



International Journal of Science, Architecture, Technology and Environment

Socioeconomic Marginality of Rural Women in Accessing Maternal Health Services in Chibombo District, Central Province, Zambia

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DOI: <https://doi.org/10.63680/ijstate0825032.52>

Abstract

Rural women encounter various factors that include low education level, early marriages, poverty and lack of employment that cause socioeconomic marginalities. Girls in Zambia usually attain primary education only and get married early, these factors negatively affect access to maternal health services. This research aimed to explore the socioeconomic marginality of rural women in accessing maternal health services in Chibombo District, Central Province, Zambia. An explanatory sequential mixed methods was used to collect and analyse data. Simple random sampling and purposive sampling were employed to recruit participants for this research. Quantitative data was collected through a questionnaire survey, qualitative data was collected through focus group discussions and key informant interviews. Quantitative data was captured and analysed using the Statistical Package for Social Sciences (SPSS version). Qualitative data was analysed thematically. Intersecting socioeconomic marginalities such as early pregnancies and marriages, low educational level and unemployment were reported as barriers to accessing maternal health services. To address the marginalities, the government of the Republic of Zambia should provide free access to maternal health services and educate rural communities on the importance of accessing maternal health services.

Keywords: Marginality, early pregnancy, education, maternal health access

1.0 INTRODUCTION

Rural pregnant women face numerous challenges that can hinder access to maternal health services. Notably, Sub-Saharan Africa (SSA) and South Asia grapple with high maternal mortality rates (MMRs). Zambia is a Sub-Saharan country that contributes significantly to the high mortality rate in the region. Relative to other SSA countries with available maternal mortality rates data, the United Nations Children's Fund (UNICEF), originally the United National International Children's Emergency Fund in 2021, reported that Zambia's maternal mortality was ranked 141 out of 185 countries and 162 out of 195 for neonatal mortality. Women in Zambia face a lifetime risk of 1 in 100 dying during pregnancy or childbirth, and 1 in 37 infants die in their first month of life (World Health Organisation, 2023). The high MMRs are often exacerbated by limited

healthcare infrastructure, socioeconomic inequality, and cultural barriers that hinder women from accessing necessary healthcare services (World Bank, 2021). Such barriers are among constraints in accessing social and economic services including maternal health. Addressing socioeconomic marginalities in accessing maternal health is essential for interventions and policies to improve maternal health outcomes.

Access to maternal health services is usually affected by the status a woman is given in her community. Socioeconomic determinants must be addressed according to the geographical, economic and social setting for positive outputs. Greene and Ostrowski (2011) agreed with health experts that it was fundamentally important to address cultural, social, gender and economic conditions that shape and often undermine access to maternal healthcare services. Pregnancy and child delivery are not simply clinical conditions to be addressed with purely medical solutions. This is why the focus of this research is the socioeconomic marginality of women and how it affects access to maternal health services.

1.1.1 Location of the study

This research study is conducted in Chibombo District, Central Province, Zambia. Chibombo District. According to the Zambia Demographic Health Survey 2013-2014, Chibombo District recorded the lowest birth facility delivery rate at 48% in Zambia in 2014 (Central Statistics Office [CSO], 2014). The lowest facility birth record is the basis for selecting Chibombo District.

1.1.2 Research Aim and Objectives

The aim of this study is to “explore the socioeconomic marginality of rural women and accessing maternal health services in Chibombo District, Central Province, Zambia”. The specific objectives are:

- i. To explore the correlation between socioeconomic marginality and access to maternal health services.
- ii. To explore strategies and interventions that address socioeconomic marginality in accessing maternal health services.

2.0 LITERATURE REVIEW

Makwana and Elizabeth (2022) define marginality as a social process in which individuals are systematically denied access to rights, opportunities, and resources. Marginality puts a person or a group of persons at margins of social, political, economic and geographical systems. Women are often at the economic margins while men are at the centre. In most settings, a woman's socioeconomic status is a key determinant for seeking maternal health services, especially in developing countries. Calvello, Skog, Tenner and Wallis (2015) note that identifying the accessibility issues to maternal health in Africa could guide decision-makers. They can guide measures towards appropriate and equitable healthcare, which can help transform the socio-economic status of African women.

All pregnant women need access to maternal health services regardless of their economic, cultural, geographical and social background. Women need access to maternal health services during pregnancy and delivery to protect their lives and the life of the unborn baby. Good quality care before and after childbirth is essential for all women (Guerrier, Grais & Keramarou, 2013). Acharya (2016:72) posited that maternal care is a pivotal factor for safe motherhood. The primary aim of maternal care is to achieve a healthy mother and a healthy baby at the end of pregnancy.

Education has been shown to help challenge negative norms and lead to better healthcare decision making. Hence, educated men are more likely to support their women to have a continuum of care (Yeji, Shibnuma,

Oduro, Debpuur, Kikuchi & Owusu-Agei, 2015). Gebeyehu, Gelaw, Lake, Adela, Tegegne and Shewangashaw (2022) found that women who were 35 years or older had 2.7 times more autonomy to choose maternal health services than women who were under 20 years old. They found that women with a primary education were 1.75 times more likely to decide maternal health services on their own than women without any education. In rural Bangladesh, Ahmed, Oni and Hossen (2021) found that household wealth and education of both wife and husband were crucial factors that lead to inequality in accessing maternal healthcare services.

Kaiser, McGlasson and Rockers (2019) findings in Zambia show that out-of-pocket costs relating to childbirth can range up to one-third of the monthly household income for the poorest Zambian households. They found that baby clothes or blankets, delivery supplies such as disinfectant or cord clamps, and transportation were the most common expenditure related to delivery. The study revealed the average spending per childbirth was \$28.760 United States (US) dollar. Chamileke (2017) also found that lower income was associated with a reduced use of antenatal services in Zambia. This can be understood as inability to pay for associated costs like food and transport. The costs must be provided by the person seeking the health service despite the service itself being free. Another study in Zambia by Mulenga (2017) revealed that the wealth status of the mother and region of residence were very important factors associated with maternal health. Women in higher wealth quintiles were more likely to make more antenatal care (ANC) visits than women in the lowest wealth quintile. Most of studies in Zambia focused on financial factors that affect access to maternal health. It is clear that there is a gap between socioeconomic marginalities and accessing maternal health services in Zambia. More studies should be conducted on socioeconomic determinants of maternal health to improve access in Zambia.

There is need for real time research to provide information on socioeconomic determinants of accessing maternal health services in Zambia. Existing gender inequity maternal health studies in Zambia have looked at maternal health care use from the women's perspective (Mweemba, Mapulanga, Jacobs, Katowa-Mukwato & Maimbolwa 2021; Sserwanja, Mukunya, Nabachenje, Kemigisa, Kiondo & Wandabwa, 2022). By contrast, others have looked at male involvement in maternal health from a male perspective (Greenspan, Chebet, Mpembeni, Moshia, Mpunga and Winch 2019; Yaya, Okonofua, Ntoimo, Udenigwe, Bishwajit 2019). These studies did not consider gender relations in accessing maternal health services. Clearly, there is need for more studies in Zambia on socioeconomic determinants in accessing maternal health services.

3.0 METHODOLOGY

The medical sociologist Ronald Andersen (1968) developed the BMHSU, which has come to be widely used to study utilisation and access to services. Andersen examined the concepts of access and accessibility. The model is used in this research to select socioeconomic predictors of accessing maternal health service use in Zambia. The model recognizes factors that impact a person's decision to use or not use existing health services (Andersen, 1995). The variables in this research that influence access to maternal health services include education, age at first pregnancy or marriage, employment status, decision making power and distance to the nearest health facility.

An explanatory sequential mixed method with the qualitative follow-up phase that builds on and explains the quantitative phase is used in this study. Creswell, Clark and Smith (2011) states that an explanatory sequential design begins with collecting quantitative data. The quantitative phase is followed by collecting qualitative data to help explain or elaborate on the quantitative results. In this design, the qualitative design helps explain certain quantitative results that include unexpected findings in more detail (Terrell 2012). Quantitative data in this research is collected using a questionnaire survey, while qualitative data is collected through focus group discussions and key informant interviews. The approach is adopted in order to get a clear and better

understanding of the research. The sample size for this research is 393.

Quantitative analysed using the Statistical Package for Social Sciences (SPSS version 23) Focus group discussions and interviews is analysed thematically through content analysis. Patton (2002) notes that raw qualitative data is organized, collated, grouped and analysed thematically using interpretive content analysis.

The analysed quantitative and qualitative data are synthesized to answer research questions as a whole. Meta-inferences are created by answering research questions in the first and second stage of data collection and analysis.

Ethical approval was obtained from the Humanities and Social Sciences Research Ethics Committee at the University of KwaZulu-Natal (ethical clearance number HSSREC/00001010/2020) and the Chibombo District Health Office. Ethical principles were adhered to at all stages of the study including voluntary participation. An informed consent, privacy when conducting interviews, anonymity and secure storage of data were also observed during data collection and analysis.

4.0 RESULTS AND DISCUSSION

Findings from the present research revealed that maternal age at first pregnancy or early marriage is a determinant of accessing maternal health services. Results from this research indicate that majority 244 (62.1%) of women were pregnant for the first time between 15 and 20 years old. Early pregnancy was reported as an obstacle to accessing maternal health services. Most participants complained that they were disrespected, humiliated and rebuked by health workers for getting pregnant early and not completing their education or getting married first. Young women that got pregnant early reported that they were afraid to access maternal health services. Similarly in Indonesia, Kurniati, Chen, Efendi and Berliana (2018) found that the rates of antenatal service utilisation and skilled delivery assistance were particularly lower for women who got married at age 19 or earlier compared to those who got married at ages between 20 and 29 years. They argued that older mothers have more knowledge and experience about maternal and reproductive health which they acquire through their formal and informal education, which, in turn, encourages them to seek professional healthcare services during pregnancy and childbirth. In Kenya, Naanyu, Mujumdar, Ahearn, McConnell and Cohen (2020) found similar results that the age of the expectant mother was barrier to facility-based childbirth if fall outside of societal norms. The findings show that female adolescents as well as older women may experience hostility and discrimination as a result of falling pregnant at an age deemed inappropriate by the community. Consequently, these women often decide to keep their pregnancy a secret and end up giving birth at home.

Focus group discussions (FGDS) revealed that women lacked income-generating employment to enable them to attend maternal services. The mothers noted that delivering at a health facility was costly, as they needed to pay for registration, buy clothing and pieces of clothing (chitenge) to be attended to. Another study in Zambia also confirmed that wealth was a predisposing factor in maternal health utilization. He, Zhang, Wang, Bishwajit, and Yang (2021) found that economic (wealth quintile), geographic (urban or rural), and cultural differences (religion or ethnicity) were determinants in utilizing the maternal healthcare services.

Results from Ghana by Novignon, Ofori, Tabiri and Pulok (2019) indicate that inequalities were pro-rich. This implies that women from richer households were advantaged in the use of maternal services compared to their poor counterparts. Afework, Gebregiorgis, Roro, Lemma and Ahmed (2014) found in Southern Ethiopia that women who belonged to the higher wealth quintiles had higher odds of antenatal care (ANC) attendance than women in lower quintiles. This could be due to the fact that women with higher economic status could

easily afford health services. Results from this study are different because most women are poor. Very few women in Chibombo reported to be rich or comfortable. However the women did acknowledge the need of income as an enabling factor in accessing maternal health.

Women's education is essential in accessing maternal health services. Shanto, Al-Zubayer, Ahammed, Sarder, Keramat, Hashmi, Haque and Alam (2023) found that women's education was significantly positively associated with the utilisation of maternal health services. Their results indicated that the level of education increases the likelihood of utilisation of maternal health services. Educated women with at least secondary education or above are more likely to attend maternal health services. While higher education is perceived as a predisposing factor in accessing maternal health services, my study found contrary results. My quantitative results findings show that the majority 182 (48.9 %) of respondents that obtained primary, 102 (27.4%) secondary education and only few 16 (4.3%) that obtained tertiary education accessed maternal health services. This can be attributed to the fact that the majority 190 (48%) of women from this present study had only obtained primary education. There is need for more studies on the association of education and access to maternal health services. It is clear that education even at primary level influences access to maternal health services as revealed by the present research.

Kinyondo, Ntegwa and Masawe (2022) in Tanzania found that the level of education affects access to maternal health services. They found that women with primary and secondary level of education have their first antenatal care (ANC) visits within the first trimester compared to women with no formal education. Other similar study findings were found in Zambia. He, Zhang, Wang, Bishwajit, and Yang (2021) found that women with no education had lower scores on observing antenatal care (ANC) facility delivery and postnatal care (PNC) services than those who had primary and higher education. The positive effect of education on healthcare service utilization in general can be interpreted through its enabling mechanism.

5.0 CONCLUSIONS AND RECOMMENDATIONS

This study has revealed that most women in Chibombo are poor and cannot afford direct and indirect costs associated with accessing maternal health services. Lack of transportation services in Chibombo, and insufficient time off work hinder women from accessing maternal health services. Rural women are more burdened with economic and social responsibilities that worsen their socioeconomic marginality. Access to maternal health services. Access to maternal health services can be improved through building hospital facilities and expanding the existing ones. In addition, there is need of deploying more health workers, nurses and midwives in Chibombo and other rural areas to improve maternal health outcomes.

5.1 RECOMMENDATIONS

Based on the findings of this research, it is recommended that the Zambian government provides free access to maternal health services. The government and non-governmental organisations (NGOs) should empower rural women with education and finances so that they can afford access to maternal health services.

My recommendations include providing transport for rural women who live far from health facilities. The findings from this study show that the government needs to build accessible health facilities in rural areas. Existing health facilities should be expanded and stocked with necessary drugs and equipment to increase access to maternal health services. There is a need for increasing the number of maternal health beds and employing more health workers. Other interventions to promote maternal health seeking behavior in Zambia should include financial and educational empowerment for women to improve their decision-making power

and quality of care.

The first conclusion to be drawn from women's socioeconomic marginality in maternal health services is that women's socioeconomic status must be improved. Women who are educated, have advanced ability to make their own decisions. Educated women do have access to fulltime wage employment. Having access to employment provides women with finances which can enable them to participate in decision making processes and access to maternal health services. Another conclusion is that maternal health seeking behaviour is an interdisciplinary study. Maternal health studies should go beyond medical science research to improve maternal health outcomes. Socioeconomic marginalities and other non-clinical determinants should be studied to improve access to maternal health services and consequently reduce maternal deaths.

Declaration of Conflicting Interests

The authors declare no potential conflicts of interest with respect to the research, authorship and publication of this article.

Funding

The author received no financial support for the research, authorship and publication of this article.

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