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RELIGION AND THE QUALITY OF MATERNAL HEALTH IN BADAGRY, LAGOS STATE

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Abstract

There is an increasing interest among health scholars to understand the relationship between religion and the quality of health among women. This is so because in the African context, religion is a pervasive phenomenon that permeates all aspects of human life. Due to the high rate of maternal mortality in Nigeria, it is expedient to know the degree of influence of religion on the health status of mothers. This paper seeks to explore this concern. The study from which the paper is derived was carried out to understand and explain among other objectives, in what ways religion impacts on mothers' health-seeking behaviour. Data was generated by questionnaire and in-depth interviews while analysis was made by simple percentage and content analysis respectively. The findings were discussed within the Health Belief Model and concluded by highlighting the importance of belief in the reduction of maternal mortality in the study area.

Introduction

There is an increasing interest among health scholars to understand the relationship between religion and the quality of health among women. This is so because in the African context, religion is a pervasive phenomenon that permeates all aspects of the human life. Due to the high rate of maternal mortality in Nigeria, it is expedient to know the degree of influence of religion on the health status of mothers. The health care system of a people includes their beliefs and patterns of behaviour and those behaviours are governed by cultural rules. This cultural interpretation of illness has been stressed by Prins (1992), Appiah-Kubi (1981) and Adamo (1999) who contend that healing in African indigenous culture is a corporate matter and that in African societies, indicative of correct relationship with one's environment and the spiritual world is a prerequisite to achieving good health.

Most religious believers emphasize the healing power in their faith. According to Jegede (1998), whether Christianity or Islam, belief system is concerned with the cosmology, that is, the nature of the universe, the spirit that may control it, and its influence in the life of mortal humans. Due to this fact, most pregnant women seek to patronize mission homes in order to be protected from all shades of evil during preganacy and at the delivery of the baby. According to WHO (1976) maternal health refers to preventive, curative, and rehabilitative health-care for mothers. As stated in United Nation's Concise Report on Reproductive Rights and Reproductive Health, reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes (United Nations, 1996). Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Embedded in this definition is the right of women to be informed and to have access to safe, effective, affordable, acceptable and appropriate health-care service that will enable them to go safely through pregnancy and child birth and provide couples with the best chance of having a healthy infant. The promotion of the responsible exercise of these rights for all people should form the fundamental basis for government and community supported policies and programmes in the area of reproductive health.

Religion and Health

Religion is a very sensitive aspect of social behaviour; it is an important factor that influences various spheres of life including woman's health status even during pregnancy. According to Babatunde (1998), religion has been acclaimed to be a significant social institution with pervasive and enduring hold on the mind and, consequently, on the behaviour of humans in society. The World Health Organization's (WHO's) definition of health, although the most acceptable and widely adopted both by researchers and policy-makers, is significantly inadequate in this regard. For example, Badru (2003) has noted that there is a problem of identifying and actually observing such abstract notion like mental and social, even if the physical dimension can be subjected to some measurement. Similarly, Asakitikpi (2007) has also pointed out the neglect of the spiritual dimension of health especially as it pertains to African societies.

For people of strong faith, religious beliefs and related cultural taboos can have a powerful impact on how they care for their health, including the medical treatments they choose to accept. Health-seeking behaviour scholars acknowledge that health control tools, where they exist, remained under utilized in some circumstances and the nature of the illness as defined by the patient or health giver. Experts in health interventions and health policy have become increasingly aware of human behavioural factors in quality health-care provision and have attempted to isolate various variables that may be associated with health-seeking behaviour. In order to respond to community perspectives and needs therefore, health systems need to adapt their strategies, taking into account the findings from behavioural studies (**Hausmann-Muela, Riberaand Nyamongo, 2003).**

Maternal Health Status in Nigeria

Although, maternal mortality is a global phenomenon, the critical issues associated with it are most profound in developing countries. From recent estimates, 500,000 women die each year from maternal causes; and for every woman that dies, approximately 20 more suffer injuries, infection and disabilities in pregnancy or childbirth (UNICEF 2005, WHO 2005). Ninety-nine per cent of these deaths occur in technologically less-developed countries, making maternal mortality one of the sharpest indicators of the disparities that exist between developing and developed nations. Nigeria is only two percent of the world's population but accounts for over 10% of the world's maternal deaths in childbirth, and ranks second globally only to India on maternal mortality (Okonofua, 2007; Abdul 'Aziz 2008). A closer look at the statistics shows that Nigeria has the worst figures in the world. In the first place, if the figures are placed in the context of the general population, Nigeria is definitely worse off. Nigeria's population of 140 million people is only about 10 per cent of India's over one billion people. So, 117,000 deaths out of one billion are surely lower than 59,000 out of 140 million.

In Nigeria, important indicators show that there is need to make significant advances in health matters. For instance, life expectancy has decreased drastically from 50 years in 1999 to 49 in 2003 and slid further to 46 in 2004 (World Health Organization, 2006). In part, this decrease in life expectancy reflects increased maternal and infant mortality and high rates of infectious diseases, among other factors. It is not that the majority of people only lived until their late 40s, rather, the large number of maternal death combined with the high rate of infectious diseases among the middle-aged can severely depress the average length of life (Lauser & Lauser, 2004). It has long been recognized that the health status of pregnant women is an important indicator of the general state of health of any population. The health of pregnant women influences the health of their babies, and fetal and infant health is one of the main determinants of health in childhood and adulthood. According to WHO (2008), every year, many women suffer pregnancy-related complications that lead to death while infants and children suffer as a result of poor maternal health..

Method and Data

This study was carried out in Badagry Local Government Area of Lagos State, between February and November, 2008. Badagry is an emerging city, in which it will be appropriate to study maternal welfare. The target population for the study was women of reproductive age from 15-49, that have ever given birth in the last two years and/or pregnancy and lives in Badagry. Existing information shows that there is one main constituency in Badagry Local Government Area of Lagos State divided into ten (10) wards. By design, three hundred and fifty (350) women of reproductive age of 15 to 49 years were randomly selected as respondents, to represent seventy (70) women in each of the selected wards in the Local Government. These comprised both educated and non literate women, who were married or unmarried and have never given birth in the last two years and those that are pregnant.

From the targeted population, the unit of sample of study was a household where multi-stage sampling technique was used to select the sample for the study. The first stage was to divide the Local Government into wards. The second stage was to pick five (5) wards out of ten (10), and the third stage was to divide the wards into streets and the fourth stage was to identify all the streets using the most current maps of the area. For every house accidental sampling was used (i.e. choosing only those who are available and meet the purposes of the study and where there is no house hold that fits the description of the respondent, the next unit was chosen and added at the end). Also, any household where there was more than one woman of specified age; random sampling was used to select the respondent. And four (4) respondents were systematically selected from each ward for in-depth interviews.

The collection of data involved both primary and secondary sources employing the use of structured questionnaire and in-depth interview respectively. It is sometimes difficult to obtain a sufficient number of responses from questionnaire, therefore, they are not suitable to investigate long, intricate issues and require a supporting method as a follow up. The secondary source of data for the study, include the review of books, journals, magazines, reports from libraries, internet, dailies etc. These provided necessary information pertaining to the background of the study and the extent of related studies.

The quantitative data gathered was analyzed for them and relationship using content analysis. First, characteristics of the study sample were described, and then frequency distributions were used to highlight the socio-demographic status of respondents. Secondly, simple percentage was used to detect statistically significant proportions of people in relation to the overall objective of the study. This entails an examination of the patterns of association between the dependent and some selected independent variables. The tape and notes from the In-depth Interview were analyzed with the use of content analysis. After discussions conducted in the local language had been translated and transcribed. Common responses within and between groups were identified for each topic included in the interview guide. In addition, divergent responses were identified to determine the range of beliefs, opinions, knowledge, attitude and behaviours among participants. Responses to each topic were summarized and important quotations are reported verbatim to highlight common individual views.

RESULT

Socio-demographic Characteristics of Respondents

This section presents the data on age, marital status, religion and educational qualification of the respondents. As shown in table 1, 42% of the respondents were currently above 30 years old, with a corresponding low level of educational background, which has a significant consequence on the age at first marriage and age at first pregnancy. The dominant religion was Christianity, with only 28.3% and 2.3% of the respondents representing the Islamic and Traditional religions respectively. This is not surprising

because the people of Badagry have been known with their indigenous religion which is usually characterized by the worship of the supreme God but serviced by numerous divinities called Vodun, and ancestors, even though they still claim to be either Christians or Moslems and see Vodun as traditional. (Asiwaju and Owonikin, 1994; Simpson, 2001).

Table 1: Socio-demographic characteristics of respondents

Variables	Frequency	%
Current Age		
Under 20	24	6.9
20-24	44	12.6
25-29	128.2	37.7
30-34	85	24.3
35-39	37	10.5
40-44	15	4.3
45-49	16.8	3.7
Total	**350**	**100**
Marital Status		
Single	9	2.6
Married	330	94.3
Divorced	6	1.7
Widowed	5	1.4
Total	**350**	**100**
Educational Qualification		
No Formal Education	55	15.7
Primary	90	25.7
Junior Secondary	22	6.3
Senior Secondary School	95	27.1
Tertiary	88	25.2
Total	**350**	**100**
Religion		
Christianity	243	64.9
Islam	99	28.3
Traditional	8	2.8
Total	**350**	**100**
Occupation		
Petty Trading	180	51.4
Farming	31	8.9
Civil Servant	56	16
House Wife	30	8.6
Artisan	53	15.1
Total	**350**	**100**

Socio-demographic characteristics of respondents' cont.

Income		
Below 10,000	99	28.3
10,000-15,000	145	41.4
16,000-20,000	66	18.9
Above 20,000	40	11.4
Total	**350**	**100**
Spouse's Educational Qualification		
No Formal Schooling	23	9.4
Primary	26	7.4
Junior Secondary School	50	14.3
Senior Secondary School	100	28.6
Tertiary Education	141	40.3
Total	**350**	**100**

Source: Field Survey, October, 2008.

The perception of illness is influenced by different religious beliefs in societies. The are many different beliefs towards prenatal care. To understand how these beli determine healthy choices among pregnant women, questions were asked in relation respondents' belief.

Table 2: Cross tabulation of respondents' religion and choice of antenatal care

		Religion		Total %
Place of Antenatal	Christianity	Islam	Traditional	
Health center	190	64	-	254 (72.5)
Traditional BA	8	15	-	23 (6.5)
Mission home	28	-	-	28 (8.3)
Home/self	-	-	8	8 (2.2)
Both TBA/Health Center	-	18	-	18 (5.1)
Health/Mission Home	17	2	-	19 (5.4)
Total	243	99	8	350

Table 3 Cross tabulation of respondents' religion and place of delivery

		Religion		Total %
Place of Antenatal	Christianity	Islam	Traditional	
Health Center	175(69.2)	78(30.8)	-	253(72.2)
Traditional BA	15	21	8	44(12.5)
Mission Home	49	-	-	49(14)
Home	4	-	-	4(1.3)
Total	243	99	8	350

Source: Field Survey, October, 2008.

Table 3 above shows that 72.2 of the respondents delivered in health centers irrespective of their religion, 39 respondents delivered with TBA, 40 respondents delivered in mission home, and only 3 respondents delivered at home.

From the above tables it can be deduced that religion does not really affect either the attendance of antenatal or the place of delivery. As it clearly shows, a significant number of the respondents attend health center irrespective of their religious leaning. This further established the conclusion by Izugbara and Ukwayi (2004); Ibeh (2008); and Lubbock and Stephenson (2008). This level of utilization may be due to awareness campaigns efforts of the government and as noted by one of the respondents: "*I go to hospital because the nurse said we should come, and I use to go, by my self to meet the nurse to check me up*". This result also shows the impact of government effort in campaigns to enlighten women in the area on the need to patronize government health centers.

The respondents were asked if they go to religious homes during the period of their pregnancy. Majority of them representing 55.1% said that they do while less than half of the sampled population do not patronize such homes. Most of the respondents said that they patronize these mission homes because of reducing the risk of death during the period of the pregnancy and during delivery.

Discussion

Two important observations are made in relation to the results obtained. First, is the syncretism that seems to be associated with health care issues among Badagry women. Like religion in the early 1980s which witnessed a great influx of religious activities and movements in Nigeria, the medical centers today face a similar trend whereby the dwindling fortune of the government and the unprecedented harsh economic climate is increasingly influencing an eclectic practice of health-seeking behaviour. In the first instance, the sheer dearth of medical personnel and the exorbitant rates of medical services are an important push-factor that may explain this new trend. Secondly, the increasing loss of pregnancy, high still-birth and infant mortality as a result of the above, are encouraging pregnant women to seek solace in the supernatural as a result of the fear of the unknown. The fear of the unknown, although may have a scientific explanation is nevertheless an important source of great anxiety among pregnant women who define their state as delicate and therefore, most vulnerable to the evil machinations of witches and sorcerers. The pervasiveness of spirituality in the lives of an average Nigerian and the belief that the supernatural has profound influence on the physical is therefore, of prime importance in explaining the findings of this study.

Secondly, the material dimension that is associated with health care delivery in Nigeria is a major factor for the trend that was observed in the course of the study. The exorbitant

cost of obtaining medical services owing to the fact that over 75% of the responden earn less than twenty-five thousand naira per month is a push factor for the patronage spiritual homes during the period of pregnancies and even during delivery of babies these unspecialized homes. The high maternal and child mortality rates in the count may therefore be partly understood from this perspective. Obviously, the spiritual hom do have some benefits to their clients at least from an ethnic perspective. Howev because there is no form of regulation or a national board to coordinate the activities these homes, negligence may be a daily occurrence associated with them while prop referrals will be completely absent.

Rosenstock and Becker (1988) developed the HBM to explain preventive heal behaviour of individuals and groups. The HBM assumes that people's actions towa health preventive measures are based on their beliefs and attitudes. But it al acknowledges that beliefs and attitudes are not spontaneous rather they are a function processual experience of the individual. Hence, in a general sense, the model does n only look at the individual as a unit of analysis but also considers the socio-cultur environment, which conditions the individual to adhere to certain beliefs. Central to th HBM are four sets of variables that may influence the health behaviour of the individu The first is the individual's perception of her vulnerability to illness and it attempts explain how the individual defines self as a biological being. The second variable is th individual's perception of the illness in terms of its severity to the person's survival an how it can impede her role in the society. The individual's judgement of the advantage that may accrue from taken an action to minimize the level of severity or vulnerabili serves as the third variable. The last set of variable is an assessment of the costs (bo physical and psychological) that may be incurred in achieving the proposed action.

Human behaviours that may be rational or irrational (depending on the context) ar believed to be influenced by these sets of variables. Particularly, a caretaker's actions a imbibed through the mechanisms of the learning process that are available to th individual. The theory assumes the principal mechanisms to include the knowledge the individual regarding her immunity toward certain ailments (which is a function of th individual's experience); the definition of the disease (which is culturally defined); an the cognitive perception of the consequence of the ailment (which is social influenced). These mechanisms present favourable or unfavourable contexts whic function as discriminative (cue) stimuli for health seeking behaviour.

The principal behavioural effects according to the theory come from interaction in under the influence of those groups with whom one is associated in the communit These groups control the sources of behavioural patterns, provide normative definitio and expose one to behavioural models and cognition. In other words when peop believe that they can be spiritually attacked by forces or other jealous human beings th there is recourse for them to take some preventive measures that are available in t

community and as prescribed by the culture. These may partly explain why the need to attend spiritual homes in spite of patronizing health centers in the area.

While the model effectively explores factors that may encourage preventive measures, other scholars have built on the model to also explain illness behaviour. The most important of these is Igun's (1982) modified version of the HBM. The socio-cultural environment in which the HBM was originally formulated though has the framework, did not make room for alternative means of addressing health problem. In North America from where this theory originated, health-seeking behaviour is predominantly left at the discretion of the individual and her physician. This setting is not exactly replicated among other peoples in other continents. Igun's (1982) revised version of the model is significant not only to the theoretical development of the model but for its relevance to this study. This version recognizes the availability of other forms of treatments that are available to the caregiver and the role of significant others to the caregiver or the patient. By the very nature of Nigerian groups, which is both diverse and eclectic, the treatment choice of the individual is not unidirectional but is based on rational evaluation and on the individual's cultural conditioning of treatment options that are available (Owumi 1989). The cultural background of the individual is also reinforced by significant members of the household or community in taking a decision on treatment pattern (Owumi, 1996).

On the whole, there is a connection to the fact that religious activity during pregnancy is used as a solace to antenatal care and to a large extent may not have a negative effect on pregnancy even though this has not been fully researched. However, similar findings by Jegede (1998) buttressed that whether Christianity or Islam, belief system is concerned with the cosmology, that is, the nature of the universe, and the spirit that inhabit and control it, and so on. Due to this fact, most pregnant women seek to patronize mission homes in order to be protected from evil and the uncertainty of life at the time of delivery. As narrated by one of the respondents during the fieldwork, she noted that:

> At five months, I was very sick, I had threatening abortion. They told me it was because I have not been resting well. I go to the hospital because one of my sisters-in-law is a nurse. Immediately I saw blood I call her. I don't like to sit at home. I don't go to TBA, but they brought herbal concoction for me and I take it. My child was born prematurely because of that sickness. The sickness was not "ordinary" "it has a hand in it" (that is, it is spiritual) because after treatment it still come back, then I go to church for anointing.

The sickness "is not ordinary" is an indication that for most of these local folks, illness transcends the physical and like other aspects of life, health, illness and diseases are all

under the direct influence of the supernatural. From this orientation, it is not awkward to find pregnant women soliciting the assistance of spiritual leaders in their quest for safe delivery. However, despite this pervasive belief in the supernatural in relation to health, it is not uncommon to find the same category of people who scramble to patronize modern health centers in addition to the spiritual homes they attend. As one of the respondents explained: *I go to hospital because, even my husband will be shouting go o, don't implicate me. He will give me money to go* (to the hospital). However contradictory it may sound that these people patronize spiritual homes and at the same time attend modern health centers only goes to reflect the great dilemma they find themselves in the bid to ensure that they have safe delivery. The extent to which they go is indicative of the fact that they will be willing to support government efforts in providing appropriate health-care delivery to the grassroots.

As has been presented above it is clear that there is a need for the government and other stake holders in the health industry to ensure that appropriate policies are not just formulated but they also drive them to a logical conclusion. Consequently, there will be need for the government to recognize the contributions of other allied sources in the provision of health care services in the country. The traditional birth attendants (TBAs) are a repository of knowledge and experience from which the government can harness for the overall development of the health sector in the country. Spiritual homes as a source of succor for pregnant women) may also be harnessed in providing a holistic health-care system to the generality of the citizenry.

Conclusion

Understanding the link between health and health-seeking behaviour is crucial towards the reduction of maternal and child mortality in Nigeria. This awareness is particularly relevant given the overriding influence of religion on the social fabric of Nigerians and the high level of maternal mortality in the whole of the country.

To a large extent, religious beliefs do not in actual fact affect the decision of women in patronizing antenatal care as well as the place of delivery. This is basically because the primary consideration is based on the adequate and proper care they need during the period of pregnancy. From this study, it is clear that religion and maternal health are related within the large social support framework. In this light, both religious and cultural practices can increase the involvement both in the enlightenment of women in relation to health matters and also on the importance of maternal health-care in general. Health-care policy makers will therefore, need to consider the role of religion in the overall delivery of health-care services in the country.

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