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DETERMINANTS AND UTILISATION OF MATERNAL AND CHILD HEALTH (MCH) CARE SERVICES AMONG WOMEN OF CHILDBEARING AGE

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Abstract
This study examined the determinants and utilisation of maternal and child health (MCH) cares services among women of childbearing age. The determinants were maternal age, maternal educational background and residential location in the utilisation of available MCH care services comprising of the blood tests, urine analyses, routine immunisation, personal hygiene and exercise during antenatal visits in pregnancy and postnatal visits after birth. It was concluded that antenatal visits during pregnancy should be encouraged to help detect when pregnancy is at risk. It was also concluded that Health care providers should emphasize the need to take babies for post-natal immunisation, as babies from 0-5 years need to be immunised at regular intervals before reaching their fifth birthday and it is necessary to discourage the use of non-prescribed drugs on children when they are ill, rather they should be taken to the health facility for proper diagnosis. It was recommended among others that women should be enlightened on the care of pregnancy and safety measures that ensure safe delivery.

Keywords: maternal health, child health, determinants, utilization, care services, women of childbearing age

Introduction

The concept of family health encompasses maternal and child health, family planning, nutrition and health education had gained wide acceptance. Family health was considered an 'approach whereby an effort is made to improve the health of the various individual in the family through multidisciplinary services and thus influence society as a whole" (WHO, 2014). Maternal and Child Health (MCH) was one of the priority programmes established by the World Health Assembly in its first convention held in 1947. Maternal and Child Health services were almost entirely limited to emergency curative treatment and did not include preventive care. However, Sacksena and Sheldon (2012) observed that MCH should not be considered as a specialized, separately administrative service, but as an integral part of total health. This is especially true where such hazards exist as poor sanitation, malnutrition and communicable diseases. These underline many of the conditions dealt with when individual care is given to a mother or infant.

Abdallah (2010) reiterated the need for appropriate health care services that will enable women to go safely through pregnancy and childbirth and produce a healthy infant. Maternal care includes care during pregnancy and should begin from the early stages of pregnancy. Women can get antenatal care services either by visiting a health centre where such services are available or from health workers during their domiciliary visits. The former gives an idea about the voluntary utilization of the services by women while the latter is related to the quality aspect of the services. One of the most important components of antenatal care is to offer information and advice to Women about pregnancy-related complications and possible curative measures for the early detection and management of complications. Health problems confronting the world today are caused by the actions and inactions of the people. In the developing or less developed countries, communicable diseases, high rate of infant and maternal mortality are largely due to the inactions of people to get themselves good housing, good supply of drinking water, not utilizing available health services, for example, pregnant women not utilizing

antenatal care services, this is an integrated and multidisciplinary service formally adopted as a strategy in 1978 during the Declaration of Alma Ata. The declaration made Primary Health Care the major strategy for achieving Health for All by the year 2000 and beyond (WHO, 2000).

In September 2000, the largest-ever gathering of Heads of States ushered in the new millennium by adopting the Millennium Declaration. The Declaration, endorsed by 189 countries, was then translated into a roadmap, setting out goals to be reached by 2015 thus,

i. Eradicating extreme poverty and hunger

ii. Achieve universal primary education

iii. Promote gender equality and empower women

iv. Reduce child mortality

v. Improve maternal health

vi. Combat HIV/AIDS, malaria and other diseases

vii. Ensure environmental sustainability

viii. Develop a Global Partnership for the development

Also, the Alma Ate declaration of Primary Health Care integrated seven (7) Basic components, namely;

- Education on prevailing health problems and the methods of Preventing and controlling them;

- Promotion of food supply and proper nutrition;

- Adequate supply of safe water and basic sanitation;

- Maternal and child care, including family planning;

- Immunisation against the major infectious diseases;

- Appropriate treatment of common diseases and injuries; and

- Provision of essential drugs (WHO 1994).

An attempt by humans to preserve and nurture the human race is as old as the history of human existence. One of such attempts is the provision of mother and child health care following the 1978 Alma-Ata Declaration by the World Health Organization. WHO (1994) identified Maternal and Child Health (MCH) as promotive and preventive health care specifically designed for mothers and children. In most developing countries, mothers and children constitute up to two-thirds of the population of an average district, they also constitute the biological vulnerable groups (WHO, 1994). Hence, mother and child health services constitute an important area of health care. Further services may be added to the concept of MCH activities depending upon local needs. For example, nutrition rehabilitation centres, mothercraft classes and demonstrations, vegetable gardens and adult literacy, especially, female literacy has an important bearing on the health of the family and several countries like Uganda, Kenya, and Malaysia have integrated programmes of adult literacy with MCH services.

Maternal and Child Health services according to WHO (2000) are aspects of modern health care specifically designed for the health promotion of the mother and child. These services involve promotive, preventive, curative and rehabilitative health care for mothers and children. The benefits of these services to the nation, community and individuals are enormous. According to Loudon (2000),

Women were most commonly in their mid-twenties when they married, and could expect the birth of their first child twelve to thirteen months later. Motherhood was considered the highest calling for a married woman, but the unmarried mother was subject to moral, economic, and social censure. Poor, unmarried mothers were on occasion driven to commit infanticide, but the harsh penalties for such a crime were not always invoked. Howell, Egorova, Janevic, Balbierz, Zeitlin and Hebert (2017) in addition to this stated that MCH services are the channel of taking health care to a greater proportion of the population. According to Howel et al (2017), women and children constitute 68 per cent of the population in any developing country including Nigeria. Maternal Child Health services thus guarantee healthy citizens. Chandra, Copen and Stephen (2013) also claim that MCH services help to reduce Ante-natal deaths and disabilities which add to the global burden of pregnancy and pregnancy-related diseases. According to him, infants do not die for most parts from diseases of childhood that are preventable but in most cases because of conditions arising while they were still in their mother's womb. This can be prevented by simple intervention during pregnancy, delivery and immediately after birth.

For benefits of MCH services to accrue to the nation and community and individuals, it requires that the services must be utilised in full.

Available MCH Care Services

Antenatal

1. Pregnancy examination
2. Blood test
3. Urine analyses
4. Routine immunization
5. Antenatal medication
6. Nutritional advice
7. Dressing codes
8. Personal hygiene
9. Exercises

Postnatal

1. Routine immunization at birth
2. Routine immunization at 6 weeks
3. Routine immunization at 10 weeks
4. Routine immunization at 14 weeks
5. Routine immunization at 9 months

Many people are reluctant to make use of medical services, largely due to ignorance or cultural beliefs, but other factors play a part too. For example, health centres and sub-centres stand out as different from other constructions and dwellings in rural areas. Their style of construction, roofing and finish is different and most are fenced in. The health workers inside them are in uniforms and usually are people who were born in some other parts of the country. They have a different lifestyle and rarely participate in the social and cultural life of the village. Naturally, the villagers are reluctant to interact with them,

this and many other factors have for long militated against the utilization of MCH in many localities (Howel et al, 2017).

The National Health Policy has as its goal to provide a level of health care that will enable Nigerians to achieve socially and economically productive lives through the system of care — Federal Ministry of Health has PHC as parts of its components — Maternal and Child Health (MCH) care and family planning. The policy pointed out that since health development contributes to and result from socio-economic development, it should be seen as an essential component of the total package of social and economic development and as an instrument of social justice and national security (Chandra et al 2013). Only recently has this policy been linked to mother and child health status and behaviour. The health status of mother and child and the behaviour of mother have been acclaimed to be directly related to societal progress (WHO, 2000).

Healthy Families America (2013) observed that relatively little is known, however, about the concept of MCH as the key to progress in reproductive health. The concept addresses the mother's ability to manage the many competing demands on her as she appreciates the value accrues in using health care services during pregnancy, understands the virtue of safe motherhood and prepare the stage for safe delivery. Several studies outside Nigeria including WHO (2000) in studies conducted on Trends in Reproductive and Family Health in the Western Pacific have shown how MCH services utilisation pattern can influence evaluation in health care provision and utilisation; and how socio-demographic factors such as age, education, residential location and so on, can influence utilisation of MCH services. Even though several studies have been conducted on reproductive health, there is a paucity of data on MCH care services as influenced by socio-demographic factors as the basis for decision-making guiding health policies in Nigeria. Little attention has been given to the practices of women in the community as they prepare to bear children and provide care for the child.

Maternal Age

Womens' health literature is filled with observations about "adolescents" and "young adults". Their vulnerability caused by their young age and their lack of access to health services put young adults at higher risk. The WHO (2000) defined adolescents as the period from 10-.15 years, and complement that broad category with the term that extends the age range "youth" 15-20 years, "young people," 10-20 years, and children," 0-18 years "young adults" has recently emerged as the preferred term but adolescents remain widely used. In practice, these terms are often used with considerable variability and overlap. Harrison and Kobilnsky (2003) remarked in a study conducted in Bangladesh on the factor of age in reproductive health that in 1994 young people (10-24 years) were estimated at almost 1.5 billion or approximately one-third of the world's population. The global teenage population (15-19 years) was estimated at 513 million, out of which 23 per cent or 118 million are women. Over half the world's population is under age 25 and more than 80 per cent of the world's youth live in developing countries.

Harrison and Kobilnsky (2003) reported further that, in poorer countries, more women bear children during their teenage years. For example, in Bangladesh, nearly two-thirds of women bear children by age 18 and one-fifth before age 15. While having a child immediately following marriage is a tradition in many societies meaning teen marriage and pregnancy may not only be highly desirable but even a societal necessity, the high number of teenage pregnancies-wanted or unwanted is a major issue for all regions.

Several pre-1997 studies in the USA concluded that the adverse health consequences associated with childbearing were greater for younger women than for older women. However, Gerd, Ophelia, and Margaretta (2000) observed that these studies did not control for socioeconomic status and other related factors. He pointed out that studies, which find age differences, tend to find them in measures that are sensitive to socio-economic factors, rather than in biological constrained outcomes of labour and delivery.

Gerd, et al (2000) reported that the risk associated with pregnancy and childbirth among the 15-19 years age group was contrasted with those among the older women. Teenagers had a higher incidence of anaemia but had a higher incidence of hypertension, disorder or hospital admissions, and they were as likely as older women to have had a formal delivery. On the issue of healthcare use, studies reported by

Gerd, et al (2000) showed that adolescents with adequate prenatal care have outcomes as good or better than their older counterparts. But many adolescent women do not get adequate prenatal care. In the United State, 45, per cent of young pregnant women do not consult their doctors until they are more than 3 months pregnant. In Britain, the figure is 27 per cent. The study in the United States of America revealed that 5.6 per cent of pregnant women under the age of 15 received no antenatal care compared with 1.5 per cent of women age 20-24 years. Nearly half of the under group began prenatal care in the 4–6 month period. The study showed that younger mothers in the United States are much less likely to receive prenatal care in the first trimester and much more likely to receive little or no care.

It is, however, discernible that a minimum of data is available on maternal age in association with - obstetrical complications and maternal death from - developing countries. The reason for the paucity of data is obvious. According to Gabrysch (2009), with over 60 per cent of pregnant women in developing countries delivering in their home, most complications including death related to childbirth go unreported.

United Nations (1994) reported that in Africa, marriage and first births occur in the teenage years in much of sub-Saharan Africa, and the relative risk of death before age five is about 46 per cent higher for children with mothers under 18 years. In urban areas, particularly, teenage pregnancy rates are likely to rise in the near future due to the weakening of traditional society due to rural-urban drift. This position was re-echoed by Gabrysch (2009) who asserted that in the urban areas, the development will bring about falling ages at menarche, rising women's age at marriage and a progressing emergence of adolescence.

Gabrysch (2009), also reported that young maternal age was found to have a strong negative effect on birth. However, the authors stressed that the entire effect of maternal age cannot be attributed to these mechanisms, because prenatal health care and perhaps other behavioural differences also play a role. It can be reasoned that distinguishing between the alternative explanations for the link between maternal age and MCH is crucial for the design of effective health intervention.

Maternal Education

Formal education is of great importance for the development of people (Child Health Dialogue, 1997). Education gives people skills and confidence and makes them aware of the choices they can make in their lives. According to Octavio and Jose (2001) educated women are more likely to marry later, have their first pregnancy later and have fewer children. In addition, they are more likely to know about contraception, start to use it earlier and rely on modern rather than traditional methods. Educated women are more likely to attend antenatal care during pregnancy. It has been generally acclaimed that the condition of a woman's life affects her health and that of her children. Conversely, lack of access to education has been identified as a key barrier to women's advancement in society (Octavio and Jose

2001). He revealed that an overview of demographic data across Africa revealed that female illiteracy rates were over 60 per cent in 1996, compared to 40 per cent for men. Certain countries have extremely high rates. Burkina Faso at 91.1 per cent, Sierra Leone at 88.7 per cent, Chad at 82.1 per cent and Guinea at 86.6 per cent.

Despite this, parents in these regions seem to still prefer to send boys to school, seeing little need for the education of girls. Takyiwaa (1998) further lamented that the few girls that ever made it to school hardly go beyond primary education. This trend has serious implications for the health of the woman in her daily home business. Again, Takyiwaa (1998) reported that womens' education beyond primary education is a reliable route to economic empowerment and long-term change in the. status quo, as well as a determinant of family's health and nutrition, Takyiwa (1998) further stressed that education beyond ten or more years of school is a reliable predictor of lower fertility, improved infant survival, reduced maternal mortality, and enhanced levels of infant and child development and educational attainment. In the same vein, Stuart, LeVine, and Rowe (2009) posited that maternal literacy and schooling have been associated with more efficient management of limited household resources, greater utilisation of available health care services, better MCH, lower fertility, and more child-centred caring behaviour. They maintained that maternal education raises awareness of the means to overcome problems and generates effective political demand.

In general, education has both a direct and indirect effect on health. The indirect effect is because increased education and literacy has a multiplying effect on development and income, which in turn contributes to improved health. The direct effect relates to the common observation that maternal education and literacy is associated with better utilisation of household resources and improved nutrition and health of children and other household members (Stuart, Howitz and John, 1999). Horwiz (2002) reported that those countries that have promoted education generally have a relatively better nutrition and health situation. He noted that primary and secondary education, especially for women, were found to be important factors contributing significantly to the effectiveness and efficiency of the health care system in Chile, Costa Rica, and Cuba.

Residential Location

Rural and urban residencies are also known for their varying characteristics and a corresponding impact on the health and living conditions of people. People living in the same place tend to experience similar problems. In a related development Gerd, et al (2000) conducted a study on the accessibility to healthcare delivery in Indonesia and noted that the potentialities for women to manage or overcome these problems might vary according to location.

These differences do not only concern their access to resources, education and employment, but also access to a social network, which is important with respect to achieving health and self-reliance. Many of these differences reflect the variations in the living situation between the poor, mostly rural and uneducated, and the well to do, mostly urban and educated women. Milwood and Gezelius (2001) expressed that most rural settings are characterized by a lack of infrastructure and services such as schools, electricity, health care facilities, water, markets, environmental sanitation, road and transport services.

These conditions have implications for the living condition of the people. Lack of access to appropriate health care services caused by difficulties involving distance, transportation problems, cost, and poor quality of available care will exert a strong impact on MCH relating to choice of treatment avenue (USAID, 2015). The effects of circumstances causing available care are especially striking, USAID (2015) established that inadequate health care facilities, lack of essential resources, unskilled personnel,

absence of an effective referral system, and insensitive of health care providers are some of the many difficulties women in rural areas face when they look for institutional care. If health actions will need to be strongly supported, it would be logical to reason and understand that, where the resources are not available, the individual's perceived health behaviour patterns, whether good or bad are upheld and adopted to suit the prevailing circumstances. Reflecting an African setting, Takyiwaa (1998) pointed out that many African rural households usually impose individual responsibilities on women to meet their personal and often collective family needs. In such situations, women are expected to actively generate the means to meet the daily needs of themselves and their children. This has increased household pressure on rural women, raising the numbers of households in the poorest health categories.

The Way Forward

1. Regular antenatal visits during pregnancy should be encouraged as much as possible. This will help to detect when pregnancy is at risk so that necessary measures can be taken before any complications.
2. Pregnant women should also be enlightened on the care of pregnancy safety measures that ensure safe delivery.
3. Pregnant women should be encouraged to go to the clinic when unusual signs and symptoms are felt or seen as the case may be.
4. Health care providers should emphasize the need to take babies for post-natal immunisation, as babies from 0-5 years need to be immunised at regular intervals before reaching their fifth birthday.
5. It is also necessary to discourage the use of non-prescribed drugs on children when they are ill, rather than for proper diagnosis.

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