partnerships and inter-generational sex between young women and older men (Diala, Olusimi, Harries & Feyisetan, 2011). In Nigeria, data also highlight low perception to SRH services especially for unmarried girls. Only 10% had visited a health facility or doctor for SRH services, with the largest proportion (15%) being girls aged 15-19 seeking contraception, abortions, pregnancy, or STI related services (World Bank, 2015).

Examples of social and physical factors affecting women of reproductive age accessing health care services include:

- ➢ Availability of resources to meet daily needs (e.g., safe housing and local food markets
- ➢ Access to educational, economic, and job opportunities
- ➢ Access to health care service
- ➢ Quality of education and job training
- ➢ Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities
- ➢ Transportation options
- ➢ Public safety
- ➢ Social support
- ➢ Social norms and attitudes (e.g., discrimination, racism, and distrust of government)
- ➢ Exposure to crime, violence, and social disorder (e.g., presence of trash and lack of cooperation in a community)
- ➢ Socioeconomic conditions (e.g., concentrated poverty and the stressful conditions that accompany it)
- ➢ Residential segregation
- ➢ Language/Literacy
- ➢ Access to mass media and emerging technologies (e.g., cell phones, the Internet, and social media)
- ➢ Culture
- ➢ Natural environment, such as green space (e.g., trees and grass) or weather (e.g., climate change)
- ➢ Built environment, such as buildings, sidewalks, bike lanes, and roads
- ➢ Worksites, schools, and recreational settings
- ➢ Housing and community design

➢ Exposure to toxic substances and other physical hazards
➢ Physical barriers, especially for people with disabilities
 Aesthetic elements (e.g., good lighting, trees, and benches)

By working to establish policies that positively influence social and economic conditions and those that support changes in individual behavior, it is important to improve health for large numbers of people in ways that can be sustained over time. Improving the conditions in which we live, learn, work, and play and the quality of our relationships will create a healthier population, society, and workforce

Hypotheses of the study

1. Family size does not have any effect on health care services unitization among women of reproductive age
2. There is no significant influence of spousal literacy level on health care services unitization among women of reproductive age
3. Cultural belief have no significant effect on health care services utilization among women of reproductive age

Materials and method

The research design adopted for the study is the descriptive and cross sectional survey design. This is because a cross sectional study is a type of observational study that involves the analysis of data collected from a population of a representative sample or subset at one specific point in time.The study area is the Central Senatorial District of Cross River State (Nigeria).The Central Senatorial District, as the name implies occupies the central position of the state with six (6) Local Governments Areas namely: Abi, Yakurr, Obubra, Ikom, Boki and Etung Local Government areas respectively.

The population of study was limited to only women of reproductive age between 18 to 45 years. This was done by asking participants their age and using antenatal record book. Data to determine the population of women of reproductive ageis unknown. However, the study sample waspurposively selected based on records of women utilizing antenatal services during clinic days. The study was conducted within the space of two months with a sample of 300 women. These women formed the population and sample for the study. The sample was selected across ten (15) health centers or facilities across five local government areas-Yakurr, Abi, Obubra, Etung and Boki Local Government Areas of the state.In each health facility or health center selected for the study, thirty women undergoing antenatal services were selected. In each local government area, 40 women were selected as representative sample for the study. The instrument used for the study was questionnaire titled-Questionnaire for Social Determinants of Health Care Service Utilization among Women (QSDHCSUW) and Interview Guide for Social Determinants of Health Care Service Utilization among Women (IGSDHCSUW). Items in the questionnaire include:
1. Family size of women
2. Number of children
3. Level of education of spouse

4. Level of awareness to caesarean session
5. Cultural/religious belief
6. Level of patronage of Tradition Birth Attendants(TBA)

The questionnaire was in both multiple option scale, the four point Likert scale of Agree, Strongly Agree, Disagree and Strongly Disagree as well as the scale measurement of Yes and No. For the purpose of this study, the researcher used primary data and secondary data through the questionnaire and the Interviews conducted. Hypotheses were tested with regression and chi-square

Results

Hypothesis One

Family size does not have any effect on health care services unitization among women of reproductive age. Accept Ho if calculated x^2 value is ≤ 6.74 at 2 degrees of freedom (df) and 0.05 level of significance. Otherwise, reject the Ho and accept the Hi. Accept the Ho if the critical x^2 value of 6.74 is greater than the calculated value of 22.389 is at 0.05 level of significant and 1 degree of freedom otherwise reject the Ho and accept the Hi. To test hypothesis one, chi-squared Analysis was used in testing the hypothesis or analysis of the two variables- family size and health care services utilization of women of reproductive age. From the analysis, the calculated x^2 value of 22.389 was tested in comparison with the x^2 table value of 6.74 at 0.05 level of significance. The calculated x^2 value was greater than the critical x^2 values. Hence the result was statistically significant (the result therefore means that family size have significant effect on health care services unitization among women of reproductive age.)

Table 1: Chi-squared analysis for statistical effect of family size on health care services unitization among women of reproductive age (N=280).

family size on health care services unitization among women of reproductive age					
			health care services unitization among women of reproductive age		Total
			POSITIVE	NEGATIVE	
Family size	1 to 3 children	Count	36	27	63
		Expected Count	36.5	26.6	63.0
	4 to 7 children	Count	97	46	143
		Expected Count	82.7	60.3	143.0
	8 to 11 children	Count	27	31	58
		Expected Count	33.6	24.4	58.0
	12 and above	Count	2	14	16
		Expected Count	9.3	6.7	16.0
Total		Count	162	118	280
		Expected Count	162.0	118.0	280.0

Source: field survey 2020

Decision

Hypothesis one above was tested using chi-square statistical to determine the significant effect between family size and health care services unitization among women of reproductive age. From the test, it showed that family size ranging from 1 to 3 children, 4 to 7 children, 8 to 11 children and 12 children and above without cumulative income to cater for this family may place a financial burden on the women to utilize further services when she is pregnant. Consequently, it was concluded that the effective utilization of health care services for women of reproductive age is dependent of the income status of the family the cater for the number of children couple may have. From this findings, there was statistical significance between these variables since the calculated value was greater than the table value at 0,05 level of significance.

Hypothesis Two

In the null form, hypothesis two states that there is no significant influence of spousal literacy level on health care services unitization among women of reproductive age. The independent variable here is the spousal literacy levelwhile the independent variable is health care services unitization among women of reproductive age. This hypothesis was tested using linear regression. The result obtained is as shown in table 3. The correlation coefficient of 230 was obtained which means that there is moderate positive relationship between the spousal literacy level and health care services unitization among women of reproductive age. The coefficient of determination of 2.30 was obtained which means that spousal litracy level for 053 percent of the variation in determining good health care services to women of reproductive age. The moderately high positive relationship means that the more the literate a spouse is, the more likely they will adhere to strick medcal advices and adopt famly planningg when the need arises. The r-square value of 2.55 percent suggests that utilization of health care services by women of reproductive age accounted is possible whrn the spouses are well educated in the study area. Result also revealed that spousal literacy level have a strong influence on women's health with a result influence of F 15.533 at 4-276 of $p < .05$).

The beta coefficient of .230 indicates that spousal literacy level influences health care services unitization among women of reproductive age$(\beta = ..230$, t 13.108, $p < .05$). The adjusted r-square, which is a measure of effect size, shows that 30.4 percent of the variance in litracy level of spouses was explained by the quality and prompt attendants at antenatal clinics. Furthermore, since the calculated r(0.230) is greater than the critical r(.0.85) with 396 degrees at the 0.05 level of significance. This means that the null hypothesis is rejected. Therefore, spousal literacy levels have a strong influence on the health care services unitization among women of reproductive age

Table 2: Influence of spousal literacy level on health care services unitization among women of reproductive age

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.230a	.053	.043	.39886

a. Predictors: (Constant), highly literate, less literate, literate

ANOVAª

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	3.521	4	.880	15.533	.000b
	Residual	62.839	276	.159		
	Total	66.360	280			

a. Dependent Variable: health care services utilization

b. Predictors: (Constant), highly literate, less literate, literate

Coefficientsª

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.469	.112		13.108	.000
	Highly literate	.283	.173	.221	1.632	.103
	Less literate	-.235	.167	-.194	-1.405	.161
	Literate	-.022	.046	-.026	-.465	.642
		-.238	.055	-.218	-4.341	.000

a. Dependent Variable: health care services utilization

Significant at 0.05, df = 280, critical r = .087, critical F = 15.533

Hypothesis three
Cultural beliefs have no significant effect on health care services utilization among women of reproductive age. In this hypothesis, the Independent variable is Cultural beliefs while the dependent variable is health care services utilization among women of reproductive age. To test the hypothesis,the linear regression model statistics was employed to test the effect of cultural beliefs on health care services utilization among women of reproductive age asshown in Table 4.3a from the first model summary result, it is statistical that there is a strong effect (R = 0.871a) ofcultural beliefs on health care services utilization among women of reproductive age. The adjusted R square (R. Square =.758) also showed thatcultural beliefs have on health care services utilization among women of reproductive age (Adjusted R2 = 0.758) of the total variation of the independent variable improves the health of women. A similar significant result difference was obtained in the ANOVA model which also showed a significant F-ratio of 1249.210 which was calculated against the critical F-ratio of 3.053 at 0.05 levels of significances and 1 degree of freedom.

The last tables of result from the coefficient regression analysis further revealed that there is significant effect of cultural beliefs on health care services utilization among women of reproductive age in Table 4.3c showed that a strong effect exists on Cultural beliefs have no significant effect on health care services utilization among women of reproductive age (β = .1199, t = 7.492 P<.05). Thus, we reject H0 and accept the H1. This implies that there is significant effect of cultural beliefs on health care services utilization among women of reproductive age

Table 3: Cultural beliefs effect on health care services utilization among women of reproductive age

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.871a	.758	.758	.15721

a. Predictors: (Constant), belief in male child preference, belief against cesarean session, belief against family planning and patronage of TBAs as best services outlets

ANOVAa

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	30.874	1	30.874	1249.210	.000b
	Residual	9.836	1199	.025		
	Total	40.710	1199			

a. Dependent Variable: health care service utilization
b. Predictors: (Constant), belief in male child preference, belief against cesarean session, belief against family planning and patronage of TBAs as best services outlets

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	.202	.027		7.492	.000
	belief in male child preference, belief against cesarean session, belief against family planning and patronage of TBAs as best services outlets	.801	.023	.871	35.344	.000

a. Dependent Variable: health care service utilization

Discussion of findings

From the study, findings from the analysis revealed that language access of women of reproductive age, income level of women or family poverty, belief system arising from large family size, male child preference and avoidance of family planning have a significant effect on women of reproductive age. From the analysis, findings revealed that, the major setback of social determinant or factors affecting women of reproductive age could be access roads to health care centers among those in rural areas, cost of transportation, attitude of health care worker/pregnant women alike, family size and systems are core determinant of health care services utilization of women or reproductive age. This finding corroborate McLeren, (2005) observations, who opines that, having many children implies having many troubles, considering the fact that the women may not have any house help and most times the burden of having to cook, clean the house and care for children rest solely on her. The adverse effect occurs when women due to a lot of stress of managing the home face complication during pregnancy and child birth and the situation may even lead to death.

Arthur, (2006) also observed that women in large family do not visit the hospitals for medications, prenatal or post-natal services due to lowincome, lesser spousal support in terms of income. This leads to poorer outcome in women's health. Blake, (2004) noted that large family greatly influence women's health leading to high blood pressure, hypertension, lower weight children, etc. Thus the more the number of children a woman bears, the increase in hypertension, blood pressure and so on. Educational background of women affects the outcome of maternal health leading to still births and even deaths of mothers or their babies. Etobe, (2005) opines that, education enables women to conceptualize family size and reproduction as being an aspect that is separated from tradition and culture and as something which is within their control. Education gives women knowledge of the possibility and means of planning birth, the power to chart their own diet and seek Medicare. It also allow for the dissemination of knowledge regarding family planning. Lim,

(1991) as cited in Etobe, (2005) observed that education increases the chance that, women will find work that pays better and has career potential, thus enabling women to achieve good health through the degree of economic dependences. Being financially empowered women could undergo medical investigation and treatment meted out for them during pregnancy, or child birth with or without the support of their spouse.

Furthermore, Arthur (2006) sees illiteracy as one of the factors that influence the health of women of reproductive age. He observed that women who are educated are likely to visit the hospital for checkup or medication and delivery while those who are uneducated don't visit the hospital but patronize the traditional birth attendant. Lack of education among women of reproductive age undoubtedly contributes to the widespread of self-neglect of many women. They tend to be inattentive to their health needs illness and fail to seek care. It is lack of education and its correlates-ignorance amongst others that often make women passive to accept the conditions of life that are meted out to them in the name of culture and tradition. On this note Nijikan, (1994) concluded that low level of education together with other factors exert a strong influence on the health of women of reproductive age especially during pregnancy, delivery and after child birth.

Socio-cultural norms and taboos regarding women sexual behavior are the most significant factors influencing women perception of reproductive health. Also women own fear and shame, judgmental attitudes of services providers and disapproval from husband and community gate-keepers influence their perception on SRH (Kennedy, Bulu, Harris, Humphregs, Malverus & Gray 2013, UNICEF, 2011). The result from a study in Pakistan showed a low level of perception amongst more than half of husbands/caregivers (58%) and pregnant women (55%). Similarly, the qualitative findings also highlighted a low perception of ASRHR among all adolescents, teachers and few doctors and the study also indicated that 71% of adolescents girls and 64% of parents/caregivers, teachers, siblings/cousins and the media (Igbal, Zakar & Fiscler 2017). The view that men should be the sole decision makers on sexual issues was held by some adolescents (Yendaw, Yeboah & Bagah 2015). Another study conducted among in-school adolescents in Bangladesh to explore ASRH knowledge and perception also indicates that the boys and girls who participated in the study had better knowledge and perception about AIDS in comparison to other issues related to adolescent reproductive health with a possible reason that AIDS is included in the secondary school curriculum (Aktar, Sarker & Jenkins, 2014).

Baumirind, (2004) suggested that, family variables such as husband or spousal level of education have been regarded as predicators of women of reproductive age attaining good health. A woman's educational background is part of those variables that influences her health outcome during pregnancy, childbirth, etc. He further noted that attending a higher level of education may give them access to resources such as income, information on health. Thus influencing the health outcome and reducing the risk of complication and maternal mortality. Sharma, (2004) revealed that, educated women realize the benefit of maternal health services and family planning method than the illiterate women. He also stressed that, with improved educational level of women of reproductive age, there is bound to be an improve outcome in maternal health. Ratzan, Filerman & Lasar, (2002) assert that, "a mothers educational level influences her health". Women's chances of

surviving during pregnancy and childbirth usually depend on the mothers' educational level. Women's education is interrelated with many other health determinant compared with less educated women, the educated woman is more likely to marry at an older age and consequently to have her first birth later. She is more likely to use family planning and to want have fewer children-all this factors bring about a better maternal and child health

From the interview, findings revealed that, apart from most men refusal to family planning, most women or reproductive age suffer due to cultural believes and traditions that places value on the male child. This in effect could lead to death or have caused the death of most women. The insistence to have a male child endangers the health of the women especially for women who may have undergone cesarean session for more than 3 or 5 times. This insistence is usually against medical advice for stoppage of conception. During the interview, health workers in the area avers that, almost all cultures within the study area belief that family planning is bad, hence, it only take an educated man to allow family planning services. This in effect also endangers the life of the women. Other factors that have a negative effect on the women could be physical accessibility, cost of transportation, language barrier and patronage of Traditional Birth Attendant. Finally, the cultural belief that, cesarean session is bad also places a burden on the women.

Recommendations

From the above analysis, the following recommendation are made or suggested

i.   Since knowledge of women toward reproductive health is low in the study area, there is need for sex education and awareness creation at homes or town halls to educate women on this subject matter

ii. There is also the need for spouses to have sex education and counseling sessions before marriage

iii. Health care professionals and relevant stakeholders should design and strengthen better family reduction programmes that would be well targeted and result in a remarkable decrease in maternal health challenges.

iv. Government of Cross River State and beyond should make effort to ensure maximum educational attainment opportunities for girl children as well as women of reproductive age in order to expose and enlighten them on those maternal health issues and ways of prevention.

v. Health professionals and ministry of health should endeavor to make policies enforceable against religious teachings on contraception. Since cost has been identified as one of the major factor negatively influencing reproduction health of adolescent, there should be free distribution of contraceptives, HIV/AID counseling and ensure hygienic environment for women.

Conclusion

From the research questions answered, the study revealed that majority women have low level of knowledge of their reproductive health in the study area. The cumulative level percent from the research analysis and findings showed that majority of the women patronizes Traditional Birth Attendants (TBAs) than government approved health centers for antenatal and pots-natal services. The cost of transportation, physical accessibility, language gap, attitude of health care workers/pregnant women, belief system have a strong

influence on women of reproductive age. Also male child preference endangers the life of women of reproductive age due to lack of family planning. From the analysis findings revealed that factors such as religion, unhygienic environment, low level of spousal education, high level of abortion, cost and age influence women reproductive health

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