

**UTILISATION OF FACILITIES AND MATERNAL HEALTH OUTCOME
AMONG URBAN DWELLERS OF OBUDU AND OGOJA LOCAL
GOVERNMENT AREAS OF CROSS RIVER STATE, NIGERIA**

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ABSTRACT

Maternal health is a crucial indicator of the quality of health care in any country. This is because maternity is the greatest single factor in high maternal mortality in developing areas. The factors that have been identified include lack of access to and utilisation of quality maternal healthcare facilities. This study was undertaken to assess the availability, utilisation and relationship with maternal health outcome (childbirth). The cross sectional study was carried out among women of reproductive age in the urban areas of Obudu and Ogoja Local Governments of Cross River State, Nigeria. The results indicated that maternal health facilities are available but majority of them do not satisfy the international standards for both Basic Essential Obstetrics Care (BEOC) and Comprehensive Essential Obstetrics Care (CEOC). In addition, the utilisation of health facilities was hampered by cost, culture and decision-making. The study also found that there was a significant relationship between utilisation of maternal health facilities and maternal health outcome manifest in successful and healthy birth outcomes. The upgrading of maternal health facilities in all areas is germane to improving maternal health outcome. This can be done by providing facilities cheaply and readily to the people and relevant information to women.

Keywords: Maternal Health, Urban Areas, Utilisation, Health outcome

BACKGROUND OF THE STUDY

Access and utilization of health facilities by the public is determined largely by availability of health facilities, location and perception of the significance of health. The choice of health facility is dictated by economic factors or influenced by significant others, in a situation whereby the cost of obtaining health services from a particular institution is unaffordable, some resort to self medication by patronizing hawkers of both herbal preparations and modern pharmaceutical drugs on streets or in transport vehicles. This attitude has serious threat to reproduction which determines the continuity of the society. Unfortunately, this gloomy picture of poor maternal health among women of child-bearing age is common among many countries of the third world. The implication here is that the life expectancy of child-bearing women is reduced due to maternal mortality. It is estimated that 37,000 maternal deaths occurred in Nigeria alone in 1999 (UNICEF, UNPFA, WHO 2000). A more recent estimate showed that over 52,000 women died of pregnancy related complications in 2007 in Nigeria (Dada, 2008).

Despite the introduction of modern facilities, available statistics show that the majority of children are born by Traditional Birth Attendants (TBAs) in rural areas of Nigeria. In any society, there are usually measures to ensure the good health of individuals generally and women. In these societies, the health care system is purely western orthodox while in others it involves the combination of orthodox and traditional ways. In Nigeria and in fact, most of Africa, the latter is prevalent. According to Martey et al., (1998), the health system in Ashanti Region, as it operates in the rest of Ghana is made up of three sub-systems, namely, public, private and traditional. The public sub-system is made up of essentially what is referred to as orthodox medical services provided in government health facilities. The private sub-system refers to orthodox medical services provided in private (including missionary) hospitals, clinics, maternity homes, chemists shops which are all profit oriented. The traditional sub-system refers to medical services provided by herbalists, bonesetters, traditional healers, spiritual healers, traditional birth attendants and many others. In Ghana for instance, the public health sector provides 60% of the health care followed by the traditional sector, which provide, 30% and the rest by the private sector (Martey et al., 1996). By implication, some amount of medical service is provided by the traditional sector with Traditional Birth Attendants (TBAs) alone making up 30% of healthcare

In Nigeria, the situation is more apt because of the fact that a majority of Nigerians live in rural areas where health facilities are often in short supply. Since women must be assisted before pregnancy, during pregnancy and after pregnancy, it is therefore necessary that some care must be given and in this case, it is the Traditional Birth Attendants (TBAs). They (TBAs) are non-professionals (in the strictest sense) who assist women during pregnancy and deliveries and in some cases advocate some form of family planning. The practice of Traditional Birth Attendant in the rural context cannot be under-rated; this is because the knowledge and practice of Traditional Birth Attendants in the improvement of maternal health is crucial and important. Besides, Traditional Birth Attendants remained one of the health resources in rural areas of Nigeria. This is also because there are still people who would not for cultural and ethnographic reasons go to the maternity wards in modern hospitals to have their babies. They would prefer to have them with the assistance of a Traditional Birth Attendant. In a study carried out by Imogie, (2004), it was reported that Traditional Birth Attendants remain attractive and convenient to both users and non – users.

From every indication, poor maternal health is a serious issue confronting the health authorities in Nigeria in particular, and Africa as a whole. Worst still, it is estimated that for every woman that dies of pregnancy related cause(s) over twenty others suffer lifelong disabilities. This situation is still prevalent despite several programmes introduced as interventions to check this trend and improve maternal health. One of such programmes is the 'Safe Motherhood Initiative'. It was introduced to suggest strategic interventions to reduce maternal morbidity and mortality in Nigeria.

STATEMENT OF THE PROBLEM

Utilization of maternal health facilities by women of child bearing age has direct bearing on maternal and infant morbidity and mortality. This feature is noticeable in most third world countries including Nigeria. The high rate of maternal morbidity and mortality therefore indicates that majority of Nigerian women do not have good maternal health as captured by the United Nations. For women to have good maternal health there must be availability and accessibility of these women to modern maternal health facilities. This is because it has been indicated that despite the introduction of modern health facilities, studies have shown that majority of children in developing areas are born by Traditional Birth Attendants (TBAs). These are untrained midwives who often do not refer complications to appropriate quarters as

a result; several women and children are subjected to preventable deaths. In a study among the Esan people of Edo state, Okolocha et al (1998) found that because of the people's location, it is difficult to access health facilities.

Lack of education among women undoubtedly contributes to the widespread self-neglect characteristic of many African women. They tend to be inattentive to their own illness and health needs and fail to seek care. It is for lack of education and its corollary – ignorance – among other factors that often make women passively accept the conditions of life that are meted to them in the name of culture and tradition. It was on this note that Njikam (1994) concluded that the low level of education together with the fact that over 60% of the population are rural –based in Nigeria that cultural norms and practices still exert a strong influence on reproductive health care especially in relation to pregnancy, delivery and child rearing. For instance, local beliefs on causation of illness, subsequent treatment and prevention often prevent timely medical intervention. Local beliefs indicate that prolonged labour is hereditary or may be just retribution for infidelity or adultery that will only abate with confession. Other issues border on ignorance or lack of education.

Economic and financial status is an important consideration in the use of health services. Most hospitals and clinics have a basic, registration and consultation fee in addition to which may be added laboratory and prescription charges. Financial considerations pose real obstacles among the low – income groups. In the traditional setting especially, a rural area, this condition may be very challenging. Sometimes, even the availability of financial power may not change the healthcare behaviour of people due to their culture of poverty

Poverty is often identified as a major barrier to human development. It is also a powerful brake on accelerated progress toward the Millennium Development Goals. Poverty is also a major cause of maternal mortality, as it prevents many women from getting proper and adequate medical attention due to their inability to afford good antenatal care.

Poverty exists when people lack the means to satisfy their basic needs. These may be defined narrowly as "those needs necessary for survival"(Safra, 2003) or broadly as "those needs reflecting the prevailing standard of living in the community". Reproductive ill health is both a cause and consequence of poverty (Family Care International 2005). Sexual and

reproductive health problems account for approximately 20 percent of the ill-health of women globally, and 14 percent of men due to lack of appropriate sexual and reproductive health services (World Health Organisation 2004).

It was estimated that in 2001, 1.1 billion people lived on less than \$1 a day and 2.7 billion people lived on less than \$2 a day in developing areas (<http://www.worldbank.org>). It follows that poverty endangers the health and lives of many in developing countries since the most widespread and severe poverty occurs in countries such as Nigeria, Togo, Liberia and so on. Poverty greatly amplifies every other risk factor for maternal mortality and morbidity from grotesque female oppression to maternal under nutrition and to inadequate medical and physical infrastructure (Harrison, 1997). The synergy in the interrelationship between poverty and maternal mortality calls for urgent steps at addressing reproductive health problem.

Residence is another commonly identified factor in maternal mortality variation. Urban residents have greater access than their rural counterparts to resources such as health services. The general presumption is that urban – rural residence distinguishes clearly between good and poor sanitation, housing structure and availability of health resources. They are also more likely to flout customs and the taboos that could negatively affect maternal survival (Worldmichaels, 2000; Balk et al. 2004). Yet many women who live in urban slums have poorer sanitary conditions than rural dwellers with cleaner air among others.

There are also factors like the timing of pregnancy. This predisposes her to health condition that affects her maternal outcomes. The age at first birth is one of these factors. Callaway (1987) concluded that the life of the Hausas of northern Nigeria is that of sudden death because young daughters are married against their will. There is forced sexual cohabitation at puberty regardless of mental or emotional development and early motherhood. These factors culminate in maternal death. Birth intervals and child sex preference are also issues that act within the household environment to cause maternal mortality. When a woman is expected to have as many children and as often as possible, the risk of complication is generally increased. Besides, when she is expected to have a desired sex of a child, the tendency of multiple births is obvious and the likelihood of morbidity or mortality is only certain.

In a study carried out by Ujah et al., (1999) it found that maternal death was a function of age, grand multiparity, educational status and non-utilization of antenatal services. The study further showed that the health risks factors contributing to maternal mortality were hemorrhage with 28.1% Sepsis (21.3%) and eclampsia (15.7%). The findings above were upheld seven years after in another study by Aisien et al (2005) that was aimed at finding factors contributing to maternal mortality in north-central Nigerian. The study found that the greatest risk of maternal mortality rate was among teenagers (>15 years) and elder women (<40 years), illiterate women were also associated with very high maternal mortality ratio. The major direct causes of deaths were hemorrhage (34.6%), sepsis (28.3%), eclampsia (23.6%) and unsafe abortion (9.6%). Studies have been undertaken to assess utilisation of healthcare facilities by women of reproductive age in different urban areas in Nigeria o the total exclusion of the present study area. The present study fills that intellectual gap by providing opportunity for exploring utilisation of health care facilities and maternal health outcome.

Data base for maternal health experience is very scarce. The present study is contributing to providing data base for women to explain their women perception on utilisation and health outcome.

Furthermore, the millennium development goals (MDGs) emphasised reduction in maternal mortality. This study is contributing its quota to this effort by providing opportunity for assessing maternal health facilities in existence and how they impinge on health outcome.

In the face of these situations and the volume of studies on maternal health, the condition of women has not improved over the years. It follows therefore that there is still much to be learnt from studying the utilization of maternal health facilities among women in urban areas of Obudu and Ogoja Local Government Areas of Cross River State.

OBJECTIVES OF THE STUDY

The main objective is to assess the utilisation of maternal health care facilities and maternal outcome in urban areas of Obudu and Ogoja Local Government Areas of Cross River State of Nigeria. Specifically, the study sought to

1. Identify maternal health facilities in the urban areas

2. Access the quality of services rendered.
3. Explore the extent of utilisation of healthcare facilities by women of reproductive age.
4. Examine utilisation and health outcome.
5. Make necessary recommendations on how to enhance maternal

RESEARCH QUESTIONS

The major research question is to access how the utilisation of maternal healthcare services affect maternal outcome. This question can be decomposed into:

1. What are the health facilities in the urban centres of the study?
2. What is the quality of services rendered in the health facilities?
3. To what extent do women utilised these facilities?
4. How does use determine outcome?

METHODOLOGY

This is a survey designed to investigate access and utilization of maternal health facilities in urban areas of Obudu and Ogoja Local Government Areas. The study adopted both descriptive and correlational designs that allowed the collection of data from a part or sub-set of a population whose analyses are generalizable on the entire population. The study employed quantitative instrument to explore access and utilization of maternal health services in Obudu/Ogoja Local Government Areas. These Local Government Areas are located at the Northern Senatorial district of the Cross River State. They lie between latitude 15N and 5S of the equator, bounded by Obanliku, Boki, Bekwarra and Yala Local Government Areas of the State. The area covers a large area of over 900 square meters with a total population of 2.8 million people (NPC 2006).

The area has two main geographical zones. The distribution of health centres and hospital/clinics are such that the urban centres have comparatively larger number while the rural areas have fewer. The access to these services is therefore determined partly by the location of the people. The population for the study comprises of all women who are of child bearing age in the two Local Government Areas. In particular, pregnant women attending antenatal clinics are used for group discussion.

The study adopted a multi-staged sampling technique. The areas for the study were clustered into the political wards. The wards are further clustered into communities. The communities are delineated into urban areas with the Local Government headquarters as urban areas. The

simple random sampling method was used to select 5% of the entire women of reproductive age population. This adds up six hundred and twenty three (623). This forms the sample for the study.

Data was collected using trained field assistants and supervisors who visits different parts of the sampled area to administer the survey and qualitative instruments. The data was edited to eliminate inconsistencies that may undermine content validity. The data was keyed into the Statistical Package for Social Sciences (SPSS) and subsequently analyzed.

RESULTS

This section presents the results computed from the questionnaire administered. The result is presented according to the study objectives and the socio-demographic characteristic of respondents is presented first.

SOCIO-DEMOGRAPHIC CHARACTERISTIC OF RESPONDENTS

The table below indicates that all the respondents were female since the study is sex specific. The mean age for the population is 23.5. The age distribution depicts a middle heavy age structure characteristics of developing areas. Over 60 percent of the respondents are presently married while about 26 percent are single. This is indicating a sexually permissive society where women have children outside wedlock. A little above five percent is either divorced, widowed or separated depicting an unstable marital arrangement.

The table also showed that a majority of the respondents are Catholics while less than one percent belongs to the Traditional African Religion (TAR). Protestants constitute about 2 percent. The educational qualification of the respondents showed an urban environment because almost 50 percent of the respondents have university degrees while about 90 percent have some secondary education and above. They are therefore potential change agents.

Table 1: Socio-Demographic Characteristics of Respondents

Characteristic Age	Number	Percent
Below 20	68	10.9
20-24	119	19.1
25-29	123	19.9
30-34	110	19.7
35-39	78	12.5
40-44	67	10.8
45-49	29	4.7
50 +	29	4.7
Total	623	100
Marital Status		
Single	167	26.8
Married	412	66.1
Cohabiting	11	1.8
Divorced	14	2.2
Widowed	8	1.3
Separated	10	1.6
Others	1	.2
Total	623	100
Religion		
Catholic	462	74.2
Protestant	135	21.7
Muslim	17	2.7
TAR	2	.3
Others	7	1.1
Total	623	100

Educational Qualification		
Never attended school	45	7.2
Primary	34	5.5
Secondary	223	35.8
Degree	305	49.0
Others	616	2.6
Total	623	100
Occupation		
Housewife	76	12.2
Professional	111	17.2
Clerk	43	6.9
Private sector	47	7.5
Trader	41	6.6
Artisan	18	2.9
Civil servant	82	13.1
Unskilled labour	32	5.1
Others	173	27.1
Total	623	100
Monthly Income		
>1000	39.6	63.6
1,001-2,000	3.1	5.5
2,001-3,000	16	2.6
3,001-5,000	40	6.4
5,001-10,000	71	11.4
10,001-20,000	35	5.6
20,001-30,000	12	1.9
30,001-40,000	14	2.1
40,001+	6	1.0
Total	623	100
Age at First Birth		
>20	250	40.1
20+	373	59.9
Total	623	100

Table also indicates that a majority of the respondents though educated but engage in occupation that is below their educational qualification. This is shown in the table above where less than 20 percent of the respondents are engaged in professional occupation. Besides, only 13.2 percent of the respondents are senior civil servants.

The data above is further justified in the incomes of the respondents. This depicts the type of occupation they engaged in. This is because 63.6 percent of the respondents earn less than a thousand Naira per month. Since their occupations are predominantly unskilled, it is obvious that earning will be poor. This is showing predominantly poor urban centres. A majority of the respondents had children very early as over 40 percent of them reported that their first children were born when they were less than twenty years of age.

HEALTH FACILITIES

Data on health facilities show that there are only eight General Hospitals that render maternal services. These hospitals are highly inadequate from the population of women that require maternal services. This is because according to the 2006 National Census, there are over ten million women in the two urban centres.

Table 2: Availability of Facilities in the Study Area

Local Govt. Area	Private	Public			Total
		Primary	Sec.	Tertiary	
Obudu Urban	4	1	Nil	Nil	5
Ogoja Urban	4	3	1	Nil	8
Total	8	4	1	-	13

The table above depicts very poor and inadequate health facilities for the urban population that require maternal services. It is obvious therefore that a majority of the women in this area will not have access as a result of non-availability of the health facilities.

QUALITY OF SERVICES RENDERED

The facilities in these facilities were classified into whether they met standards prescribed for Basic Essential Obstetrics Care (BEOC) or Comprehensive Essential Obstetrics Care (CEOC) on the basis of performance of signal functions as specified in the guidelines. While the international guidelines focused on the performance of such services within the last three months to the data collection exercise. The definition used in this study was based on the “routine performance” of signal functions. This was hoped will provide a more complete situation of EOC facilities bearing in mind that certain functions may not have been performed in the last three months prior study because of non-occurrence or geographical location, demographic factors and service utilization pattern.

To ensure that the classification met the EOC standard at the time of study, information on relevant functional equipment for the performance of the signal functions and health

personnel were used to determine the true capacity of the facilities to perform the signal functions at the point in time.

Table 3: Signal Functions used to Identify Basic and Comprehensive EOC

Basic EOC Services	Comprehensive EOC Services
1. Administer parenteral antibiotics	(1-6) All service on children in Basic EOC
2. Administer parenteral drugs	
3. Administer parenteral anticonvulsant	7. Perform surgery (caesarean)
4. Perform manual removal of placenta	8. Perform safe blood transfusion
5. Perform removal of retained products	
6. perform assisted vaginal delivery	

The table below shows the proportion of the facilities that met the specified standard for Basic Essential Obstetrics Care (BEOC) or Comprehensive Obstetric Care (CEOC) on the basis of performance of signal functions as discussed above. In the two urban areas, a few of private facilities met the standard for both Basic Obstetric Care service and the standard for Comprehensive Obstetric Care service.

Table 4: Quality of Health Facilities

L.G.A	Total Facilities	BEOC Facilities			CEOC Facilities		
		Private	Public	Total	Private	Public	Total
Obudu	5	4	Nil	4	4	Nil	4
Ogoja	8	3	Nil	3	3	Nil	3
Total	13	7	-	7	7	-	7

From the table above, it can be seen that only the secondary health facilities that satisfied the standards for BEOC and CEOC. This is because a wide range of health facility type was included in the category, ranging from health post to primary health care centres. These facilities may have satisfied the standard but utilization may be different.

UTILIZATION OF HEALTH CARE FACILITIES

The availability of health facilities may not influence the utilization of these facilities. The study showed that the level of utilization of these facilities was not in cognizance with availability. The question “what is the source of antenatal services?” was used.

Table 5: Utilization of Health Facilities

Source(s)	Frequency	Percent
At home (TBAs)	172	31.5
Govt. hospital	343	55.1
Private hospital	75	12.0
Others	9	1.4
Total	623	100

A substantial number of women utilize the Traditional Birth Attendant services. Over 30 percent of the women indicated that their source of antenatal service was TBAs which is known to have its hazards of poor knowledge of clinical conditions; they are unwilling to refer cases that are beyond them to appropriate quarters. Over 60 percent of the respondents utilize the private and public health facilities for antenatal care. Despite the high percentage, a good number of women (172) are exposed to the risk of maternal mortality as a result of their choice of antenatal health care.

DELIVERIES IN HEALTH FACILITIES

The table below indicates that a majority of deliveries took place outside health facilities.

Table 6: Proportion of Estimated Births that take place in Health Care Facilities by L.G.A

L.G.A	Estimated Birth	No. of	Number of Deliveries					
			Private facilities			Public Facilities		
			No	%	Pri	%	Sec	%
Ogoja	28010		254	0.6	406	0.7	314	1.1
Obudu	21201		537	2.5	409	2	-	-
Total	49211		791	3.1	815	2.7	314	0.0

- Total Annual estimate were derived from the mathematical expression (Pop x CBR)/100 as shown in the NPC figures.

Since at least 15% of pregnancies are assumed to be associated with some complications needing medical intervention, whenever the number of women receiving care in any health care facility is not at least 15% of all the women giving birth in the population. It is certain that some proportion of obstetric complications is being treated in facilities without adequate facilities for treatment of such conditions. Data showed that a majority of births in the study area take place in other places.

About 40 percent of the respondents indicated that good service was the single most important reason for their choice of a particular health facility. However, about 26 percent identified cost as the reason for their choice of health facilities.

Table 7: Reason for Choice of Health Facilities

Reason	Frequency	Percent
Cost	166	26.6
Convenience	161	25.8
Good services	259	41.6
Suggested by others	14	2.2
Work place of husband	7	1.1
culture	9	1.4
Others	7	1.1
Total	623	100

The proportion of birth in health facilities serves as a crude indicator of the utilization. From the data above, it means that a substantial proportion of the population is managed outside a health facility hence exposing the women to the risk of maternal mortality.

OUTCOME OF DELIVERIES

The utilization of maternal health care service is expected to affect the outcome of delivery. The table below shows that though a small proportion of women utilize health facilities but a majority of them had successful birth outcome. Over 72 percent of respondents reported that their deliveries were successful in their last pregnancies.

Table 8: Outcome of Deliveries

Outcome	Frequency	Percent
Successful	453	72.7
Child died after birth	145	23.3
Discovered dead at delivery	7	1.1
Others	18	2.9
Total	623	100

Table 8 indicates that though a majority of the women received antenatal care outside the maternal health care centre, yet they come out successful.

Table 9: Socio economic Status and Birth Outcome

Categories	Birth outcome		Total	X ²	Df	P<.0.5
	Live birth	child died				
Marital Status						
Single	61	106	167			
	36.5%	63.5%	100.0%			
Married/cohab	373	50	423			
	88.2%	11.8%	100.0%	165.677	2	.000
DSW	19	14	33			
	57.6%	42.4%	100.0%			
Age at first birth						
<20	108	12	120			
	90.0%	10.0%	100.0%	300.892	2	.000
20>	331	42	373			
	88.7%	11.3%	100.0%			
Employ status						
Employed	323	89	417			
	78.7%	21.3%	100.0%			
Not employed	105	72	177			
	59.3%	40.7%	100.0%	22.766	2	.000
Edu Qualification						
No schooling	31	14	45			
	68.9%	31.1%	100.0%			
Primary	19	15	34			
	55.9%	44.1%	100.0%			
Secondary	180	43	223			
	80.7%	19.3%	100.0%	233.454	4	.000
Tertiary	216	89	305			
	70.8%	29.2	100.0%			
Religion						
Catholic	344	118	462			
	74.5%	25.5%	100.0%			

Protestant	95 70.4%	40 29.6%	135 100.0			
Muslim	12 70.6%	5 29.4%	17 100.0%	12.206	4	.016
TAR	0 0.0%	2 100.0%	2 100.0%			
Others	2 28.6%	5 71.4%	7 100.0%			

The bivariate analysis showed varied levels of significance. Using the Chi Square test of independence, table 7 showing analysis of selected socio economic status and birth outcome is quite instructive. Married respondents experienced far better or successful birth outcome than the other category. Over eighty percent had safe deliveries and child (ren) alive against over sixty percent of single mothers whose child (ren) died at delivery. It is instructive that maternal health facilities utilisation is higher among married women hence the higher successful birth outcome. There is statistical significance at .05 alpha level.

Age at first birth showed a very curious result as those who were less than 20 years had a slightly better birth outcome than those over 20 years. This could be as a result of more respondents falling within the 20 years and above. Despite this, there is a significant relationship between age at first birth and birth outcome.

Those that are employed obviously have better birth outcome compared to those that are not employed. Over 75 percent of those employed had successful birth against less than sixty percent among the unemployed. Education has long been identified as a crucial factor in maternal health facilities utilisation (Balk et al. 2004; Callaway, 1987; Family Care International, 2005; Martey et al. 1994). This finding is upheld in the present analysis as those with secondary education and higher had the best birth outcome compared to those with no education. There is a significant relationship between education and birth outcome.

All religions showed good birth outcome except the Traditional African Religion (TAR) which is common knowledge that they are more likely than others to patronise Traditional Birth Attendant (TBA) with its attendant negative consequences.

Table 10: Antenatal Source and Birth Outcome

Categories	Birth outcome		Total	X ²	Df	P<.0.5
	Live birth	child died				
Govt. Hospital	268	107	375			
	81.9%	37.1%	100.0%	25.953	1	.000
Private hospital	163	30	193			
	84.5%	15.5%	100.0%	18.587	1	.000
Health centre	135	36	171			
	78.9%	21.1%	100.0%	4.195	1	.000
TBAs	29	13	42			
	69.0%	31.0%	100.0%	.139	1	.347
Others	21	8	29			
	72.4%	27.6%	100.0%	.000	1	.588

The sources of antenatal care are a factor in birth outcome. This is obvious from the table above as all those who delivered in any modern health facility had over seventy percent of successful birth outcome. Those who delivered in government hospital had 81.9 percent of live birth while those who delivered at the private hospital had 84.5 percent and those at the primary health centre had 78.9 percent successful birth outcome. Following from this, it is convenient to conclude that the utilisation of modern maternal facility is capable of ensuring successful birth outcome and this should be encouraged and vigorously pursued.

DISCUSSION OF FINDINGS

The study area is generally below accepted standard required for maternal health services and basic essential obstetric care facilities required for the available population (4 BEOC facilities per 500,000). There are a large number of private secondary facilities. In fact there are only private secondary health facilities in Obudu Local Government Area. It follows that since the facilities are not available, utilization is not enhanced. This is because the facilities lack relevant equipment for delivery and skills on the available personnel to perform critical essential obstetric care functions. The pattern of utilization is poor because most deliveries take place outside health care centres.

The findings agree with several other studies that have shown the various factors including education, health facilities contribute to poor birth out come. For instance, Njikam stated that lack of education among women undoubtedly contributes to the widespread self-neglect

characteristic of many African women. They tend to be inattentive to their own illness and health needs and fail to seek care. It is for lack of education and its corollary – ignorance – among other factors that often make women passively accept the conditions of life that are meted to them in the name of culture and tradition. It was on this note that Njikam (1994) concluded that the low level of education together with the fact that over 60% of the population are rural –based in Nigeria that cultural norms and practices still exert a strong influence on reproductive health care especially in relation to pregnancy, delivery and child rearing. These may be defined narrowly as "those needs necessary for survival"(Safra, 2003) or broadly as "those needs reflecting the prevailing standard of living in the community". Reproductive ill health is both a cause and consequence of poverty (Family Care International 2005). Sexual and reproductive health problems account for approximately 20 percent of the ill-health of women globally, and 14 percent of men due to lack of appropriate sexual and reproductive health services (World Health Organisation 2004). The age at first birth is one of these factors. Callaway (1987) concluded that the life of the Hausas of northern Nigeria is that of sudden death because young daughters are married against their will. There is forced sexual cohabitation at puberty regardless of mental or emotional development and early motherhood. In a study carried out by Ujah et al., (1999) it found that maternal death was a function of age, grand multiparity, educational status and non-utilization of antenatal services. The study further showed that the health risks factors contributing to maternal mortality were haemorrhage with 28.1% Sepsis (21.3%) and eclampsia (15.7%).

RECOMMENDATIONS

The following recommendations are made following from above.

1. There is an urgent need to upgrade the skills of health staff through training and re-training
2. The operational capacity of facilities for quality maternal health service should be improved.
3. Periodic monitoring of development with regards to maternal health should be conducted.
4. Since a large proportion of deliveries take place in TBAs homes, government should review and evaluate the training and related facilities to improve standards of care given by TBA.

CONCLUSION

This study was under taken to assess the utilisation of maternal health facilities and how this affect birth outcome. The objectives included among others the assesement of women status, availability of facilities, quality of facilities and accessibility to women. The sample was drawn from two local government areas using a multi staged sampling technique. The study found that though the health facilities fell below international standard for BEOC and CEOC, yet deliveries in any modern health facility was more likely to be successful compared to others that are traditional. Consequent upon this, there is an urgent need to upgrade both personnel and equipment to measure up with international standard and a constant drive towards maintaining quality and the institutionalisation of perennial equipment and capacity upgrade.

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