HEALTH BEHAVIOUR AND MATERNAL MORTALITY IN EGOR LOCAL GOVERNMENT AREA OF EDO STATE

BY

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BENIN CITY

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BEING A MASTER RESEARCH DISERTATION PRESENTED TO THE DEPARTMENT OF SOCIAL WORK, FACULTY OF SOCIAL SCIENCES, IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF MASTER DEGREE IN SOCIAL WORK (MSW), UNIVERSITY OF BENIN, BENIN CITY.

SUPERVISOR

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CERTIFICATION

This is to certify that this proposal "**HEALTH BEHAVIOUR AND MATERNAL MORTALITY IN EGOR LOCAL GOVERNMENT AREA OF EDO STATE"** was presented to the Post Board in the Department of Social Work, Faculty of Social Sciences, University of Benin, Benin City.

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Date

Prof. Ernest Osas Ugiagbe
Project Supervisor

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Dr. (Mrs.) T.B. E. Omoroguiwa **Date**
Head of Department

DEDICATION

I dedicate this work to God Almighty, who has been my pillar all the time. Yahweh, you never cease to amaze me. To my lovely and supportive husband, Mr. Jeremiah Wisdom, and to my lovely son, Master Princewill Jeremiah, you have made me stronger, better, and more fulfilled than I could have imagined. I also extend my gratitude to my understanding sibling for their continuous holistic support.

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Olofua Egwonor Love
University of Benin
June, 2023.

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Abstract

This study examines the health behaviour and maternal mortality in Egor Local Government Area of Edo State and adopted a qualitative research method with survey instruments deployed to gather relevant data for analysis. The study examines the socio-economic factors that influence women's health behaviours in Egor Local Government Area; evaluates the cultural variables that contribute to women's delayed access to healthcare in the study area; interrogates the types of healthcare services that influence women's access to healthcare and health-related behaviours in the research area, it examines the type of health habits of women in the area and investigates how common maternal mortality in the research area. Findings revealed that positive relationship exist between socio-economic factors and women's health behaviours in the study area; it was also revealed that there is a relationship between cultural variables and women's delayed access to healthcare in Egor local government area. Based on these findings, it was recommended that the health workers such as mid-wives should be knowledgeable enough to understand the possible risk factors affecting pregnant women in the communities where they practice. It was also recommended that health worker be trained and, they should be able to provide emotional support, education, and practicalities that are personalised.

CHAPTER ONE

BACKGROUND TO THE STUDY

1.1 Introduction

Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity. An important implication of this definition is that mental health is more than just the absence of mental disorders or disabilities (WHO, 2018). In this context, healthy behavior is implied but involves the perception of illness or discomfort. It encompasses the actions taken in response to such symptoms to seek help at clinics, hospitals, herbal homes, drugstores, pharmacies, healing homes, or religious institutions.

Good health is a universally important precondition for leading a socially and economically successful life. It is asserted that households suffering from poor health face several difficulties, including significant financial hardship, income loss, and occasionally death. The well-being of the household, particularly maternal health and child development, is compromised by the health of adults since it affects their ability to work (Asenso-Okyeme et al., 2015). Health is a key component of human capital, and the literature unanimously states that maternal mortality and economic development are linked through the relationship between capability and poverty (Strass & Thomas 1998, in Awoyemi et al., 2011).

Health is a fundamental human right, and most governments throughout the world agree to provide healthcare systems and services in a way that allows all citizens to have equitable access to care. Access to affordable, basic healthcare for all people is an objective in and of itself (Kabiri, 2011). However, the public's access to and use of healthcare services are significantly influenced by the availability of health at a given moment, in accordance with the needs of the

community. Some people resort to self-medication by buying drugs from modern pharmaceuticals and herbal cures from street vendors when the expense of seeking medical care from a certain institution is out of their price range.

Economic considerations or pressure from close family members may influence the choice of healthcare facility. This health-seeking behavior poses a major threat to women's health and their capacity to procreate, which determines maternal health and the survival of society (Ugal et al., 2012). It has been posited that poor maternal health is common among women of reproductive age in third-world nations like Nigeria, suggesting that maternal mortality lowers the life expectancy of a childbearing-aged woman (Dada, 2008, UNICEF, UNFPA, WHO, 2000; Ugal et al, 2011).

Health behavior is a crucial component of the overall analysis of maternal health in a community or country as people make a number of decisions throughout their lives that are connected to and associated with a variety of behaviors. Nevertheless, choosing a behavioral attitude toward healthcare is one of the most important choices one can make, as wise healthcare behavior is closely related to a person's quality of life, which is determined by a number of factors (Gross & Howard, 2001; Kim, Geistfield & Seiling, 2003).

The three key components of the behavioral model of maternal health and mortality are need factors, such as perceived health risks, status, disease symptoms, and the use or non-use of care. Risk factors include age, sex, education, employment, marital status, belief systems, and cultural heritage (Kroeger, 1983; Pokhrel & Sauerborn, 2004; Eweka, 2018). Economic and psychological factors also have an impact on health behavior. Since it is unusual for all three ideas to exist simultaneously in a person's health, they do not necessarily conflict with one another.

It is asserted that because a woman's choices and behaviors during prenatal care or other crucial times can significantly and negatively affect her health if they are erroneous, delayed, or not done at all. Additionally, maternal mortality and health behavior are interwoven, as pregnancy and various related maternal health issues are inextricably tied to a healthy mother, child, and nation. Therefore, the main subject of this study is the connections between maternal mortality and health behavior.

1.2 Statement of the Problem

There are urgent problems with maternal mortality and health behaviors worldwide, including Nigeria. Health and illness behaviors refer to a person's perception, assessment, and reaction to pain, discomfort, and other organic signs of ill health or bad health that an individual recognizes as symptoms of sickness (Mechanic, 2018 in Eimosho, 2019). The actions people take in response to pain, discomfort, and other symptoms of illness, such as seeking medical care at modern clinics or opting for alternative treatments, are greatly influenced by their behavioral responses.

These responses can have an effect on their recovery from illness, the possibility of complications, or even death. Health and disease behavior, a key predictor of maternal health, is one of the three delays that typically impact women's health before, during, and after childbirth (Jawali, Wantamutte & Mallapur, 2014). Health behavior refers to any action taken by a person who considers themselves healthy, with the goal of preventing illness or identifying it in an asymptomatic stage. Behavior, on the other hand, refers to any action taken by an ill person to evaluate their condition and select an appropriate course of treatment (Quah, 2014).

The appraisal of and access to healthcare services by women to ensure healthy pregnancies and deliveries are viewed as human rights (Reduction of Maternal Mortality, 1999). This may explain the unacceptably high incidence of maternal and newborn deaths observed globally. In South East Asia, there are approximately 68,000 maternal fatalities annually, and one in every 22 women in Sub-Saharan Africa, including Nigeria, is at risk of dying from maternal causes (World Health Statistics, WHO, 2014).

The adjusted maternal mortality ratio (MMR) for 2005 was 900 fatalities for every 100,000 live births (WHO, 2007). The precise number of women who die annually while pregnant or nursing is unknown due to significant underreporting and misclassification of maternal mortality. Most deaths go unreported as these individuals are often poor, living in rural areas, and may not be registered in any health facility at all. In countries like Nigeria, which has one of the worst rates of maternal mortality in the world, deaths and their causes are also rarely recorded (Patel, 2016).

The health and behavioral dispositions of women before, during, and after childbirth have been associated with several issues, but the most significant one is maternal mortality in countries like Nigeria. Women worldwide are more likely to experience potentially deadly problems due to various biological and behavioral factors. Maternal mortality is not only caused by medical issues but also by underlying social and economic problems that make it challenging to access early and effective interventions. Consequently, maternal mortality and health behaviors are closely linked. In Nigeria, health behaviors that hinder obtaining prompt and appropriate emergency care are a major contributor to maternal death (Shah et al., 2009; Will, Vapattamawong & Vong-ok, 2015).

Maternal mortality is high in the study area, as in other parts of the country, due to its composition of urban, urbanizing, and rural areas. It is crucial to examine and evaluate how

various geographic factors, rural-urban culture, the status of rural and urban women, and poverty affect healthcare accessibility and the behavior of ill Egor women. The association between illness behavior and maternal mortality is the primary focus of this study. To the best of our knowledge, no research has specifically examined the relationship between healthy behaviors and maternal mortality in the study area.

Hence, there is a gap in the literature and actual data concerning the subject of maternal mortality, which is the main problem addressed by this study. The aim of this study is to fill the void in the existing discourse on this critical issue by comparing health behaviors to maternal mortality in the study area.

1.3 Research Questions

This study was guided by the following questions:

1. What socio-economic factors influence women's health behaviours in Egor Local Government Area in Edo State?

2. What cultural variables contribute to women's delayed access to healthcare in Egor Local Government Area in Edo State?

3. What types of healthcare services influence women's access to healthcare and health-related behaviours in the study area?

4. What type of health habits do women in Egor Local Government Area in Edo State have?

5. How common is maternal mortality in the research area?

1.4 Objectives of the Study

The main aim of this study was to investigate the effect of health behaviour on maternal mortality in Egor Local Government Area, while the specific objectives were to:

1. To examine the socio-economic factors that influence women's health behaviours in Egor Local Government Area in Edo State.
2. To evaluate the cultural variables that contribute to women's delayed access to healthcare in Egor Local Government area in Edo State.
3. To interrogate the types of healthcare services that influence women's access to healthcare and health-related behaviours in the study area.
4. To examine the type of health habits of the women in Egor Local Government in Edo State.
5. To investigate how common is maternal mortality in the research area**.**

1.5 Significance of the Study

An empirical study of this magnitude focused on the pressing issues of maternal mortality and health behavior in the study area. The Sustainable Development Goals (SDG) targets, which have replaced the Millennium Development Goals and call for lowering maternal and infant mortality worldwide, including in Nigeria, are in line with this. The findings of this study contribute to the theoretical and empirical understanding of the relationships between maternal mortality and health behavior. Future conversations will rely on and particularly focus on Egor Local Government Area of Edo State, becoming more rigorous and inclusive.

The findings of this study help the general public and academic community comprehend maternal mortality and health behavior. Additionally, this study provides essential empirical data

that support other stakeholders' decisions to reduce maternal mortality in the study area, as well as the creation and implementation of policies. As a result, the data are very useful to the government and policymakers in figuring out how to stop the monster known as maternal mortality in the study area.

Academics, students, and anyone else interested in learning more about maternal mortality and health behavior in the study region find the findings of this study to be fascinating reading. The study is a helpful starting point for additional research on the subject of maternal mortality. Future researchers may want to replicate this study in various parts of Nigeria and determine if the findings reveal any appreciable variations, whether they decide to extend their focus or alter the methodology used in this study.

The findings of this study add to the body of knowledge about maternal mortality, women's health, and health behavior in the study area. This study established the link between women's health behaviors and maternal mortality but also attempts to pinpoint the salient distinctions and outcomes of health behaviors across urban, urbanizing, and rural women in Egor Local Government Area of Edo State.

1.6 Scope of the Study

The sole objective of this study was to examine the relationship between women's health behaviors and their impact on maternal mortality in the Egor Local Government Area of Edo State. The study focused on women between the ages of 16 and 52 who were capable of having children, and only those who had resided in the study region for at least a year were eligible to participate. Therefore, this study included de-jure childbearing women.

1.7 Operationalization of Basic Concepts

Health Behavior: This refers to how people perceive and evaluate their symptoms, react when they become aware of their illness and seek the appropriate care or aid from a medical facility, organization, or persons as all behaviors are linked to health and disease.

Maternal Health Mortality: This refers to the wellbeing of women before, during, and after childbirth.

Maternal Mortality: This refers to the death of a woman while pregnant or within 42 days of the termination of her pregnancy from any cause related to or aggravated by the pregnancy or its management.

CHAPTER TWO

LITERATURE REVIEW

This section focuses on analyzing the relevant literature pertaining to the subject matter of the study. It also provides an explanation of the theoretical underpinnings behind the investigation.

2.1 Health and Illness Behavior

Health and illness behaviors are associated with the level of disability, quality of life, patterns of illness, and the risk of death. It may be tempting to view these health-related outcomes solely through the lenses provided by the biomedical sciences. However, the factors that significantly shape individuals' experiences of sickness or wellness, and life or death, are more comprehensively understood from a sociological perspective. The confluence of individuals' life histories, their personality characteristics and social experiences, and their social positions influences health and illness behaviors, providing valuable insights on how to enhance health and well-being while mitigating disability and sickness. Therefore, an examination of health and illness behaviors holds important implications for public health.

Health and disease behaviors encompass how a person perceives, assesses, and reacts to symptoms or signs of ill health. This includes being aware of pain, aches, and other signals of discomfort, as well as other indications of organic system failure. Essentially, a person's behavior related to their health and illness includes all the aspects that influence their decision to seek healthcare services, as well as a wider range of behaviors (Mechanic, 2019; Eimosho, 2018). Regarding health and illness behavior, a patient's journey begins the moment they openly admit or express physical and psychological suffering, which may be subjective or observable through professional inquiry or careful, critical observation by another person, but not due to accidental or incidental causes, regardless of the length or location of the predicament (Kifle et al., 2017).

When a person expresses bodily or psychological distress, a series of behaviors and activities commence, some of which involve the individual's close friends, neighbors, and significant others (the prospective patient). The potential patient may decide to seek help on their own initiative or with the support of family members and/or significant others from medical experts, conventional or herbal homes, religious institutions, or a nearby pharmacy. Referral sources are individuals or groups that assist patients in locating medical care (Eimosho, 2018). Both formal and informal referral agents are available.

Referral agents include relatives such as spouses, siblings, parents, children, and significant others like friends and neighbors. Other parties include the court, police, traditional healers, social workers with formal training in healthcare, clinical psychologists, and in some cases, head teachers, pastors, and group leaders (Janz and Becker, 2019). One explanation for individual health behavior is provided by the Grossman model of health demand (1972), which conceptualizes health as a durable capital, similar to other forms of capital that depreciates and can be maintained, enhanced, or avoided through an individual's way of life.

It encompasses aspects such as diet, exercise, recreation, discipline, reducing psychic overload, and avoiding the seven deadly emotions of worry, hatred, anger, bitterness, unforgiveness, envy, jealousy, and grief (Kalin, 2011). The model states that the demand for health is influenced by the demand for medical services, indicating that factors influencing the desire for excellent health also drive the demand for medical services (although not always in the same way). Medical services are necessary to achieve optimal health, not for their own sake. The use of healthcare leads to improvements in health systems, while the use of medical services reduces consumption of other goods (Grossman, 1972; Kalim, 2011).

The social ecology model suggests that there are five nested, hierarchical levels of determinants of behavior, namely individual, interpersonal, community, organizational, and policy/enabling environment, in the research related to health and sickness behavior. The theoretical premise of this framework is to understand the complex and interacting effects of individual and environmental factors that influence health and sickness behavior. The model is illustrated below with a diagram for convenience of understanding.

Another paradigm to explain health and sickness behavior is the health belief model, which focuses on the individual and the variables or circumstances that affect their health behavior. The health belief model states that self-efficacy, or a person's perceptions of their own vulnerability, benefits, seriousness, barriers, and behaviors, are modifying variables that affect behavior. These variables include culture, education level, prior experiences, skills, and motivation to act (Dyer, 2015; Stretcher, Risenstock, 1997).

Therefore, in addition to deciding whether or not to seek medical assistance, someone who is ill must also decide what form of healthcare to use. When people who are ill are required to select from a number of options, each of which has the potential to affect their health differently. In order to choose between different providers, including self-care, people weigh the potential benefits against the perceived expenses, which include both monetary costs and access costs, such as the opportunity cost of travel time and the potential for a negative reaction from their spouse, as well as socio-cultural limitations and religious prohibitions/injunctions (Dor et al., 1987; Kalin, 2011).

2.2 Maternity Health and Mortality

Health was first defined by the World Health Organization (WHO) in 1978 as a complete state of physical, social, mental, and spiritual soundness, encompassing not only the absence of disease or incapacity. Similarly, illness is a consequence of compromised healthy functioning or errors in design or implementation, leading to undesirable outcomes and discomfort for individuals. Thus, a healthy person should be free from any physical or objectively verifiable ailments, including deprivation, psychological restrictions, psychopathological conditions, and poverty.

This suggests that various aspects are involved in the concepts of health and sickness. Therefore, apart from maintaining homeostasis, a disease-free individual should also not experience any illnesses that make them feel unwell (Erinosho, 1998). The state of a woman's physical and mental health before, during, and after pregnancy and childbirth is referred to as "maternal health." In contrast, maternal mortality refers to the death of a woman while she is pregnant or within 42 days after the termination of her pregnancy, regardless of its duration or location, caused by or exacerbated by the pregnancy or its management, excluding accidental or incidental causes (Samson, 2012).

Medical terminology simply uses the term "maternal health" to refer to pregnancy-related health. This encompasses maternal mortality, morbidity related to specific illnesses, and nutrition concerns during pregnancy (Bergson & Goodborn, 2001 in Banda, 2013). Women can access prenatal care services by visiting health centers where such services are available or by receiving care from healthcare professionals during home visits, especially for those in urban areas or living near healthcare facilities in rural regions. Prenatal care is a component of maternal care that should ideally begin in the early stages of pregnancy.

The maternal mortality rate (MMR), measured as the number of maternal deaths per 100,000 live births, remains a burden on healthcare systems, particularly in developing countries. Maternal death, irrespective of pregnancy duration or location, is defined as the death of a woman while she is pregnant or within 46 days after the termination of her pregnancy due to causes associated with or aggravated by the pregnancy or its management, excluding accidents (WHO, 2005; Banda, 2013).

Most maternal deaths occur shortly before, during, or after childbirth. The primary complications of pregnancy include high blood pressure, severe bleeding, pre-eclampsia, and eclampsia. Ensuring a safe birth with the assistance of skilled healthcare providers and receiving appropriate maternal care during pregnancy, labor, delivery, and the postpartum period can help prevent many of these obstetric complications, although some are unpredictable (WHO, 2014; Degroot, 2012; Dyer, 2015). Educating women about the challenges of pregnancy and potential early detection and management of issues is crucial in prenatal care.

Prenatal care also plays a significant role in preparing women and their families for childbirth by building trust between them and healthcare professionals and providing tailored health promotion messages. Prenatal care can increase awareness among pregnant women and their families about the importance of labor and delivery care during visits or familiarize them with medical facilities, facilitating easier access to help when needed (WHO, 1996; Graham et al., 1996; Sai & Measham, 1992; Chandhiok et al., 2006).

The problem of maternal mortality in developing countries like Nigeria stems from pervasive socio-cultural inhibitions, beliefs, and restraints, combined with widespread poverty, inadequate healthcare services, and cultural barriers that negatively affect women's health behavior in all its manifestations (Janz & Becker, 2019). In low-income countries, particularly in the Sub-Saharan

region, complications and issues related to pregnancy and childbirth are the leading causes of mortality among women of reproductive age (WHO, 2012).

Disparities, inequities, and variations arise from both overt access barriers, such as distance and cost, and covert barriers, such as women's lack of decision-making autonomy and control over household resources. The health and illness behaviors of women of reproductive age influence their utilization of healthcare facilities and services. The previously mentioned reasons for these disparities include poverty, illiteracy, access issues, distance, unequal care, lack of knowledge, belief systems, peer pressure, cultural restrictions, and the subordinate roles of women in African societies. As a result, women are up to 50% less likely than men to seek medical attention when they are ill or uncomfortable (Kalin, 2011).

According to Wild, Backlay, Kelly, and Martin (2010) and Dyer (2015), access to high-quality maternal health services guarantees safe pregnancy and delivery. However, this is not the case in Sub-Saharan Africa, which may explain why 800 women die every day from preventable issues during pregnancy or childbirth. The number of maternal deaths in Nigeria may be higher due to underreporting of these deaths, as well as pregnancy-related problems influenced by socio-cultural beliefs, prohibitions, and mystique. Several interconnected factors contribute to maternal mortality, including limited knowledge of safe pregnancy practices, inadequate engagement with midwives, and limited access to prenatal care, skilled birth attendants, and facility-based delivery services.

Maternal health and mortality in developing countries, like Nigeria, are adversely affected by medical causes and underlying societal beliefs that lead to delays in receiving prompt and effective intervention or seeking medical care. Delay in receiving timely and appropriate care during obstetric emergencies is one of the main causes or contributors to maternal death (Shas et

al., 2009). The three-delay model, developed by Thaddeus and Main in 1994, identifies three phases of delay between the onset of a maternal problem and receiving the necessary care, with social factors being implicated in maternal mortality. These delays include:

• Choosing to seek medical attention when symptoms appear

• Getting the right care

• Receiving treatment at a medical facility.

A healthcare center may not be equipped to treat the ailment or provide basic first aid, so going there does not always guarantee the end of the journey or the resolution of the problem. The first two delays are directly associated with the care and include family pressure to give birth at home, lack of cash for transportation, and restrictions on decision-making without the husband's approval, among other factors. These issues stem from the general flaws in the healthcare system, which may be a result of poor infrastructure, lack of qualified employees, inadequate transfusion equipment, or other factors. The inability to deliver critical care promptly may be due to delayed or incorrect diagnosis as well as subpar staff performance (Yunus et al., 2013; Thaddeus & Maine, 1994; UNFPA, 2009).

2.3 Maternal Mortality: A Critical Review

Maternal death is defined as the death of a woman while pregnant or within 42 days of the termination of the pregnancy from any cause associated with or aggravated by the pregnancy or its management, but not from accidental or incidental causes, regardless of the length or location of the pregnancy (ICD, 1993; Banda, 2013). Late maternal deaths are defined as those that take place more than 42 days but less than a year after the end of the pregnancy. The number of maternal fatalities (OD, POO, live births) within a specific time frame is known as the maternal

mortality ratio. It also includes fatalities of pregnant women that occur during labor or within 42 days after delivery, regardless of the cause.

The possibility that a woman may die during a particular pregnancy is known as obstetric risk, and the maternal mortality ratio is a measure of this risk. It is the most employed indicator of maternal health (DHS Analytical Report, 1997). Maternal mortality rate is defined as the number of deaths per 4,000 women of reproductive age (usually 15-49). The term "lifetime risk of maternal death" refers to the cumulative risk of becoming pregnant and experiencing pregnancy-related complications over the course of a woman's lifetime.

It is calculated by multiplying the annual maternal mortality rate by the length of the reproductive period, which is typically 35 years. It serves as both a risk indicator for maternal mortality among reproductive-age women and a measure of the burden of maternal mortality among adult female populations. Physical health problems associated with the concepts of healthy childbearing, being free from illnesses, and avoiding dangers associated with pregnancy make up the illness known as reproductive mortality (DHS Analytic Report, 1997).

The maternal death ratio has significantly decreased globally despite the strategies and numerous initiatives that prioritize maternal health. However, Sub-Saharan Africa still has the highest maternal mortality ratio in the world (Hogan et al., 2010; WHO, 2012). In 2010, it was projected that 500 deaths per 100,000 live births occurred in Sub-Saharan Africa. The maternal mortality rate in Sub-Saharan Africa is still exceedingly high, despite the great and ideal goals set by the now-defunct Millennium Development Targets (MDGs) and their successor program, the Sustainable Development Program (Banda, 2013).

According to the UN, Nigeria has the highest prevalence of the main medical causes of maternal death. The numerous stages of development of the country have a substantial impact on maternal health and mortality due to insufficient infrastructure. Poor development planning, poverty, illiteracy, and low uptake of official maternal healthcare services are the main causes of Nigeria's high maternal mortality rate (Reports in Medicine and the Health Sciences, 2019).

Maternal healthcare services have been among the most important endeavors in the majority of countries, especially Third World countries, in reducing maternal mortality and mortality in general. Maternal health, for instance, has received significant attention from the government of Ethiopia during the past 50 years. As a result, it is one of the six priority areas in the country's reproductive health policy. Ethiopian women's perception of maternity healthcare services is still incomplete despite an increase in the number of women obtaining sporadic maternal healthcare treatments (Yared & Asnakech, 2003).

Other reports claim that maternal deaths in Ethiopia are caused by or linked to a number of socio-economic and demographic factors, such as the mother's and spouse's educational levels, their occupations, age, knowledge of danger signs, marital status, and women's autonomy/gender issues. These elements relate to the use of maternity care services, as they do in other nations, and the use is connected to barriers (CSA, 2014; Bahilu, Abebe & Yohannes, 2009; Zaine, Mirkuzie & Shindes, 2010; Kifle, Azale, Gelaw, and Melsew, 2017).

A further report on maternal death in the Nepalese republic asserts that Nepal has one of the worst rates of maternal mortality in the South Asian region, partly due to the low usage of maternal health facilities and the high percentage of adolescent pregnancies. According to this survey, the mother-in-law and other family members were extremely influential in the use of professional maternity health services. Due to lack of information on maternal and reproductive

health, traditional beliefs, reliance on husbands and in-laws alone, and limited decision-making autonomy, they used these services less frequently. Teen-friendly maternal healthcare is explored at the level of health systems. Their access to services was restricted by defined operating hours of public health institutions, difficulties in locating suitable maternal care, and maternal health services (Shahabuddin et al., 2019).

Banda (2013) asserts that the majority of women of reproductive age in Malawi were aware of the importance of targeted antenatal care services for pregnant women and post-natal moms in the Ntiduist area. The factors that determined whether a woman used maternity health services included her age, travel distance, whether she needed permission, and her prenatal beliefs, particularly her witchcraft beliefs. Similarly, a 2013 study in Myanmar by Vap et al discovered that more than half of women had to make daily judgments about whether to seek medical help, which was followed by delays in getting the correct care at medical facilities and delays in getting there. In that poll, the majority of moms was aged between 35 and 39; only one had a higher level of education; more than half had jobs; and 82% lived in rural areas. Although more than 50% of the women received between one and four prenatal visits, the majority of postpartum deaths among women were directly related to their initial encounters with unskilled caregivers. Even though the majority of moms lived within 5 miles of medical facilities and could travel there in an hour, over half of them waited 1-2 hours or longer to go to the nearest hospital (Wing et al., 2013).

Jayaramen, Chandrasekhar, and Gebreselassie (2008) opined that the variables impacting the behavior of women of reproductive age in Rwanda who seek out maternal health care were household assets. The study used cross-sectional data sets from all data rounds to develop a wealth index. The results show that women who gave birth five years before the RDHS in 2000

and 2005 were less likely to deliver their children in hospitals than women who gave birth five years before the RDHS in 1992. The study's findings show that the proportion of assisted deliveries has gradually increased as women now seek prenatal care at much higher rates. This study contributes to the understanding of why many women continue to give birth at home without assistance from medical professionals.

2.3.1 Impact of a Social Workers on Health Behaviour and Maternal Mortality

The overall health of a community offers insight into many aspects of society and how systems within that society care for people. By examining the health outcomes of certain groups within a population compared to others, much can be learned about the overall health of that population, the status of certain groups within society, and the equity of systems such as healthcare and welfare. Maternal mortality and infant mortality are two of the strongest indicators of overall community health (Durch et al., 1997).

According to the Center for Disease Control (CDC) and Pregnancy Mortality Surveillance System (2018), black infants die at more than twice the rate of white infants. This data similarly demonstrates that between 2011 and 2016, the maternal mortality rate among black mothers was more than three times higher than the Caucasian maternal mortality rate. Exploring these two groups outlines the worst outcomes alongside some of the best outcomes. This vast disproportionality exposes many realities of social inequality, poverty, and racism while calling attention to the linked social, economic, and public health implications.

The complexity and intersectionality of this issue call for a multidisciplinary, dynamic approach towards improvement and speak to an area of interest for the social work community. Many active public health and medical interventions also aim to address social and health factors. According to the California Department of Public Health Black Infant Health Program (2020),

the mission of this program is to support the African American population by addressing both their medical and social needs. This highly effective program employs the expertise of public health nurses as well as social workers and has shown success in empowering African American women within their communities and improving immediate and generational health outcomes.

The effectiveness of this program speaks to the benefits of taking a multidisciplinary approach at a practice level. According to the National Association for Perinatal Social Workers (2016), a major goal of the job as a medical social worker is to mitigate the effects of medical and psychosocial challenges faced by women, children, and families. Applying strong multidisciplinary support at the point of medical contact is integral to addressing the psychosocial needs of these women and infants. In this setting, the scope of practice of medical providers cannot accommodate an in-depth biopsychosocial assessment, which highlights the importance of competent social workers working alongside medical professionals.

The shared responsibility for improving community health is spread among the communities, including public servants, medical providers, public health officials, policymakers, and social workers. The social risk factors and barriers associated with this medical reality call for a strong social work and associated policy response. The National Association of Social Workers (NASW) Code of Ethics (2017) indicates the responsibility of social workers to practice with racial and ethnic competence, advocate for social justice, and remain educated on updated research and areas of diverse needs. The complexity of these issues should be met with structural analysis and a systems approach. The interconnected nature of health outcomes and social and environmental factors emphasizes the importance of developing and implementing meaningful social work interventions and practices, as well as integrating this knowledge into social work education.

2.4 Theoretical Framework

This inquiry will be guided by Thaddeus and Maine's (1994) three delays model. According to this model, the key socio-cultural factors that prevent or contribute to maternal mortality in all nations are the three main delays. Age, education, culture and tradition, belief systems, peer pressure, and spouse permission are just a few socio-cultural constraints and barriers that influence women's behavior and, consequently, their choice to seek out and use local health facilities. These considerations include socio-cultural restrictions and barriers in addition to medical difficulties.

The model suggests that a woman's decision to seek medical attention and subsequently use the nearby healthcare facility is influenced by a variety of variables, including her level of education, her line of work, the timing of her most recent birth, and her awareness of pregnancy danger signs, among others. The core tenet of the concept is that there are three phases of delays that might prevent a woman from receiving proper prenatal care and ultimately play a significant role in maternal death (Win et al., 2014). Pregnant women, their husbands, or other family members must first decide to seek care, then travel to a health facility, and then wait to obtain the necessary care after arriving at the facility.

According to Yunus, Kauser, and Ali (2013), timing is key when addressing maternal mortality and disability because most issues have a window of 12 hours or more during which life-saving maternity care can be provided. For instance, postnatal hemorrhage can result in a woman's death in less than two hours. The three delays model is a useful tool for managing obstetric difficulties and formulating laws to safeguard expectant mothers from injury or death. Yunus et al. (2013) envisioned and enumerated the three delays as follows:

- Avoiding medical attention, delaying proper treatment, or
- holding out for hospital treatment.

The first two specifically deal with issues surrounding access to care, such as peer or community pressure, a lack of transportation options, and pressure from within the family to give birth at home. When a patient arrives at a hospital, her journey may not necessarily be over because there may be a need to direct her to another institution, as the closest clinic may not be equipped to handle the disease or provide basic first aid. The third focuses on issues within the entire healthcare system, which could result from poor infrastructure, inadequate transfusion equipment, a lack of qualified employees, or other problems. Two additional reasons for delays in the timely delivery of necessary care are delayed or inaccurate diagnosis and staff errors. No safe motherhood program can be successful until these three delays are addressed (Yuri and company, 2013).

The three delays model emphasizes the cognitive and psychological factors that influence the choices and actions of women of reproductive age who seek medical attention, which is the paradigm that best informs our study. The complex relationships between social, economic, and cultural restrictions, as well as the elements influencing women's health behaviors and maternal mortality in the study area, are better understood with this model. The model also helps to identify and categorize the variations in women's health behaviors found across the study's rural, suburban, and urban areas.

CHAPTER THREE

METHODOLOGY

3. 0 Introduction

The section focuses on the various techniques that were utilized in collecting and analyzing the data for this study. In order to achieve its objectives, the techniques, processes, proportions, and sample size of the research activity are reviewed and provided in this section. It also evaluates the research design of the study, explains the various data gathering techniques used, analyzes the acquired data, and presents the findings.

3.1 Research Area

Egor Local Government Area is located in Edo State, in the South-South geopolitical zone of Nigeria, with its headquarters in Uselu. The local government area is comprised of several towns and villages, including Okhoro, Uselu, Uwelu, Iguikpe, Ugbighoko, Iguediaye, Evbougide, and Oghedaivbiobaa. The population of Egor local government area is estimated to be 258,442 inhabitants, and it is home to members of various tribal groups such as Esan, Bini, and Owan. The area is inhabited by Christians, Muslims, and traditional worshippers, and languages spoken in the area include Bini, Owan, and Esan. Egor falls under the Tropical Savannah Climate, covering a total area of 93 square kilometers. The region experiences two distinct seasons, namely the rainy season and the dry season, with an average temperature of 28 °C. The estimated humidity level of Egor local government area is around 68%.

3.2 Research Design

A research design is a design and blueprint that a researcher uses as a benchmark throughout the various stages of the research process. According to Yomere and Agbonifo (1999), a research design refers to the inferences made about the connections between and among the variables being studied in the project. The study design defines the population being investigated, the sample size, the sampling method, the data sources, the measuring techniques, the questionnaire design, and the method of data collection. In this context, a cross-sectional survey of the population under study was required. This approach was used in this study because it is both affordable and appropriate for studying the occurrence of the issue being investigated.

3.2 Population of the Study

This study consisted of female residents of the study area who were 17 years of age or older, had lived there for at least one year, and possessed prior knowledge of the study's subject matter, which included health and illness behavior as well as maternal mortality. The selection of this population was not influenced by their religion, ethnicity, level of education, or any other social factors. The study area, Egor local government area, comprised 12 wards based on the population forecast for 2019. To randomly choose 5 wards, the names of all the wards were written on pieces of paper and placed in a bowl or container for lucky draws.

3.3 Sample Size and Sampling Technique

The sample is a small portion of the target population that represents all its characteristics. Taro Yamani's formula was used to compute the sample size for this study, utilizing the entire population of the study area as displayed. The study's sample consisted of 450 randomly selected female participants from the chosen 5 wards of Egor LGA, Edo State. Find these figures in the formula depicted below.

$$Pn=p^0 (1tr/100)^n$$

Where:

Pn = Current Year Population

P^O = the Base Year Population

R = Annual Growth Rate

n = Number of Intermediary Year

$Pn = 339,899 (1+2.74/100)^{14}$

Pn = 492,854

Consequently, 492,854 people by census predicted to live in Egor Local Government in 2020. The sample size is supplied to calculate the sample size.

$n = N/1+n (e)^2$

$n= 492,854/ 1+492,854 (0.047)^2$

n = 492,854/1089.7 = 452 = 450

The area has a total of 12 wards, out of which 5 were selected in a methodical manner to serve as a sample and analysis unit for the study. The study employed a multi-stage sampling strategy and a stratified method. The following steps were followed: Randomly selecting five major streets from the five wards, houses numbered 1, 5, 10, 15, and 20 were chosen from each street until a total of 50 households were selected. This process was repeated in each of the selected wards until the required number of volunteers was obtained.

However, if a residence was an industrial, public, religious, or educational establishment, the next house was chosen, regardless of its current residential status. If the first woman approached declined or refused to participate in the study, another woman who satisfied the criteria of being in the reproductive years and having resided in the area was approached. The questionnaire was administered to adult females in the selected residential households who were of reproductive age, specifically between 17 and 49 years old.

Women who had relocated to the neighborhood within the past year or had refused to participate in the study were not included. Males and females older than the reproductive age were also not eligible for participation. In addition to the 50 individuals chosen from each street, five additional individuals were interviewed using the interview guide. One female staff member from each of the five wards, specifically female medical or paramedical staff members working in hospitals in the study area, were intentionally selected.

The health officer or health centre managers at the secretariat for the Egor local government area were contacted. The primary goal of the study was to understand the health behaviors of women of reproductive age and how these behaviors may impact maternal mortality and health in the region. Additionally, access to the medical records and archives of the research area was sought. In-depth interviews were conducted to supplement the information and data gathered from the questionnaire administered to the participants.

Interviews were conducted with the five selected individuals. After the fieldwork, the interviews were recorded and transcribed. Three research assistants received training to aid in administering the questionnaire and recording the in-depth interviews. Three female students in the Department of Social Works, who were in their final year, received training on research ethics, best practices, and questionnaire administration to ensure a better understanding of the rights and privileges of research participants and obtain informed consent.

3.4 Method of Data Collection

The study utilized a one-time sample survey to administer a structured questionnaire and conduct semi-structured interviews with prospective participants in the study area. Both qualitative and quantitative primary data were collected using various approaches. The qualitative data was obtained through in-depth interviews with a selected sample of participants, while the quantitative data was gathered through the questionnaire. Secondary data were acquired from newspapers, books, reports in the archives of the local government territory under investigation, as well as publications, journals, the internet, and magazines.

3.5 Research Instruments

The instruments used in this study were a structured questionnaire and an interview guide. Questionnaires were distributed to the selected individuals. Section A of the questionnaire contained two questions and collected participants' personal information, such as their age, sex, location of residence, religion, marital status, level of education, position, occupation, and number of children. Section B comprised questions about the phenomenon being examined, specifically Health Behaviour and Maternal Mortality.

The aim was to avoid measurement error, surrogate information error, and any deviation from the phenomenon under investigation. The questions in the questionnaire were written clearly and concisely in English to ensure early comprehension and to elicit necessary and relevant responses from the participants. The survey included both open-ended and closed-ended questions to allow participants to freely express their opinions. Additionally, an in-depth interview guide was used to conduct interviews with a subset of participants, aiming to gather further relevant information that would enhance the study's findings.

3.6 Reliability and Validity

To ensure the accomplishment and secure sustained validity and reliability of the instrument utilized in this study, and to prevent ambiguity and subjectivity, the accuracy of the instruments and consistency in their administration to the research participants were assured. The research instruments (the questionnaire and interview guide) were validated by the researcher and other senior faculty members prior to the beginning of the fieldwork. Although participants in the pilot study were not included in the final field survey, the research instruments were administered during the pretesting or piloting phase. A pretest and pilot survey were conducted before the fieldwork survey and questionnaire administration.

3.7 Method of Data Analysis

The main goal of any research endeavor is to characterize and define the population through data collection from the study sample and data analysis. Data analysis, according to Yomere and Agbonifo (1999), is a crucial phase of the research process since it aims to create meaning from the data collected during the course of the investigation. Therefore, if the analysis is not done properly, researchers are likely to come to erroneous findings that will negate the entire goal of the study. Efforts must be made to ensure that the questionnaire is administered and retrieved appropriately.

The administered copies of the questionnaire should be gathered, tagged, labeled, screened, and preserved before entering the data into the computer for analysis using the Statistical Package for the Social Sciences (SPSS) (Version 21). Univariate analysis was used to examine variables and was accompanied by the appropriate usage of sample frequency, percentage, charts, and graphs, while the content of the qualitative data was reviewed. The main points made in the interview were identified through transcription before any conclusions were made. Finally, key themes

were developed by grouping related emergent concepts. The qualitative and quantitative data were enhanced and used to draw conclusions from the study.

CHAPTER FOUR

PRESENTATION OF DATA AND DISCUSSION OF FINDINGS

4.0 Introduction

This chapter contains the data presentation, analysis, and interpretation of the data collected for this study. Consequently, it entails the application of both mathematics and statistical techniques to provide the basis for analyzing the research objectives listed in Chapter One. Hence, it is a vital part of this study as it forms the basis for the conclusion and policy recommendations.

4.1 Presentation of Results

Tables and percentages were used as the most appropriate means of interpreting information for easy understanding. In analyzing the data, judgments were based on the number of favorable or unfavorable responses received for each statement in the questionnaire. Generally, the favorable responses are "strongly agree" and "agree," while the unfavorable responses are "strongly disagree" and "disagree." The results of the collected data are analyzed below based on each research question. Out of the four hundred and fifty (450) questionnaires distributed, four hundred and five (405) were well completed and valid for the analysis of this study.

4.2.1 SECTION A: Socio-demographic Characteristics of the Respondents

Gender of the respondents

Variable		**Frequency**	**Percentage (%)**
Gender	Male	0	40
	Female	405	100
	Total	**405**	**100**

Source: Field Survey, 2023

The table above shows the gender of the respondents. There were no male respondents (0%), while 100% of the respondents were females. This means that the target respondents were females.

Age Distribution of the Respondents

Variable	Frequency	Percentage (%)
Below 20 years	45	11
21-25 years	50	12
26-30 years	75	19
31-35 years	42	10
36-40 years	82	20
41-45 years	74	18
46- 50 years	37	9
51 and above	0	0
Total	**405**	**100**

Source: Field Survey, 2023

The table above shows the gender of the respondents. The table indicates that 45 respondents (11%) were below 20 years old, while 50 of them (12%) were between the ages of 21 and 25 years. Furthermore, 75 of the respondents (19%) were between the ages of 26 and 30 years, and 42 respondents (10%) fell within the age range of 31 to 35 years. In addition, 82 of them (20%) were between the ages of 36 and 40 years, while 74 (18%) were between the ages of 41 and 45 years. Moreover, 37 respondents (9%) were between the ages of 46 and 50 years. Meanwhile, there were no respondents representing (0%) those aged 51 years and above. Consequently, this data reveals that the largest portion of the respondents fell within the age group of 36 to 40.

Marital Status of the Respondents

Variable	Frequency	Percentage (%)
Single	62	15

Married	318	79
Divorced	6	1
Widowed	16	4
Separated	3	1
Total	**405**	**100**

Source: Field Survey, 2023

In the table above, 62 respondents representing 15% were single, 318 (79%) were married, 6 respondents (1%) were divorced, 16 of them (4%) were widowed, while 3 representing 1% were separated. This shows that a larger number of the respondents were married.

Education Status

Variable	Frequency	Percentage (%)
SSCE	86	21
NCE/OND	59	15
HND/B.Sc	204	50
M.Sc	21	5
Others	35	9
Total	**405**	**100**

Source: Field Survey, 2023

In the table above, 86 of the respondents (21%) were SSCE holders, 59 of them (15%) were NCE/OND holders, 204 (50%) were HND/B.Sc. holders, 21 (5%) were M.Sc. holders, while 35 (9%) were holders of other degrees. This shows that a large number of the respondents were HND/B.Sc. holders.

Occupation of the Respondents

Variable	Frequency	Percentage (%)
Public Servant	53	13

Civil Servant	45	11
Self-employed	182	45
Others	125	31
Total	**405**	**100**

Source: Field Survey, 2023

The table further shows that 13% of the total respondents were public servants, 11% of them were civil servants, 45% were self-employed, while 31% of the respondents had another occupation.

Religion of Respondents

Variable	Frequency	Percentage (%)
Christianity	312	77
Islam	85	21
ATR	0	0
Others	8	2
Total	**405**	**100**

Source: Field Survey, 2023

In the table above, 312 of the respondents, representing 77%, were Christians, 85 (21%) were Muslims, and none (0%) practiced ATR, while 8 of them (2%) belonged to other religions. This shows that a large number of the respondents are Christians.

SECTION B

Research question one; to what extent does socio-economic factors influence women's health behaviours in Egor Local Government Area in Edo State

Research Questions

Key: SA (Strongly Agree), A (Agree), U (Undecided), SD (Strongly Disagree), D(Disagree**)**

Table 7: Respondents responses to the extent to socio-economic factors that influence women's health behaviors in Egor Local Government Area in Edo State

S/n	The Socio-economic factors influence women's health behaviors in Egor Local	SA 5 f/(%)	A 4 f/(%)	U 3 f/(%)	D 2 f/(%)	SD 1 f/(%)	Mean (x)

	Government Area in Edo State.						
7	Economic and psychological factors do not have an impact on women's health behavior.	40 (10)	32 (8)	12 (3)	190 (47)	131 (32)	4.22
8	Socio-economic considerations or pressure from close family members influence the choice of healthcare service	142 (35)	153 (38)	11 (3)	48 (12)	51 (13)	4.02
9	Women's health behavior is a crucial factor in the overall analysis of maternal health in Nigeria	232 (57)	152 (37)	2 (1)	8 (2)	11 (3)	3.81
10	Healthcare behavior is closely related to a person's quality of life	235 (58)	140 (35)	10 (2)	12 (3)	8 (2)	3.91
	Average	**162(40)**	**119(30)**	**9(2)**	**65(16)**	**50(12)**	**3.99**

Source: Field survey (2023)

The table above shows an average of 3.99 out of a maximum of 5, which is a strong indication that socio-economic factors influence women's health behaviors in Egor Local Government Area in Edo. It also clearly shows that a significant proportion of respondents, 38.55%, strongly agreed and 30% agreed that socio-economic factors influence women's health behaviors in the area of study. On the other hand, 16% expressed their disagreement, 12% strongly disagreed, while 2% articulated a neutral opinion.

Table 8: Respondents' responses to the extent to which cultural variables that contribute to women's delayed access to healthcare in Egor Local Government Area in Edo State

S/N	**The cultural variables that contribute to women's delayed access to healthcare in Egor local government area in Edo State**	**SA 5 f/(%)**	**A 4 f/(%)**	**U 3 f/(%)**	**D 2 f/(%)**	**SD 1 f/(%)**	**Mean (x)**
11	Behavioral attitude towards healthcare is one of the most important choices one can make in life	202 (50)	180 (45)	5 (1)	10 (2)	8 (2)	4.06
12	Some people resort to self-medication by buying modern pharmaceuticals and herbal cures for infertility	240 (59)	132 (33)	7 (2)	12 (3)	9 (2)	3.81
13	Unhealthy behavior poses a major threat to women's health in Nigeria context	120 (30)	150 (37)	8 (2)	112 (28)	15 (4)	3.59
14	Unavailability of proper	208	191	0	2	4	3.78

	healthcare service by the government result in various diseases among women	(51)	(47)	(0)	(1)	(1)	
	Average	**193(48)**	**163(40)**	**7(2)**	**34(8)**	**8(2)**	**3.81**

Source: Field survey (2023)

Table 8 above shows an average of 3.81 out of the maximum of 5, which is a strong indication of cultural variables that contribute to women's delayed access to healthcare in the study area. It also clearly shows that a significant proportion of respondents, 88%, expressed agreement, with 48% articulating strong agreement and 40% articulating agreement, regarding cultural variables that contribute to women's delayed access to healthcare in Egor local government area in Edo State. On the other hand, 10% expressed disagreement, while 2% articulated a neutral opinion.

Table 9: Respondents responses on the extent to which types of healthcare services that influence women's access to healthcare and health-related behaviours in the research area.

S/N	The types of healthcare services that influence women's access to healthcare and health-related behaviors in the research area	SA 5 f/(%)	A 4 f/(%)	U 3 f/(%)	D 2 f/(%)	SD 1 f/(%)	Mean (x)
15	The state of a woman's physical and mental health prior to, during, and following pregnancy and childbirth is referred to as maternal health	245 (60)	152 (38)	1 (1)	2 (1)	4 (1)	3.93
16	Poor maternal healthcare is common among women of reproductive age in Nigeria	262 (65)	127 (32)	0 (0)	10 (2)	2 (1)	4.16
17	The Nigerian government doesn't provide healthcare services in order to allow all citizens to have equitable access	221 (54)	181 (44)	0 ()	1 (1)	2 (1)	4.25
18	Women's choices and behaviors during prenatal care sometimes have a significant effect on their health	129 (32)	155 (38)	10 (2)	30 (8)	81 (20)	3.72
	Average	**214(52)**	**154(38)**	**3(1)**	**11(3)**	**22(6)**	**4.02**

Source: Field survey (2023)

Table 9 above shows an average of 4.02 out of a maximum of 5, which is a strong indication that the types of healthcare services influence women's access to healthcare and affect women's health-related behaviors in the study area. It also clearly shows that a significant proportion of respondents, 90%, expressed that the types of healthcare services influence women's access to healthcare and their health-related behaviors in the research area. On the other hand, 9% disagreed, while 1% expressed a neutral opinion.

Table 10: Respondents' responses to the extent the type of health habits of the women in Egor Local Government in Edo State have

S/N	The type of health habits of the women in Egor Local Government in Edo State have	SA 5 f/(%)	A 4 f/ (%)	U 3 f/(%)	D 2 f/(%)	SD 1 f/(%)	Mean (x)
19	Pregnancy and various related maternal health issues are inextricably tied to a healthy mother, child, and nation.	152 (38)	138 (34)	18 (5)	55 (14)	42 (10)	4.07
20	Maternal mortality and health behavior are not intertwined	136 (34)	143 (35)	20 (5)	68 (17)	38 (9)	3.74
21	Maternal mortality is not only brought by medical issues but also by underlying social and economic problems	142 (35)	151 (37)	11 (3)	40 (10)	60 (15)	3.97
22	Health behaviors that postpone obtaining fast and appropriate care in an emergency are a major contributor to maternal death	235 (58)	149 (37)	1 (1)	9 (2)	11 (3)	3.77
	Average	**166(41)**	**145(36)**	**13(3)**	**43(11)**	**38(9)**	**3.89**

Source: Field survey (2023)

Table 10 above reveals an average of 3.89 out of a maximum of 5, which is a strong indication that there are different types of health habits among the women in Egor Local Government in Edo State. It also shows that a significant proportion of respondents, 77%, of which 41% expressed strong agreement and 36% expressed agreement, believe that there are different types of health habits among the women in the area of study. On the other hand, 20% expressed disagreement, while 3% remained neutral in their opinion.

Table 11. Respondents' responses to the Extent of common is maternal mortality in the study area

S/N	How common is maternal mortality in the research area	SA 5 f/(%)	A 4 f/(%)	U 3 f/(%)	D 2 f/(%)	SD 1 f/(%)	Mean (x)
23	Women's access to healthcare services to ensure a healthy pregnancy and delivery is regarded as human rights	129 (32)	68 (17)	10 (2)	110 (27)	88 (22)	3.89
24	Poor management of health workers can lead to maternal mortality	241 (60)	145 (36)	2 (1)	10 (2)	7 (2)	3.87
25	The precise number of women who die during pregnancy or nursing is unknown due to underreporting and misclassification of maternal mortality	252 (62)	141 (35)	0 (0)	7 (2)	5 (1)	4.08
26	Maternal mortality is very low in the research area	135 (33)	151 (37)	55 (14)	36 (9)	28 (7)	3.82
	Average	**189(47)**	**126(31)**	**17(4)**	**43(11)**	**32(8)**	**3.92**

Source: Field Survey (2023)

Table 11 above shows an average score of 3.92 out of a maximum of 5, which is a strong indication that there are common maternal mortality issues in the research area. It also clearly demonstrates that a significant number of respondents, 78%, expressed their agreement, with 47% strongly agreeing and 31% agreeing that there are common maternal mortality issues in the research area. On the other hand, 19% expressed their disagreement, while 4% held a neutral opinion.

Section C

Interview Guide

Please, tell me what you know about maternal health

Feedback from Maternal Health

The majority of the respondents believed that maternal health means motherly care, postnatal care, post-delivery care, nurturing, parenting, guiding, among others, while some respondents answered that they truly understand maternal health.

1. What are the challenges of women in accessing health services during pregnancy in your area?

The respondents said that this will result in a poor upbringing of the child, leading to diseases, poverty, inadequate training, delinquencies such as stealing and drug abuse, and other vices. They also mentioned an unstable family environment, characterized by rancor and misunderstandings.

2. How do you access health facilities in your area and how many of such health facilities in your area?

Some mentioned inadequate facilities and health personnel, harassment from health personnel, non-residency of health personnel, and inaccessibility to health centers.

3. How do you rate the services of the maternal health facilities in your area and what are the usual attitudes of the health workers in the health facilities in your area?

Most of the respondents said they didn't have up-to-date facilities at the Egor Health Centre, while some complained bitterly about the attitudes of health workers in various health centres. Some respondents had misconceptions about the causes of maternal mortality, as many mentioned evil spirits. Some respondents felt that "lack of having sex after the onset of

pregnancy can cause labor obstruction." Yet another traditional ruler suggested that "once a woman is pregnant, she should not be given too much food, as it will cause the baby to grow big, and she may not be able to deliver the baby." Meanwhile, a married woman declared that "mental stress and over ambition will cause hypertension in some women, and they will die in labor because of the hypertension."

4. What do you think are the roles of culture and belief systems in maternal mortality in your area?

Based on the respondents' responses, there is a psychological impact on both the husband and the child left behind. This was the response of most of the respondents. The psychological issues affecting the husband include the stress of losing his wife, the difficulty of finding another wife similar to the one who passed away, and the responsibility of caring for the child or children left behind. "The husband is usually left with problems," as indicated by a community leader who was a victim of maternal death. He added, "I'm in the same situation; my first wife died and left me with eight (8) children, and as a result, we are all facing difficulties."

5. Please suggest the way forward in the context of maternal mortality in your area?

Opinions regarding what can be done to reduce maternal mortality were provided by the respondents. Suggestions include:

1. Government and community leaders should inform, educate, and sensitize people on maternal and child health. This can be accomplished through mass media, advocacy to community and religious leaders, community sensitization, and mobilization, especially targeting rural dwellers.

2. Some respondents emphasized the importance of educating and counseling husbands. They should not only allow their wives to attend antenatal services but also support hospital delivery and encourage early health-seeking behaviors when necessary.

3. For the government, most respondents recommended prayers and good governance. They also suggested locating clinics closer to rural dwellers, providing free or affordable drugs, controlling expired drugs and foods, limiting traditional birth attendant (TBA) activities, increasing the number of qualified health personnel in government clinics, equipping clinics with basic equipment, and expanding poverty alleviation programs to reach more poor rural dwellers.

4. Respondents advised health personnel to be more dedicated to their duties, show concern for their patients, and refrain from harassing them.

5. Husbands and parents were encouraged to provide good nutrition for their families, allow their wives to attend antenatal clinics and give birth in hospitals, avoid early marriage of their daughters, invest in girl-child education, practice child spacing, and not overwork their wives, especially during pregnancy.

6. Women were advised not to patronize traditional medicine sellers but to attend antenatal clinics and deliver in hospitals. They should also avoid delays in seeking medical attention and consume nutritious food. One female respondent specifically suggested that women should prioritize good nutrition over fashion and avoid sacrificing their health for material possessions.

4.2 Discussion of Findings

Positive relationships exist between socioeconomic factors and women's health behaviors in Egor Local Government Area in Edo State. This is in line with the study conducted by Chandhiok et al.(2006), who assert that prenatal care also plays a key and significant role in

preparing a woman and her family for childbirth. Prenatal care fosters trust between the woman and her healthcare professional, tailors health promotion messaging, and may make pregnant women and their families more aware of the importance of labor and delivery care. It can also familiarize them with medical facilities so they can easily seek help when needed.

Other reports suggest that maternal deaths in Ethiopia are caused by or linked to various socioeconomic and demographic factors, such as the mother's and spouse's educational levels, occupations, age, knowledge of danger signs, marital status, and women's autonomy/gender issues. These elements are associated with the utilization of maternity care services, similar to other nations, and the utilization is connected to various barriers (CSA, 2014; Kifle et al., 2017).

There is a relationship between cultural variables and women's delayed access to healthcare in the study area, which aligns with the findings of a study in Myanmar conducted by Vap et al. (2013). The study revealed that more than half of the women had to make daily judgments about whether to seek medical help, leading to delays in receiving appropriate care at medical facilities and delays in reaching the facilities. In that survey, most of the mothers were aged between 35 and 39; only one had a higher level of education; more than half had jobs, and 82% lived in rural areas.

There is also a relationship that examines the types of healthcare services and women's access to healthcare and health-related behaviors in the research area. This finding is consistent with a study by Banda (2013), which stated that women can obtain prenatal care services by visiting a health center where such services are accessible or by receiving care from medical experts during domiciliary visits, especially those in urban centers or those who live close to a health facility in a rural region. Prenatal care is included in maternal care, which generally starts in the early stages of pregnancy.

Additionally, there is a relationship between types of health habits and women in Egor Local Government in Edo State. This finding supports the World Health Organization (WHO, 2012) report, which highlighted disparities, inequities, and variations resulting from both overt access barriers, such as distance and cost, and covert barriers, such as women's lack of autonomy in decision-making and control over household resources. The health and illness behaviors of women of reproductive age have an impact on how they utilize health facilities and services.

CHAPTER FIVE

SUMMARY, SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

The study examined the effect of health behavior on maternal mortality in Egor Local Government Area of Edo State. This chapter focuses on summarizing the research findings, providing conclusions, recommendations, and suggestions for further research.

5.1Summary

This study, titled "Health Behavior and Maternal Mortality in Egor Local Government Area of Edo State," was structured into five chapters to effectively carry out this research. The study raised five objectives on which research questions were formulated. The significance of the study was also discussed, along with the area of study, scope, and delimitations. Chapter two reviewed literature related to the topic, which critically examined and analyzed the views of psychologists, social workers, and other concerned scholars on the concepts, types, and theories of the main variables. The theoretical framework used in the study was the three delays model.

In chapter three, the design and methodology of the study were discussed. The research design employed was a survey design. The population for the study consisted of all female residents from the study area. A total of 450 female residents were sampled using a simple random sampling procedure. The instrument used for data collection was the questionnaire. The returned questionnaires were analyzed using simple percentage tables. Chapter four presented the analysis of the collected data, which were analyzed through the use of descriptive and inferential statistics. Chapter five presented a summary, conclusion, summary of findings, and recommendations.

5.2 Summary of the Findings

A number of findings were made in the study of which they were enumerated below;

1. A positive relationship exists between socio-economic factors and women's health behaviors in Egor Local Government Area in Edo State.
2. There is a relationship between cultural variables and women's delayed access to healthcare in the study area.
3. There is a relationship between the types of healthcare services and women's access to healthcare and health-related behaviors in the study area.
4. There is a relationship between types of health habits and women in Egor Local Government in Edo State.
5. There is a common maternal mortality rate in the research area.

5.3 Conclusion

The study explores the effect of health behavior on maternal mortality in Egor Local Government Area of Edo State. The results showed a positive and significant relationship between socioeconomic factors and women's health behaviors. It was also discovered that cultural variables influenced women's delayed access to healthcare in the area. Additionally, there is a relationship between the types of healthcare services available and women's access to healthcare and health-related behaviors in the area.

The sustained commitment of political leaders, governments at various levels, development partners, and other stakeholders is necessary to ensure that pregnancy and childbirth become safer for women in Nigeria. At all levels of government, there is a need for greater attention to policies that improve women's and girls' access to safe sexual and reproductive health services, as well as the expansion of human and material resources for maternal health. Reducing maternal

deaths in Nigeria is not solely the responsibility of healthcare workers, as there is only so much they can achieve on their own without support from the top.

Therefore, the government should provide a platform that makes the work of every healthcare worker more manageable. This can be done by creating health promotion policies, providing necessary infrastructure (modern hospitals, equipment, good roads, regular training of healthcare workers, and so on), and encouraging local communities to abandon their old beliefs by creating awareness about the benefits of visiting a health center during and after pregnancy. Purposeful leadership and strong political will are key in translating the goal of maternal health and wellbeing into reality. The behavior of healthcare workers towards pregnant women and nursing mothers is an important but often overlooked factor contributing to the high maternal mortality rate in Nigeria.

5.4 Recommendations

Based on the foregoing, it is necessary to make the following recommendations:

i. Health workers, such as midwives, should possess sufficient knowledge to comprehend the potential risk factors that affect pregnant women in the communities they serve.
ii. Training for health workers should enable them to provide personalized emotional support, education, and practical assistance.
iii. The health professional should play an active role in the protective and preventive measures that ensure a safe delivery for mothers.
iv. Improving the quality of care given to women plays an important role in enhancing patient outcomes. Making healthcare more patient-focused by obtaining feedback and opinions from patients would help initiate the process of delivering quality care.

v. Appraisal forms should be given to patients to ascertain their feedback and satisfaction regarding the care they have received. Based on the feedback received, queries or positive reinforcements can be provided as deemed fit by supervisors.

vi. Proper training for healthcare workers would help to build proper interpersonal and communication skills and teach them to show empathy and compassion. An example of a resource that can help achieve this is the World Health Organization manual titled "Counseling for Maternal and Newborn Healthcare."

vii. After training, proper supervision is necessary to ensure accountability, adherence, and the application of skills learned. Positive reinforcement and incentives, such as monetary bonuses and "staff of the month" awards, can serve as motivation for staff.

viii. There is a need for improved working conditions and welfare of healthcare workers in the country, which may translate into improved attitudes towards their patients.

5.5 Suggestions for Further Research

Due to the limitations of this study, the following suggestion were made;

1. Further studies should be carried out to explore whether health behavior and maternal mortality will replicate the results in another region in Nigeria
2. Similar studies should be carried out using a larger sample to see whether it will replicate the findings of this study.
3. Others researchers should conduct similar studies using privately owned health centers to find out what their responses would be.
4. Carrying out similar studies to this one, using other foreign-owned health centers, to find out whether similar results will be produced.

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Appendix

Department of Social Work,
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University of Benin,
Benin City, Edo State.

3rd April 2023.

Dear Sir/Madam

REQUEST FOR FILLING OUT QUESTIONNAIRE

I humbly request your assistance in filling out this questionnaire. This questionnaire is aimed at eliciting responses on **"Health Behaviour and Maternal Mortality in Egor Local Government area of Edo State"**, in partial fulfillment of an award of M.Sc. in Social Work from the University of Benin. Your prompt response will be highly appreciated and used exclusively for academic purposes. Any information given will be treated in strict confidence.

Thanks in anticipation.

Yours faithfully,

Olofua Egwonor Love

SECTION B

Please kindly tick (√) on your choice of answer.

Instruction: Please indicate as appropriate.

1. Gender: Male { } Female { }

2. Age: below 20 years { }, 21-25 years { }, 26- 30 years { }, 31-35 years { }, 36- 40 years { }, 41 -45 years { }, 46 -50 years { }, above 50 years { }
3. Marital Status: Single { }, Married { }, Divorced { }, Widowed { } Separated ( )
4. Educational Qualification: SSCE { }, ND/NCE { }, HND/BSC { }, M.Sc. { }, others, please specify…….
5. Occupation: Public servant{ }, Civil Servant { }, Self-Employed { }, Others { }
6. Religion: Christianity ( ) Islam ( ) ATR ( ) Others please specify…….

Section B

Instructions: please indicate the extent to which you agree with the following, you are to assess the following on a scale of "strongly agree to strongly disagree".

Key: SA= Strongly Agree, A= Agree, U= Undecided, D= Disagree, SD= Strongly Disagree

S/n	**The Socio-economic factors that influence women's health behaviours in Egor Local Government Area in Edo State.**	**SA**	**A**	**U**	**D**	**SD**
7	Economic and psychological factors do not have an impact on women's health behavior.					
8	Socio-economic considerations or pressure from close family members influence the choice of healthcare service					
9	Women's health behaviour is a crucial factor in the overall analysis of maternal health in Nigeria					
10	Healthcare behaviour is closely related to a person's quality of life					
	The cultural variables that contribute to women's delayed access to healthcare in Egor local government area in Edo State					
11	Behavioural attitude towards healthcare is one of the most important choices one can make in life					
12	Some people resort to self-medication by buying modern pharmaceuticals and herbal cures for infertility					
13	Unhealthy behaviour poses a major threat to women's health in Nigeria context					
14	Unavailability of proper health care service by the government result in various diseases among women					
	The types of healthcare services that influence women's access to healthcare and health-related behaviours in the research area					
15	The state of a woman's physical and mental health prior to, during, and following pregnancy and childbirth is referred to as maternal					

	health					
16	Poor maternal health care is common among women of reproductive age in Nigeria					
17	The Nigerian Government doesn't provide health care services in order to allow all citizens to have equitable access					
18	Woman's choices and behaviours during prenatal care sometimes have a significant effect on their health					
	The type of health habits of the women in Egor Local Government in Edo State have					
19	Pregnancy and various related maternal health issues are inextricably tied to a healthy mother, child, and nation.					
20	Maternal mortality and health behaviour are not intertwined					
21	Maternal mortality is not only brought by medical issues but also by underlying social and economic problems					
22	Health behaviours that postpone obtaining fast and appropriate care in an emergency are a major contributor to maternal death					
	How common is maternal mortality in the research area					
23	Women's access to healthcare services to ensure a healthy pregnancy and delivery is regarded as human rights					
24	Poor management of health workers can lead to maternal mortality					
25	The precise number of women who die during pregnancy or nursing is unknown due to underreporting and misclassification of maternal mortality					
26	Maternal mortality is very low in the research area					

Interview Guide

1) Please, tell me what you know about maternal health

2) What do you think are the determinants of maternal health behaviour of women in your area?

3) What are the challenges of women in accessing health services during pregnancy in your area?

4) How do you access health facilities in your area and how many of such health facilities in your area?

5) How do you rate the services of the maternal health facilities in your area and what are the usual attitudes of the health workers in the health facilities in your area?

6) Comment freely of the rate of maternal mortality in your area?

7) What do you think are the roles of culture and belief systems in maternal mortality in your area?

8) Please suggest the way forward in the context of maternal mortality in your area?