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SOCIO-CULTURAL DETERMINANTS OF MATERNAL HEALTH CARE SEEKING BEHAVIOUR IN SEME SIDE OF BENIN REPUBLIC

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ABSTRACT

Research on maternal health was conducted among the residents of the *Seme* border community in republic of Benin to determine the available maternal health care services in the community and the level of accessibility to residents, to find out the pattern of the maternal health seeking behaviour and to examining the relationships between the socio-cultural characteristic and maternal health care seeking behaviour in the area. The major instruments used were structured questionnaire, key informant interview and non-participant observation method. The study established that there are a considerable number of maternity hospitals and health centers in the community, many of which are privately owned. Residents tend to have a terrible level of access to the maternity services as there is no enough publicity either through word of mouth referrals or information from social service workers. The study also discovered that a very large proportion of the residents of the area use both the western maternal health care services and traditional substances. Due to the setting of this border area, a central cultural connotation is not prominent; hence the cultural influence on the maternal health seeking behaviour is not general to the society as a whole. Though many residents use the western (private and public) services, factors like husbands approval, money for treatment, and personal cultural preferences still had negative effects on the maternal health seeking behaviour in the area.

Keywords: Maternal Health, Health Seeking Behaviour and Socio-Cultural Determinants

1. INTRODUCTION

As custodians of family health, women play a critical role in maintaining the health and well-being of their communities. The health of families and communities are tied to the health of women – the illness or death of a woman has serious and far-reaching consequences for the health of her children, family and the community at large. Becoming pregnant for some women in the world today is a cause, not for joy but for fear, not a celebration of new life but an acceptance that death in childbirth is a very real possibility. Pregnancy-related complications are a leading cause of death among women in the reproductive ages (15–49) in developing countries

(Ajala, Sanni and Adeyinka, 2005). In Kenya, the incidence of maternal mortality is estimated to be 365 deaths per 100,000 live births (MOH, 2007). Some Sub-Saharan African countries record extremely high maternal mortality rates, for example, Mali, 1750; Somalia, 1100; Ghana, 1000 deaths per 100,000 live births (MOH, 2009). These are in contrast to lower rates in developed countries like 5 in Sweden; 3 in Denmark, Norway and Israel (Population Action International, 2010).

There are over half a million maternal deaths per year, 99% of which are from developing countries (86% in Sub-Saharan Africa and Asia) and for each of these deaths, an estimated further 30 women will become disabled, injured or ill owing to pregnancy. Pregnancy is a life threatening condition in the majority of developing countries, and its outcome reduces the life expectancy of childbearing women. UNICEF, UNPFA and WHO (2000) indicated that 37,000 maternal deaths occurred in Nigeria in 1999 only. It has also been indicated that maternal mortality ratio varied from 700 to 1,500 per 100,000 live births in 2005 (State of Nigeria Health, 2006). A most recent estimate in 2010 showed that over 52,000 women died of pregnancy complications in 2008 in Nigeria (Dada, 2010). According to the Demographic Health Survey (NDHS) report, Nigeria (2011) maternal mortality, in the seven years preceding the survey was 545 per 100,000 live births. Complications of pregnancy and childbirth cause more deaths and disability than any other reproductive health problems (EC/UNFPA, 2011). According to the Demographic Health Survey of Republic of Benin, the maternal death rate is estimated to 397 maternal deaths per 100 000 live births for the period 1999-2006.

Health seeking behavior highlights factors and demonstrates the complexity of influences on an individual's behavior about his health at a given time and place. However, in addition to the focus on the individual as a purposive and decisive agent, there is a growing concern that factors promoting 'good' health seeking behaviors are not rooted solely in the individual, they also have a more forceful, collective, interactive elements. Health and disease state as much as it affects the individual, is greatly subjective to the socio-cultural pattern of the community to which the individual belongs.

There have been notable researches on some international borders that centers on health (Asegbe, 2009 and Sakpo, 2011) but it is not the same for Africa. Also it is evident from studies that migration has an effect on the health status and behaviors of migrants. For example, it is said that the association of migrant with the spread of AIDS in Sub-Saharan Africa is well documented, yet the social and behavioral mechanisms underlying this relationship remain poorly understood (Martin and Ann, 2008; Asegbe, 2009 and Sakpo, 2011). Border communities are significant yet neglected parts of neighboring countries in terms of the people's health care system, especially in Africa. They exist at the extremes of the two countries and most times may be rural settings with neglected health care system, despite their importance in international trade and foreign relations.

It is reasonable to assume that utilization of maternal health services depends on individual and household factors, as well as factors operating at the community or policy levels (Dada, 2010).. The review of literature however shows that very few studies have gone beyond individual and household factors to consider factors at the community and higher levels (Martin and Ann, 2008; Asegbe, 2009 and Sakpo, 2011). The implication of this omission is that some determinants are inadvertently missing, leaving a serious research and programmatic lacuna. Secondly, failure to consider the role of factors operating beyond the household level in service utilization may result in serious bias in the estimate. Individuals are nested within families, which are in turn nested within communities (Dada, 2010).

Due to the peculiar characteristics of border communities and taking into consideration that maternal health care seeking behaviour is always largely dependent on external factors especially the society to which one belongs to, it is important to answer various questions such as: Does the porosity between border communities include their social systems, cultural values

and customs; Does this in turn affect their systems and settings; Is there an artificial merging of the two neighboring communities or there is no merging at all; How does the socio-cultural and geographical setting of the Seme border community in Republic of Benin affect the use of the maternal health care services available; What is the pattern of antenatal, delivery and post natal health behavior; Does the location have any significant effect on the people's pattern of behavior? A major focus of this paper is to go beyond the individual and household factors and investigate the effects of community and state level factors on maternal health care services utilization. Some of these questions have been answered through several studies on maternal health seeking behavior but interests here is on the particular socio-cultural setting that exist in the study area and its influence on the maternal healthcare seeking behavior of the residents.

2. MATERIALS AND METHOD

Data from both primary and secondary sources were utilized in the study. These include non-participant observation, key informant interview, and structured questionnaire, while the secondary source involved the consultation of relevant documents like newspaper, articles, and journals.

The study was conducted in Seme-kpodji border community in Oueme Department, Republic of Benin. Seven Key informants were purposively selected from the study area. These include private health care providers (Doctors and Nurses), government health officials (Mid-wives); married male residents were interviewed in Seme border community. A total of 10 streets was randomly selected. In each street, ten houses were selected using a systematic random sampling method. In each house, the simple ballot method was used to select one household and the mother in each household was thereafter interviewed. From the above, a total of fifty-five (55) copies of the questionnaire were administered in the study area. The questionnaire was in two parts; the first part was the family records, which elicited information on the socio-demographic characteristics of the respondents, while the second part of the questionnaire was used to obtain information on the socio-cultural determinants of maternal health care seeking behavior.

Of the fifty-five (55) questionnaire that were distributed, fifty (50) was returned and the data generated from the survey were processed for entry into computer. Thereafter, the edited data were coded and entered into the Microsoft excel package for statistical analyses using simple percentage frequency table. The qualitative data from the in-depth interview and non-participant observation were recorded, and analyzed using content analysis. Statistical analysis such as chi-square test which is a test of independence was also used to determine the relationship between variables.

3. RESULT AND DISCUSSION

The key variables of the discussion are mother's age, mother's age at birth, educational status, marital status, occupation, religion, etc. the variables are viewed as capable of eliciting the socio-cultural determinant of maternal health care seeking behavior in the study area. The information in the table below shows that 50% were in the age bracket the ages of 20-34 and 48% between 35-49 years, and only 3% are between 15 and 19. Then,46% of the women had their first child at the age of 20-34years which is a reasonably good age for healthy birth delivery (Atlas, 2010), while 6% of the respondents had their first child at age 15-19 years and also 6% between 35-45years. The majority of the mothers (84%) are married and living together with their spouses, 6% are singles and 6% and 4% are separated and widowed respectively. 48% of the respondents lived in monogamous homes and 30% in polygamous families which shows

an averagely balanced out community with no shift towards a particular family setting. 58% had between 2-4 children, 30% had more than 5 children while just about 12% has 1 child.

The women's level of education attainment shows that, 4% attended tertiary education, while 36% and 32% attended up to primary and secondary school respectively. About 20% did not have any educational qualification. This signifies that the level of literacy is low, though they have enough level of literacy to carry out their trading activities conveniently. In the same line, the husband's most educational level is also the secondary school level (38%), followed by other educational study like vocational study (28%). This may be related to how (64%) of the women are traders and just 12% of the women are civil servants while just about 4% are into farming. Trading is the predominant occupation in the study area and this substantiates the views of Asiwaju (1984), that 'porous border post' are a business-like environment and had implication on the community members. According to the table on the level of income (see appendix), it indicates that 26% of the respondents earning over 20,000cfa per month, an approximate of about 7,000 Naira per month which in turn amount of living below 1 dollar per day. 74% of the respondents earn less than 20,000cfa, 18% earns between 10,000cfa and 20,000cfa, 16% earns between 1,000cfa and 5,000cfa, 26% earns between 5,000cfa and 10,000cfa and 14% earns just 1,000cfa.

The study area is a border community with people from different part of the world. 32% of the residents are Nigerians and 62% are Beninese. Though the study area is situated in the republic of Benin, there seem to be a high rate of Nigerian population residing there, though it shares borders with Niger, and Burkina Faso. The high rate of trading activities and exchange between Nigeria and Republic of Benin seems to be the reason for the population distribution. The ethnic distribution of the study area indicates that 42% are Yoruba, 22% Fons, 4% Adjas, 4% batombou/baribas while others are 28%. 42% of the respondents speak Yoruba, 22% speak fungbe, 22% speak Egun while 8% and 6% speak French and English respectively. This shows that trading and interaction are majorly by native languages. Though a large proportion of people residing in Benin republic as a whole and the interior of Cotonou are African traditional religious people, only about 2% of the respondents pick traditional religious. Muslims are 52% while the combination of Catholics and protestant Christians are 44%. 76% of the respondents are permanent residents of the study area, yet 16% are born in the community, 34% have been living there for over 10 years, 24% have stayed between 9-5 years while 13% have only lived between 4-1 years.

Table 2 shows that 48% of the respondents are aware that there are government maternal healthcare services in the study area, 22% are aware of the availability of private health services and 20% are aware of traditional services, though this traditional services are not about birth attendants but the use of herbs and traditional substances that the women take when they are pregnant is more prominent in the study area.2% consented to the availability of faith home (more of attention from spiritual leaders) and 8% of the respondents are aware of other health care services but such services are not mention.

The antenatal health care attendants of the respondents show that 14% of the respondents are being attended to by doctors while 30% are attended to by the nurses or mid-wives in the health centers; 16% were attended to by traditional health service providers while 10% signified other means of antenatal care, 30% signified no one. Links with this is the number of times the respondents attended antenatal care, 10% attended more than four times which according to the World Health Organization is the least every mother should go for, 19% go for 2-3 times, 14% go once during their pregnancy while 37% do not go at all. The other 20% fall under the respondents that do not know or give any response. Responses to the time of post-natal visits show that 20% visited within 2days after delivery, 20% went 3-6days after and while 34% attended 7-41days and 28% did not attend post-natal care at all.

Due to the nature of the border community and its porosity, there seems to be no particular cultural influence that is dominant. According to table on the cultural influence (see appendix), 50% of respondents said that cultural taboos in the community did not have influence in the community, 42% have no knowledge of cultural taboos or its influences. Only about 8% said taboos had an influence. 56% of the respondents said that the culture in the society supports the use of western maternal health care, 20% said it does not support it while 24% said they do not know. This indicates that the cultural setting in the community does not disturb the use of professional health care in the community but according to the extract below it was discovered that there are traditional people that are opposed to western medicine.

The maternal health care facilities available in the study area are inadequate and the little ones available are not provided with adequate drugs and equipment. There are three hospitals, of which one was already closed down, another one is the health center (Ministere de la Sante Republique Centre de santé De Krake) and had only one scanning machine. The health center is short staffed and most of the times, the doctors are not around as many of them have other hospitals in the main town of Cotonou and Porto Novo, hence those situated are just small centers of the larger ones. The location of the health center is very far from the residential areas in the community. In an interview with one of the staff, a sage femme (midwife), said the location is far and people are always afraid of robbery attacks due to the seclusion of the area. She made it known that even though several complications arise during labor, caesarian sections and many other forms of operation is not carried out in the health center but they are referred to the main hospital at Agege in Cotonou town.

Many of the clinics use word of mouth in ensuring people of their existence, while a doctor in Clinique Cooperative de SanteKrake made it clear that the social service segment of the hospital ensure to pass the information about the existence of maternal health services and this has since increased attendance. Only this particular cooperative hospital had a scanner, few staff and raises its fund partly from the government and the cooperation of the members of the community. One of the private hospitals complained of low maintenance and lack of equipment since they depend on the money made from the patients and this makes equipping and maintaining the hospital very difficult. This problem led to the closure of one of the private hospitals.

The distance of the hospital from residential homes makes accessibility very difficult, coupled with low economic status of the residents who are predominantly petty traders and have a low monthly income. Hence, the costs of services in the private hospitals constrain many residents from using them. Although some of the health care providers are not really sure of the existence of traditional birth services, interview with some of the members of the society revealed that there were sales of traditional herbs and some other substances that are available for pregnant women. Many of the women used these products alongside the western medicines. Also, during complications, some admitted to some nurses referring them to traditional treatment. This shows that, although there were no dominant traditional services publicly recognized in the community, they are much more available for the use of the residents in one way or the other.

Residents in the area engage in giving birth at home and as extracted from interviews with both health providers and residents, they are sometimes assisted by relatives, "sage femmmes", nurses, and sometimes doctors especially when complications arise. During the observation and interview, the bike man that helped around confirmed that sometimes, spiritual leaders are called upon to pray or perform activities that could help alleviate fears during complications.

According to the interview conducted with some of the residents in the study area among the younger age-groups, it was discovered that they are of the opinion that professional health care is relevant, though was taken to be too expensive, they still preferred it. Women that

were middle aged were a lot more biased as to the antenatal health care and some even argued they were not as competent as expected as even the nurses who attended to them during their child birth in seeing the problems associated with difficult pregnancies often secretly advised them to go for traditional treatment. The majority of the women does not attend ante-natal care especially because of the fear of the unknown that may be discovered during the antenatal care. They are afraid to discover that they are diabetic, hypertensive and have heart conditions but they would prefer to go through their pregnancy oblivious of these problems.

Many of the residents uses health clinics because that is the major services available but due to the implications of cost, distance and their family system, many are forced to use alternative medicines. During the in-depth interview with the health professionals, it was noted that some women gave birth at home and they were majorly the Hausa speaking people who are perceived to be strong. Some of them make use of assistance and some don't, but when complications arise they rush them to the hospital or call the doctors in neighbouring countries.

Many do not take post-natal checkups seriously, since they see the worst during child birth and do not have enough money neither do they have the time. Furthermore, most of them are always in a hurry to return to their trading business as it is their only source of living and there is no one to fill in for them.

The socio-cultural environment creates, sustains and enforces community beliefs and practices, which in turn, influence the maternal healthcare seeking behaviour. The study location is a border area that is highly porous, so there are varieties of people that are resident there. They are of different cultural background; hence there is no particular dominant culture in the area. The area reflects a neutral, seemingly mixed cultural area due to intense economic activity that occurs through the area, yet it was discovered that the individual culture greatly affects their decision making especially their maternal health care seeking behavior.

During the interview, it was established that the patriarchal system is strong in the community and this affects the women's decision in a great way. Hence, the women do not have much control over their maternal health decisions. In fact, during administration of the questionnaire, many of the respondents' husbands intruded and caused distractions claiming that they are the ones to be asked such questions and not their wives. The husbands are the one to foot the bill, help get to the hospitals if need be, and most importantly make decision on choices of place of delivery and what to do during complications. The patriarchal system also puts decision making in the hands of older relatives like mother-in-laws and sister-in-laws. One of the nurses during the interview spoke of a woman who was beaten by her husband because she came to the hospital for treatment.

During one of the interviews, it was discovered that many of the residents go to the neighboring country for efficient treatment especially during pregnancy complications. When they are referred by the doctors to bigger and specialized hospital in town, many of them go back to their mother-in-law or their own mothers for the use of traditional treatments and services that is not available in their own base which is believed to be very effective. This shows that though the traditional culture of the community as a whole has been corrupted due to the accumulation of various and different people of different cultural backgrounds, yet people are still adhered to their cultural backgrounds and it influences their maternal health care seeking behavior.

Prevalent in the Seme-krake border area is the strong latent effect of culture that surfaces under suitable conditions. For example, though many of the residents claim to be Christians and Muslims, yet most of them are still fundamentally tied to their traditional beliefs. Many of them join in the practice of the Voodoo festival, since the whole country (Republic of Benin) recognizes the traditional ritual and even have a public holiday ascribed to it. The porosity of the border which makes it more of an artificial boundary makes the return and practice of the people's culture very easy. Even though, it is not openly practiced in the

community because of the societal setting, residents easily retreat to the neighbouring country to practice their traditional religious rite and return when they are through.

4. CONCLUSION AND RECOMMENDATIONS

The level of significance for this research study (under social science) is 0.05, while the degree of freedom from the above calculation is 4 and the chi-square [x^2] table value is 9.49. According to the decision rule that, the researcher should accept the null hypothesis [H0] when the calculated chi-square [X^2] value is less than the chi-square table value and reject the alternative Hypothesis [H1]. Thus from the data analysis, it can be deduced that the calculated chi-square [X^2] is 6.938 while the chi-square value is 9.49 and therefore the null Hypothesis [H_0] i.e. "religion of the residents does not affect their choice of the place of delivery, is accepted and the alternative hypothesis [H_1] 'religion of the residents affects their choice of the place of delivery is rejected.

The level of significance for this research study (under social science) is 0.05, while the degree of freedom from the above calculation is 1 and the chi-square [X^2] table value is 3.84. According to the decision rule that, the researcher should reject the null hypothesis [H_0] when the calculated chi-square [X^2] value is more than or greater than the chi-square table value and accept the alternative Hypothesis [H_1]. Thus from the data analysis, it can be deduced that the calculated chi-square [X^2] is 8.125 while the chi-square value is 3.84 and therefore the null Hypothesis [H_0] "the husbands does not have the final say on where to go during pregnancy and birth' is rejected while the alternative hypothesis [H_1] 'husbands have the final say on where to go for pregnancy care and birth' is accepted. At Seme border in the Republic of Benin, there are not enough health care services and the available ones are not well equipped and adequately staffed. Many of the clinics are distant from the residents and they have problems with the cost of treatment and cost of transportation. Hence, the availability and accessibility of maternal health care services are low in the study area.

The practice of respondents, are poor as only about 44% attends antenatal care, 28% have the recommended number of antenatal visits. They prefer to use the health clinics yet end up using traditional means. Lots of economic activities occur through the border community yet they are used as door mats and the residents are of low-economic status (74% traders and only 26% earn above 5000 Naira monthly from sales) which hinders their use of health services. Due to the porosity of the area, it is a place of variety of cultures with no particular culture dominant, yet the patriarchal system is dominant (80% respondents husbands had the final say). Though many residents (58%) use the western (private and public) services for simple procedures, but when there are complications, they are referred to specialist hospitals in Cotonou town and most of them eventually go back to their neighboring communities to seek for traditional treatments.

This supported the ecological systems theory by identifying latent failures in utilization of maternal health care services and intervention to treat maternal health problem, along with the more obvious active failures through the interaction with the social environment. In case of maternal health seeking behavior in this area, among the factors that contributes to both latent and active failures are cultural (such as belief, patriarchal norm, etc.), occupation, income, and educational factors. Others are environment (in terms of residence, ethnicity, etc.), public perception of the method of intervention and the will to adhere to medical regime, which is in line with the position of Black and Hawks, (2005).

The boundary of the community is predominantly artificial and the porosity is high, hence there are various kinds of people in the community who practice their culture latently in the community and this in turn affects the behavior of the residents. The majority of the people goes back to their home countries and engages in traditional medicine in conjunction with the traditional substances they use in their own base. Therefore, despite the corrupted nature of the

traditional settings in the border community, there are socio-cultural factors and they have strong influences on the maternal health seeking behaviors of the residents.

4.2 RECOMMENDATIONS

The following measures can be put in place for improving the maternal health care seeking behaviour in the study area.

- The intervention of the government to provide more health care facilities and to equip the existing one with adequate facilities that will improved services and make them more available and easily accessible to the mothers.

- Cost of treatment should be reduced and laboratory tests and drugs subsidized by the government, this will motivate the residents in the area to utilize the maternal health services.

- The general public and the border community members should be enlightened on the negative impact of the patriarchal system on the maternal health behaviors and the other defective practices. The media houses should design indigenous programmes in form of audio-visual in national and the major indigenous languages in the area as a method of educating and sensitizing the public.

- Non-electric methods like billboards, market outreach, and town criers should also be used on a frequent basis at the Seme border community on the grave consequences of not attending ante-natal care, giving birth without assistance and use of unprofessional facilities and that husbands and mother-in-laws should reduce their enforcement of decisions on the mothers.

- Decisions should be made objectively and based on what is the best for the health of the mother and the child and not based on cultural beliefs and practices only.

- The government and other concerned bodies should also make efforts to expand general community based education so that women can have better access to information concerning maternity care.

- Women should be able to understand that they benefit from maternity care services. They should, thus, be able to take proper measures recognizing that prevention is much better than cure.

- The government should be more focused on the activities in the border area. Proper and adequate attention should also be given to the lives of the people in the study area and attention should be given to how to raise their income. Better jobs by the government and non-government agencies should be provided for residents to empower them, so that as they earn more money, they will be able to use the available healthcare services.

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APPENDICES/TABLES

Table 1: socio-demographic characteristic

Variables	Description	Frequency	Percentage%
mothers age	15-19	4	8
	20-34	25	50
	35-49	24	48
	no response	2	6
age at birth			
	15-19	3	6
	20-34	25	50
	35-49	3	6
	no response	19	38
marital status	Single	3	6
	married & living together	42	84
	Widowed	2	4
	Separated	3	6
level of education	None	10	20
	Primary	18	36
	Secondary	16	32
	Tertiary	2	4
	others(vocational, etc)	4	8
husbands level of education	None	5	10
	Primary	6	12
	Secondary	19	38
	Tertiary	6	12
	others (vocational, etc)	14	28
Religion	Catholic	15	30
	Protestant	7	14
	Muslims	26	52
	Traditionalist	1	2
	Others	2	4
Ethnicity	Adja	2	4
	Fon	11	22
	Yoruba	21	42
	batombou/bariba	2	4
	Others	14	28
Nationality	Nigerian	16	22
	Benenise	31	62
	Togolese	2	4
	Ghanaian	0	0
	Others	1	2
language spoken	English	3	6
	French	4	8
	Fungbe	11	22

	Egun	11	22
	Yoruba	21	42
family structure	Monogamous	24	48
	Polygamous	15	30
	Nuclear	6	12
	Extended	5	10
Occupation	civil servant	6	12
	Farming	2	4
	Trading	37	74
	Others	5	10
monthly income(in CFA)	1000	7	14
	1000-5000	8	16
	5100-10000	13	26
	10,100- 20,000	9	18
	over 20000	13	26
number of children	1	6	12
	2 to 4	29	58
	5 and above	15	30

Source: Field survey, 2012

Table 2: Awareness Of Availability Health Services

Health services	frequency	percentage
private services	11	22
government services	24	48
traditional services	10	20
faith homes	1	2
others	4	8

Source: Field survey, 2012

Table 3: antenatal attendants

Antenatal attendants	frequency	percentage
Doctor	7	14
nurse/midwife	15	30
Attendants	0	0
traditional services	8	16
no one	15	30
others	5	10

Source: Field survey, 2012

Table 4: complications during pregnancy and who makes decision during complications

Complications	frequency	percentage
None	16	32
Bleeding	10	20
high blood pressur	9	18
stroke/convulsion	4	8
Infection	3	6
urine likage from vigina	0	0
postpaturm depression	8	16

Source: Field survey, 2012

Table 5: place of treatment of complications

Treatment of complication(place)	frequency	percentage
private hospitals	8	16
government hospital	11	22
traditional assistant	16	32
Other	12	24
not treated/stayed home	3	6

Source: Field survey, 2012

APPENDIX II

KEY INFORMANT INTERVIEW GUIDES

1. How are the maternal health care services sustained and maintained?
2. Are there cultural beliefs, practices or taboos that influence pregnant women's choice of place of delivery?
3. Can it be concluded that the community is gender-equal and does the answer affect maternal health care choices?
4. How does the community being at the border affect the availability and use of health services?
5. Comment on the relationship between the people's religion and their choice of pregnancy care and birth?
6. Is there any migration effect on the residents' maternal health seeking behaviour?
7. Comment on the people's ethnicity, nationality and their maternal health care use