

Culture and Maternal Health: A Study of Oruagu and Nnewichi Women of Reproductive Age between 15-49 Years in Anambra State

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ABSTRACT

For women of childbearing age, the major challenge is the risk of maternal death as a result of poor health during pregnancy and childbirth. This study explores socio-cultural factors and their implications on maternal health in rural communities in Nigeria using Owukpa community and Obollo-Eke community as study areas. The data were generated from a cross sectional survey of mothers aged 15-49 years in both communities whether married or unmarried. A cluster random sampling procedure and non probability sampling were adopted to select 572 respondents for the study, out of this 560 constituted the questionnaire which was the major instrument for data collection, and 12 was based on in-depth interview guide. The result shows that most of the factors identified have serious implications for maternal health in the two communities though the degree at which the factors affect health varied. The factors include; education, poverty, nutrition, lack of basic social amenities, inadequate and inaccessible health care services, lack of family planning, low status of women, gender base violence, and paternity pattern. The study revealed that paternity pattern practised in the two communities differed, The result also shows that certain attitudes like; early marriage, delay in seeking service, sex preference and desire for many children, and sexual activities among the unmarried affect the health of women however with certain degree of variations among the two communities.

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Introduction

Globally, at least one woman dies every minute from complications related to pregnancy or child birth. That means 500,000 women deaths a year (United Nations Millennium Summit, 2000). Amala, Indra, Jerker, Martins, Lalin, and Prabha (2003) put the figure at 515,000 while WHO (2005b) put it at 529,000. United Nation Millennium Summit (2000) reported that the number - one killer of women in developing countries is not disease whose cure eludes the world or condition which the world lacks resources to treat rather it is pregnancy and childbirth. World Health Organization (2005b) noted that in addition to every woman who dies in child birth, around 20 or more others suffer injury, infection or disease.

The choice of the two rural communities that is (Obollo Eke and Owukpa) is to examine disparity in the socio-cultural factors and their implications on maternal health in the two communities.

Statement of the Problem

Many women suffer and die carelessly because they lack access to good health care and clear useful information about their health. According to Abejide,

Makanjuola and Okonofua (1992), high maternal mortality rate in sub-Saharan Africa and other developing nations is currently a major source of concern to policy makers throughout the world. Adetokunbo and Gills (2003) noted that poor maternal health leads to maternal mortality. According to the Prevention of Maternal Mortality Network PMMN (1992), 10% of the maternal deaths that occur in the world each year take place in Nigeria.

The conditions that produce poor maternal health in Nigeria are to be found almost everywhere in sub-Saharan Africa and are surely worse in some places. Adetokunbo and Gilles quoted above have observed that the medical and obstetric cause of poor maternal health leading to maternal mortality is now known. WHO (1985) maintained that 75% of maternal death in Africa are attributable to direct obstetric complications such as hemorrhage, obstructed labor, infections, toxemia and unsafe abortions.

Based on the foregoing, this study aims at finding out the socio-cultural factors affecting maternal health in Obollo Eke and Owukpa communities in Udenu L.G.A of Enugu State and Ogbadigbo L.G.A of Benue State respectively.

Research Questions

1. What is the situation of maternal health in Obollo Eke and Owukpa communities?
2. What are the socio-cultural factors affecting maternal health in Obollo Eke and Owukpa communities?
3. What are the consequences of poor maternal health in Obollo-eke and Owukpa communities?
4. What are the health implications of paternity pattern on women in Obollo-eke and Owukpa?

Hypotheses

The following hypotheses are put forward to guide the study

1. Women with higher levels of education are more likely to be aware of their health needs than women with lower levels of education

2. Women who have a higher level of occupation are more likely to utilize modern medicine than women who have a lower level of occupation.
3. Women who believe in traditional medicine are much less likely to seek professional help than women who believe in modern medicine.
4. Women who live in a community where paternity is customarily determined exclusively by biology are more likely to have their health endangered than women who live in a community where paternity is determined both biologically and socially.

The ages of the respondents ranged from 15-49 years. This is because only women of child bearing age were used. These fell into seven age group intervals (see table I)

Table I. Percentage Distribution of Respondents' by Age

Age		Owupka		Obollo- Eke	
		f	%	f	%
15	-19	52	(19.4)	21	(7.7)
20	-24	98	(36.6)	33	(12.2)
25	-29	44	(16.4)	61	(12.5)
30	- 34	36	(13.4)	84	(31.0)
35	- 39	21	(7.8)	39	(14.4)
40	- 44	11	(4.1)	16	(5.9)
45	- 49	6	(2.2)	17	(6.3)
Total		268	(100.0)	271	(100.0)
Mean		25.8 years		30.7 years	
Standard deviation		7.48 years		7.56 years	

Field survey, 2011.

Majority of the respondents in Owupka (56%) were below 25 years of age as against (19.9%)% in Obollo-eke (table.1). In Owupka, those within the age group of 20-24 years had the highest proportion of respondents 36.6% (98), while in Obollo-eke those within the age group of 30-34 years had the highest respondents of 84 (31.0%). Those within the age range of 45-49 years had the least number of respondents 6 (2.2 %) in Owupka while those in age range of 40-44 years had the least number in Obollo-Eke 16 (5.9%). The average age of the distribution in Owupka was 26 years while that of Obollo-eke was 31years. This shows that though the two communities are rural, women bear children earlier in Owupka than in Obollo-Eke.

Table II. Percentage Distribution of Respondents Opinion on the Situation of Maternal Health in the Two Communities.

Opinion	Owupka		Obollo-eke	
	f	F	f	F
	(%)	(%)	(%)	(%)
Very Good	-	8	-	3.0
Good	-	73	-	26.9
Fair	17	119	17	43.9
Poor	122	41	122	15.1
Very Poor	129	30	129	11.1
Total	268	271	268	100.0

Field Survey, 2011.

The above table shows that majority of the respondents 251(93.6%) in Owupka indicated that the situation of Women's health in the community was poor/very poor, while only 17 (6.3%) said that it was fair. On the other hand, 119 (43.9%) respondents which constituted the majority in Obollo-Eke indicated that the situation was fair, 73 (26.9%) said it was good, while 71(26.2%) said that it was poor/very

poor, only a few respondents 8(3.0%) said was very good. This distribution shows that there was poor health situation in the two communities. However, the situation seems to be worst in Owupka community. Thus, poorer health condition in Owupka could be attributed to high illiteracy level as indicated on table III which also has association with type of occupation. This is also presented in fig.1. below for easy grasping.

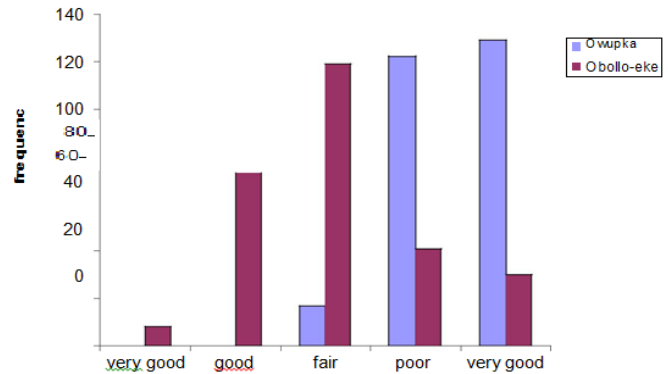


Figure 1. Distribution of Respondents by Situation of Maternal Health in the Two Communities Socio-Cultural Factors Affecting Maternal Health in Owupka and Obollo-eke Communities

The focus here is to identify the various socio-cultural factors that affect women's health in the two communities. The first identified factor here was education. The respondents were asked to describe women's level of education in their communities. Table II shows their responses.

Table III. Percentage Distribution of Respondents Opinion on the Description of Women Level of Education in the Two Communities

	Owupka		Obollo-eke	
Education	f	(%)	f	(%)
Very high	-	-	23	(8.5)
High	8	(3.0)	80	(29.5)
Medium	11	(4.1)	116	(42.8)
Low	81	(30.2)	40	(14.8)
Very low	168	(62.7)	129	(4.4)
Total	268	(100.0)	271	(100.0)

Field Survey, 2011.

In Owupka community, only 8(3.0%) of the study population described women's education as high, while in Obollo-eke community, 23(8.5%) and 80(29.5%) of the respondents described it as high and very high respectively. Though the majority of the respondents in the two communities described the educational level of women as low and very low, the illiteracy level in Owupka has been identified before as higher than that of Obollo-eke community. This factor has serious health implication for women since it is the chief determinant of every other factor.

Table IV. Percentage Distribution of Respondents Opinion on the Effect of Poverty on the Health of Women in the Two Communities

Poverty	Owupka	Obollo-eke
	f(%)	F(%)
No effect	4(1.5)	5(1.8)
Adversely/badly	192(71.6)	152(56.1)
Very adversely/badly	72(26.9)	141(42.1)
Total	268(100.0)	271(100.0)

Field Survey, 2011.

The table above shows that majority of the respondents in the two communities indicated that poverty has adverse effect on the health of women (Owupka 98.5%; Obollo-eke

(98.2%). This was not surprising in the sense that the poor health of the women has generally been attributed to the poor condition of life which is characteristics of most rural communities in Nigeria.

Table V. Percentage Distribution of Respondents' Opinion on whether Pregnant Women Eat what they are Supposed to Eat

Eating Habit	Owupka		Obollo-eke	
	f(%)	f(%)	f(%)	f(%)
Yes	8(3.0%)	58(21.4)		
No	260(97.0)	213(78.6)		
Total	268(100.0)	271(100.0)		

Field Survey, 2011.

This table shows that very few of the study population in Owupka community 8(3.0%) indicated that pregnant women eat what they are supposed to eat while pregnant, as against 58(21.4%) proportion in Obollo-eke community who are of the same opinion. However, majority of the respondents in the two communities, 260(97.0%) and 213(78.6%) in Owupka and Obollo-eke respectively, indicated that pregnant women do not eat what they are suppose to eat while pregnant. This could however have association with both level of education and type of occupation.

Table VI. Percentage Distribution of Respondents Opinion on Adequacy and Accessibility of Health Care Services in the Communities.

Adequate and Accessible Health Care Services	Owupka		Obollo-eke	
	f	(%)	f	(%)
Adequate	12	(4.5)	27	(10.0)
Inadequate	111	(41.4)	117	(43.2)
Accessible	20	(7.5)	18	(6.6)
Not accessible	125	(46.6)	109	(40.2)
Total	268	(100.0)	271	(100.0)

Field Survey, 2011.

Table VI shows that most of the respondents in Owupka community 111(41.4%) and 125 (46.6%) maintained that health care services are inadequate and inaccessible respectively, the situation was the same in Obollo-eke as majority of the respondents 117(43.2%) and 109(40.2%) also indicated that health care services were not adequate and accessible respectively. These conditions could be as a result of poor socio-economic and political system of Nigeria which has for years neglected the rural part of the country.

Table VII. Percentage Distribution of Respondents Opinion on the Availability of Medical Professionals

Availability of Medical Professionals	Owupka		Obollo-eke	
	f	(%)	f	(%)
Readily available	5	(1.9)	74	(27.4)
Not readily available	254	(94.8)	187	(69.3)
Don't know	9	(3.4)	9	(3.3)
Total	268	(100.0)	271	(100.0)

Field Survey, 2011.

The table above shows that most of the respondents (Owupka 254(94.8%); Obollo-eke187(69.3) indicated that

medical professionals were not readily available. However, while only 5(1.9%) respondents in Owupka indicated that they were readily available, a reasonable proportion of the respondents in Obollo-eke with 74(27.4%) indicated that medical professionals were readily available. On the other hand, equal number of respondents 9(3.4%) were recorded for those who had no knowledge of the situation in the two communities. The information provided by the data confirms that there were structural differences in the two communities.

Table VIII. Percentage Distribution of Respondents by Distance to the Nearest Hospital

Distance to the Nearest Hospital	Owupka		Obollo-eke	
	f	(%)	f	(%)
3-3.9km	4	(1.5)	11	(4.1)
4-4.9km	5	(1.9)	40	(14.8)
5-5.9km	9	(3.4)	36	(13.3)
6-6.9km	51	(19.0)	40	(14.8)
7-7.9km	64	(23.9)	56	(20.7)
8km and above	87	(32.5)	36	(13.3)
Don't know	48	(17.9)	52	(19.2)
Total	268	(100)	271	(100)

Field Survey, 2011.

The above table indicate that the majority of the respondents 87(32.5%) in Owupka and 56(20.7%) in Obollo-eke live 8km and above, and 7-7.9km respectively from the nearest hospital. However, a significant number of the respondents in the two communities Owupka 48(17.9%); Obollo-eke 52(19.2%) could not measure the distances from the hospital.

Table IX. Percentage Distribution of Respondents Opinion on Practice of Female Circumcision

Practice of Female Circumcision	Owupka		Obollo-eke	
	F	(%)	f	(%)
Yes	7	(2.6)	7	(2.6)
No	261	(97.4)	264	(97.4)
Total	268	(100)	271	(100)

Field Survey, 2011.

This table shows that, in the two communities very few respondents with an equal percentage of 2.6% indicated that there was a practice of female circumcision, while the majority 261(97.4%) and 264(97.4%) in Owupka and Obollo-eke respectively said that the practice was not in existence in the communities. Thus, the data show that female circumcision was not a common practice in the two communities.

Table X shows that majority of the respondents in Owupka community199 (74.3%) indicated no knowledge of birth control, only 69(25.7%) have the knowledge. However, of those that have the knowledge only 47(17.2) actually use birth control methods. While in Obollo-eke 227(83.8%) indicated knowledge of birth control and only 44(16.2%) indicated no knowledge of birth control. Though a significant proportion 49.1%(133) of women in that community are not using birth control method, up to 138(50.9%) indicated that

Table X. Percentage Distribution of Respondents' Opinion on Knowledge and use of Birth Control

Knowledge and Use of Birth Control	Owupka Knowledge		Use		Obollo-eke Knowledge		Use	
	f	(%)	f	(%)	f	(%)	f	(%)
Yes	69	(25.7)	46	(17.2)	227	(83.8)	138	(50.9)
No	199	(74.3)	222	(82.8)	44	(16.2)	133	(49.1)
Total	268	(100)	268	(100)	271	(100)	271	(100)

Field Survey, 2011.

they are using it, showing a higher level of both knowledge and use for the women of Obollo-eke. The high knowledge and use of birth control methods among women of Obollo-eke community could equally be attributed to the women's level of education which is higher than that of women of Owupka community.

Table XI. Percentage Distribution of Respondents Opinion on Availability of Basic Social Amenities

Basic Social Amenities	Owupka		Obollo-eke	
	f	(%)	f	(%)
Fair	-	-	35	(12.9)
Bad	98	(36.6)	103	(38.0)
Very bad	170	(63.4)	133	(49.1)
Total	268	(100)	271	(100)

Field Survey, 2011.

Table XI shows that there was lack of basic social amenities in the two communities as 98(36.6%) and 170(63.4%) in Owupka and 103(38.0) and 133(49.1%) in Obollo-eke indicated bad/ very bad situation of basic amenities respectively, only 35(12.9%) in Obollo-eke indicated that the situation was fair. The implication of these is that government has not done fairly well in the provision of basic social amenities in the two communities and this has effect on the women's health.

Table XII. Percentage Distribution of Respondents by Age at Marriage

Age at marriage	Owupka		Obollo-eke	
	f	(%)	f	(%)
less than 15years	84	(31.3)	28	(10.3)
15-19years	126	(47.0)	61	(22.5)
20-24years	46	(17.2)	107	(39.5)
25-29years	-	-	54	(19.9)
30years and above	-	-	21	(7.7)
don't know	12	(4.5)	-	-
Total	268	(100)	271	(100.0)

Field Survey, 2011.

Majority of the respondents in Owupka 126(47.0%) answered that women marry within the age range of 15-19years, up to 84 (31.3%) indicated that women marry at age less than 15years while 46(17.2%) said that women marry within age 20-24years. However, in Obollo-eke majority of the respondents 107(39.5%) indicated that women marry within the age of 20-24years,61(22.5%) answered 15-19years,54(19.9%) indicated 25-29years,28(10.3%) indicated less than 15years while 21(7.7) indicated 30years and above. This means that even though there is early marriage in the two communities, it is more in Owupka than Obollo-Eke. The differences in the age at marriage could however be attributed to illiteracy which is higher in Owupka than in Obollo-eke. However, a line graph will enhance our view of this and hence enable us appreciate the differences in age at first marriage (see fig.2 below).

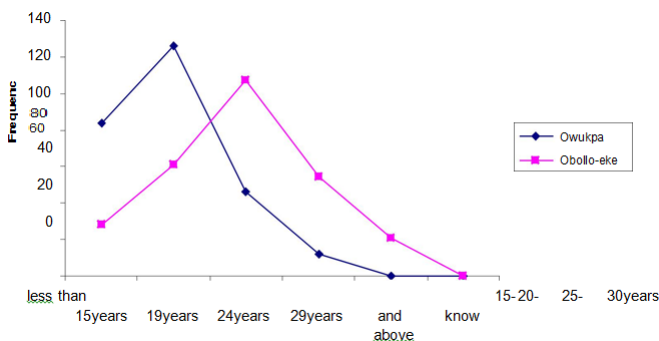


Figure 2. A line graph: Distribution by Age at First Marriage.

Table XIII. Percentage Distribution of Respondents Opinion on Probable Cause of Delay in Seeking Health Care Services

Delay in Seeking Health Care Services	Owupka		Obollo-eke	
	f	(%)	f	(%)
Poverty	78	(29.1)	130	(48.0)
Lack of knowledge of ill health	30	(11.2)	35	(12.9)
Distance to health care	45	(16.8)	31	(11.4)
Poor transportation	46	(17.2)	20	(7.4)
All of the above	62	(23.1)	55	(20.3)
Don't know	7	(2.6)	-	-
Total	268	(100)	271	(100)

Field Survey, 2011.

Majority of the respondents 78(29.1%) in Owupka and 130(48.0%) in Obollo-eke identify poverty as the major cause of delay in seeking health care services, while 62(23.1%) in Owupka and 55(20.3%) in Obollo-eke attributed such delay not only to poverty but also to other factors like lack of knowledge of ill health, 30(11.1%) and 35(12.9%); distance to health care center 45(16.8%) and 31(11.4%); and poor transportation 46(17.2%) and 20(7.4%) in Owupka and Obollo-eke respectively, while 7(2.6%) in Owupka indicated that they don't know.

Consequences of Poor Maternal Health

Another issue to be considered here is the consequences of poor maternal health. The study tried to investigate the respondents opinion on what could be the implication of women's poor health. These were their responses.

Table XIV. Percentage Distribution of Respondents' Opinion on the Consequences of Poor Maternal Health

Consequences	Owupka		Obollo-eke	
	f	(%)	f	(%)
Increase in death rate	79	(29.5)	63	(23.2)
Suffering for the children, family and society	83	(31.0)	47	(17.3)
All of the above	104	(38.8)	161	(59.4)
Don't know	2	(.7)	-	-
Total	268	(100.0)	271	(100.0)

Field Survey, 2011.

This table above shows that the majority of the respondents in the two communities Owupka 104(38.8%); Obollo-eke 161(59.4) indicated that both increase in death rate, suffering for the children, family and society are all consequences of poor maternal health. Only 2(.7%) indicated don't know as a response. Having investigated the situation of maternal health in the two communities, effort was made towards finding out from the respondents the possible measures that could be adopted to address the problem of poor maternal health.

Test of Hypotheses

In testing the hypotheses that guided this study, the two areas of study were merged together since the two communities are considered rural. The purpose of this section is to establish whether there is a statistical significant relationship between the identified dependent and independent variables that had been stated in the hypotheses

Hypothesis I

Hypothesis one state that women with higher levels of education are more likely to be aware of their health needs than women with lower levels of education.

Findings similar to those in the preceding section had been reported by Adetokunbo and Gills (2003); Harrison 1985; PMMN (1992). For instance Harrison 1985 in his study of 22,774 consecutive births in Zaria reported that education is a strong determinant of maternal health. Based on this, it

has been hypothesized for this study that women with higher levels of education are more likely to be aware of their health needs than women with lower levels of education. Though, the categorize we had under the educational variable included no formal education, FSLC, WASC, NCE/OND, BSC/HND, and M.Sc/PhD, for purposes of analysis, these were regrouped into low which included no formal education and FSLC, medium which is WASC and high which is NCE and above. To test this hypothesis, questionnaire item 37 which sought to obtain information on where the respondents usually go to for assistance in time of pregnancy (since it is believed that choice of health facilities is dependent on awareness of health need and level of education) was cross tabulated with level of education. This hypothesis was tested using chi-square statistic. (See table XV below).

Table XV. Percentage Distribution of Respondents' Choice of Health facility by

Educational attainment	Modern		Choice of health facility				Total	
			Traditional		Non medical(faith)			
	f	(%)	f	(%)	f	(%)	f	(%)
Low	151	(39.7)	53	(60.2)	31	(43.7)	235	(43.6)
Medium	131	(34.5)	24	(27.3)	31	(43.7)	186	(34.5)
High	98	(25.8)	11	(12.5)	9	(12.7)	118	(21.9)
Total	380	(100.0)	88	(100.0)	71	(100.0)	539	(100.0)

Level of Education
 $\chi^2 = 18.877, df=4, p \text{ value}=.001$

This table shows that of 235 (43.6%) number of respondents that had low level of education, 151(39.7%) consult modern health facilities, 53(60.2%) go to traditional health facilities while 31(43.7%) consult non medical professionals like pastors, and priest. As the level of education increased, there was a high reduction on the proportion of the respondents that patronize traditional health facilities 24(27.3%), and 11(12.5%), for medium and high educational attainment respectively. Though, both those in low and medium level of education recorded equal number of respondents 31(43.7%) for those who patronize non medical facilities, there was also a significant reduction as the number of respondents continues to fall as the level of education become higher. However, of 181(21.9%) respondents that had high educational attainment, 98(25.8%) respondents consult modern health facilities while only 9(12.7%) consult non medical facilities.

However, with the calculated χ^2 exceeding the critical χ^2 value at 0.00 level of significance, we therefore accept the hypothesis which state that there is statistical significant relationship between level of education and choice of health facilities at 0.05% level of significance.

The next is hypothesis two, where we will find out the relationship between the occupational level of the respondents and the utilization of modern medicine.

Table XVI. Percentage Distribution by Type of Occupation and Utilization of Modern Medicine.

Type of Occupation	Utilization of Modern Medicine									
	Strongly agree		Agree		Strongly disagree		Disagree		Total	
	f	(%)	f	(%)	f	(%)	f	(%)	f	(%)
Unemployed	8	(2.1)	0	(.0)	0	(.0)	0	(.0)	8	(1.5)
Student	47	(12.2)	0	(.0)	0	(.0)	0	(.0)	47	(8.7)
Apprentice	99	(25.8)	32	(27.8)	0	(.0)	0	(.0)	131	(24.3)
Farming	60	(15.6)	30	(26.1)	5	(50.0)	0	(.0)	95	(17.6)
Civil servants	77	(20.1)	0	(.0)	0	(.0)	5	(16.7)	82	(15.2)
Business/ trading	81	(21.1)	32	(27.8)	5	(50.0)	8	(27.7)	126	(23.4)
Artisan	8	(2.1)	21	(18.3)	0	(.0)	17	(56.7)	46	(8.5)
Other	4	(1.0)	0	(.0)	0	(.0)	0	(.0)	4	(.7)
Total	2384	(100.0)	115	(100.0)	10	(100.0)	30	(100.0)	539	(100.0)

$\chi^2 \text{ value} = 194.979, df=21, p \text{ value}=0.00$

Hypothesis II

Hypothesis two states that women who have a higher level of occupation are more likely to utilize modern medicine than women who have a lower level of occupation. To test this hypothesis, a table showing the cross tabulation of item 5 and one of the items on no 8 will be constructed. Item 5 was raised in the questionnaire to determine the occupational level of the respondents while one of the items on no 8 was raised to determine the accessibility of health care services in the communities. Here it is believed that the accessibility of health care services will be dependent on occupational level. See table XVI below.

The table shows that with the exception of 5(50.0%) Proportion of respondents whose occupation was farming and business/trading among all the occupational status no other occupational groupings indicated strong agreement to the fact that level of occupation determines utilization of modern medicine. However, 17(56.7%) of those who were artisan indicated just disagreement to this fact, this was followed by 8(27.7%) respondents who had business/trading as their occupation and 5(16.7%) of respondents who were civil servants. On the other hand, higher proportion of those who agreed/strongly agreed were recorded for apprentice 131(53.6%), business/trading 113(71.1%), farmers 90(41.1%), Students 47(12.2%). Artisan and unemployed recorded equal number of respondents of 8(2.1%) each while other like house wife also recorded 4(1.0%) number of respondents.

However, to arrive at a justifiable conclusion, we may need to establish the statistical significance of the observed relationship. To do this, it was hypothesised in this study that "women with higher level of occupation are more likely to utilize modern medicine than women with lower level of occupation" the variables on table XVI above were used to test this hypothesis using chi square (χ^2) statistic.

With the calculated χ^2 exceeding the critical χ^2 value at 0.00 level of significance the null hypothesis stands rejected. The conclusion therefore is that there is a statistical significant relationship between the level of occupation and utilization of modern medicine. This is important for the current campaigns for improvement in women' status as this will definitely lead to improve in quality of health, though, the situation is dependent on other factors like education. This finding confirms the social class theory propounded by Karl Marx which was one of the theories reviewed in this study. The theory tried to categorize the society based on their economic strength. This also validates the assertion made by Haralambos, Holdborn, and Heald (2004), which state that the concept of health vary according to social group.

With these, we may proceed to the next issue of the study which is relationship between belief system and seeking of professional help.

Hypothesis IV

This hypothesis states that women who live in a community where paternity is customarily determined exclusively by biology are more likely to have their health endangered than women who live in a community where paternity is determined socially. To establish if paternity pattern can endanger the health of women item 31 was cross tabulated with one of the items on 33 and 34 for exclusive and social paternity in the two communities respectively. Item 31 was raised in the questionnaire to obtain information on the type of paternity practice in each of the communities while exclusive paternity exposure of women to sexually transmitted diseases (STD) was picked from item 33 and social paternity exposure to Abortion was picked from item 34 (see table XXVIII).

The above table shows that a higher proportion of the respondents indicated that exclusive paternity exposes women to sexually transmitted diseases and combined social and exclusive paternity as well encourages abortion. It was a strong agreement with 178(58.7%), and 125(41.3%) respectively. While those that indicated just agree were 18(13.3%) and 117(86.7%). On the other hand, while 60(65.9%) and 31(34.1%) respondents indicated a strong disagree to this fact, only few respondents with 5(50.0%) respondents each for both exclusive and combined social and biological fatherhood indicated just disagreement.

However, despite the fact that majority of the respondents in both communities indicted that paternity poses health hazard for the women, there was varied opinion on preference for particular pattern of paternity as regards the health of women during the interview segments. While majority of the respondents in Owupka would not like to go for any thing less than exclusive paternity as they consider it an abomination to have father-child relationship with a child whom you do not have biological relationship with, some of the respondents lamented high level of promiscuity owing to the fact that the unmarried women are not worried about the paternity of any child that comes out of unmarried relationship since they know that such child will surely have a father. However, one of the respondents stressed on this very issue as she observed that there have been a high increase of sexually transmitted diseases like HIV/AIDS in the community. She also noted the rate at which women (both married and unmarried) give birth and the parity level. However, in Obollo-eke some respondents were equally

skeptical about social paternity. According to one woman during the interview section, "the psychological trauma that goes with social paternity for both child and mother is usually too difficult to come by, thereby leading to depression state".

To establish the significance of this relationship it was hypothesized that women who live in a community where paternity is customarily determined exclusively by biology are more likely to have their health endangered than women who live in a community where combined social and biological paternity obtains.

This was supported by the chi-square (χ^2) value 90.666 which was found to be significant at 0.05 level. One may be led to conclude therefore, that paternity pattern can endanger women's health. However, one may not be surprised over this considering the social context of male dominance in our society.

Having established the relationship between health and some identified socio-cultural factors, it becomes necessary to determine the background variable that has the strongest influence on maternal health. Though a number of variables suggested to have effect on maternal health, education, poverty, eating habit and early marriage were chosen (see section 4.7).

Conclusions

Results from the analysis of data which are in agreement with earlier findings indicated that, fundamental changes in the health status of women in Owupka and Obollo-eke communities required greater opportunities for education and employment. These facts were made obvious in the study as most respondents even during the interview section indicated low education and poverty level as the major underlying cause of poor health among women in the two communities. However, the dimensions and consequences of the health problems of women in the two communities require urgent improvement in their health systems.

Maternal health means more than access to health care. To be truly healthy women need the chance to make decisions necessary for good health and they need access to a fair share of the resources in their communities and in the world. Little wonder why WHO recognized that health is more than the absence of disease. This concept keeps before government and the public the understanding that health is not something which can be achieved exclusively by medical services. It is profoundly influenced by conditions of life. The value of this interpretation means that health involves elimination of poverty, universal education, full and rewarding employment.

Table XVII Percentage Distribution by Opinion on whether Paternity Pattern Endanger the Health of Women

Paternity pattern	Opinion on whether paternity can endanger women's health									
	Strongly agree		Agree		Strongly disagree		Disagree		Total	
	f	(%)	f	(%)	f	(%)	f	(%)	f	(%)
Exclusive paternity Pattern (exposes women to sexually Transmitted diseases)	178	(58.7)	18	(13.3)	60	(65.9)	5	(50.0)	261	(48.4)
Combine Social And Exclusive paternity pattern (encourages abortion)	125	(41.3)	117	(86.7)	31	(34.1)	5	(50.0)	278	(51.6%)
Total	303	(100.0)	135	(100.0)	91	(100.0)	10	(100.0)	539	(100.0)

$$\chi^2 = 90.666 \text{ df} = 3. \text{ p value} = 0.00$$

Recommendations

Based on this study the following recommendations are made;

1. An area that calls for urgent attention has to do with women-centered policy making and programming in rural communities in Nigeria. This means that a call for action should go beyond the health sector into areas such as education, employment, legal and judicial framework.
2. It is acknowledged that most rural communities in Nigeria are male dominant, hence, the promotion of human rights of women especially in rural communities is recommended as this will help women to take certain decisions about their health and free them from coercion and violence.
3. Improving awareness of obstetric complication among members of a pregnant women's immediate and wider social network is very important. In other words, effort should be directed towards involving men in certain reproductive health issues since they are the dependent factor in most families especially in rural communities.
4. Changing social norms is imperative to quality health for women. Gender disparity leaves women powerless over certain issues concerning their health. Women should be empowered economically in rural areas through micro credit and increasing employment opportunities.
5. Improvement should be made on availability and accessibility of health facilities in order to enhance and promote health care delivery system in rural communities.

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