

**ATTITUDE TO AND PRACTICES FOR SAFE MOTHERHOOD
INITIATIVES AMONG WOMEN OF CHILDBEARING AGE ATTENDING
HEALTH FACILITIES IN IGBO-EZE SOUTH LGA OF ENUGU STATE.**

BY

EZE, PAULINUS ONYEBUCHI

PG/M.ED/10/52329

DEPARTMENT OF HEALTH AND PHYSICAL EDUCATION

UNIVERSITY OF NIGERIA NSUKKA

SEPTEMBER, 2015

Title Page

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DEPARTMENT OF HEALTH AND PHYSICAL EDUCATION

UNIVERSITY OF NIGERIA NSUKKA

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SEPTEMBER, 2015

Approval Page

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Dedication

This work is dedicated to God, the author of my inspiration, my wife and children.

Acknowledgments

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Abstract

The study investigated the attitude to and practices of Safe Motherhood Initiative (SMI) among women of childbearing age (WCBA) attending health facilities in Igbo-Eze South LGA of Enugu State. Eight specific objectives were formulated with eight corresponding research questions and six null hypotheses were postulated to guide the study. Literatures relevant to the study were reviewed. Population for the study was 7210 registered WCBA who attended health facilities in Igbo-Eze South LGA of Enugu State. The study adopted a cross sectional survey research design, Multistage sampling procedure was used to select the sample which was 144. A three section (27 item) researchers designed questionnaire was the instrument used for data collection. Face validity of the questionnaire was established by five experts and split half method of spearman's Rank difference correlation method was employed to test the reliability of the study. The instrument was administered to respondents by the researcher by hand. Mean scores, frequencies and percentages were used to answer the research questions while t-test and ANOVA were used to test the hypotheses at .05 level of significance. Results of the study among others show that there was significant difference in attitude and practices of WCBA towards prenatal as it regards age, level of education and level of monthly income. The study recommended that Health Education programmes should be established and intensified at the grass-root level to increase and promote the utilization of SMI services among childbearing mothers

CHAPTER ONE

Introduction

Background to the Study

Safe motherhood is very crucial for making pregnancy and childbearing safe and enjoyable for the childbearing mothers. Pregnancy and childbirth are natural processes but they are by no means risk-free. They pose a lot of challenges to human-kind and medical science, both in the developed and developing countries of the world. Globally, a large number of women die due to factors related to pregnancy and child birth. World Health Organization-WHO (1998) submitted that more than half a million women die each year as a direct result of pregnancy-related complications such as severe bleeding which accounts for 25 per cent; indirect causes 20 per cent; infection 15 per cent; unsafe abortions 13 per cent; eclampsia 12 per cent; obstructed labour 8 per cent; and other direct causes 8 per cent. The above report further indicated that at least another 20 million mothers suffer serious and long lasting illnesses or disabilities. Ara and Islam (2013) observed that worldwide, about one woman dies in every single minute of the day and that for each woman who dies, an estimated 100 women survive childbearing but suffer from serious disease, disability, or physical damage caused by pregnancy-related complications. These statistics are startling. It appears this is also the case with infant deaths and morbidity.

The number of deaths and morbidities of newborn babies globally is still high. WHO (2012) noted that every year, 4 million newborn infants die and millions more are disabled because of poorly managed pregnancies and deliveries. Requejo (2013) indicated that 43 per cent of child deaths occur during the first month of life. In 2011 alone, 6.9 million children under the age of five died (United Nations Children Fund-UNICEF, 2012). The trend of maternal and child mortality and morbidity appears to be worse in the developing countries.

Reports show that there is high rate of maternal mortality and morbidity due to pregnancy and child birth in developing countries compared to their developed counterparts. World Bank (1993) notes that of all the human development indicators, maternal mortality rate (MMR) represents the greatest disparity between the developed and developing countries. Nigussie, Mariam and Mitike (2004) submit that the risk of dying from pregnancy-related complications is highest in Sub-Saharan Africa while in some countries the maternal mortality ratios are more than 1,000 deaths per 100,000 live births. According to WHO (2012), 99 per cent of global maternal mortality occur in developing countries, where a woman's lifetime risk of dying from pregnancy-related complications is 45 times higher than

that of her counterparts in developed world. Even among the countries in the developing world, there appears to be disparity in the rates of maternal mortality.

Some countries in the developing world record low maternal mortality rates while others rate high. Nigeria has been named as one of the countries in Sub-Saharan Africa with very high MMR. Nigeria constitutes 10 per cent of the world's maternal and child deaths (Kusiako, Ronsmans & VanDer, 2000). According to Hill, Thomas, AbouZahr, Say, Inoue and Suzuki (2007), Nigeria's maternal and child mortality ratio of 1,100 is higher than the regional average. Okonofua (2010) reports that Nigeria has been ranked as the number two country (after India) with the highest absolute number of maternal deaths in the world. The foregoing reports indicate that MMR is very high in Nigeria. Underneath the foregoing statistics lies the pain of human tragedy, for thousands of families who have lost their children and/or mothers especially in developing economy, including Nigeria. Maternal mortality has far reaching socio-economic implications.

A mother's death carries profound consequences not only for her family, especially her surviving children, but also for her community and country. Ara and Islam (2013) observe that in some developing countries, if a mother dies, the risk of death for her children under the age of 5 is doubled or tripled. They add that because a woman dies during her most productive years, her death has a strong social and economic impact, her family and community lose a productive worker and a primary care giver. Daly, Azefor and Nasah (1993) note that women produce most of the food necessary for a household, cook for the family, fetch water, clean the house and care for the children, the sick and the elderly at home. Therefore, their death appears to be a very big loss to their families and friends. A mother's ill-health condition may also affect her baby and by extension, her household. At least 7 million pregnancies worldwide result in stillbirths or infant deaths as a result of maternal illness (Daly, Azefor & Nasah, 1993). The above report further indicated that among infants who survive the death of the mother, fewer than 10 percent live beyond their first birthday. It is regrettable to note that these maternal and child health mishaps are still high when they can be prevented.

It is devastating to know that intervention reaching these women and babies on time would have averted most of these deaths and morbidities. The World Bank (1993) has estimated that 74 per cent of maternal deaths could be averted if all women had access to interventions that address complications related to pregnancy and childbirth, especially emergency obstetric care. Suffice this to say that maternal and child mortality rates would

drop if there were sufficient maternal and child health services, interventions and programmes.

It seems that there are insufficient maternal and child health services and programmes in the developing world. WHO (2012) observe that poor women in remote areas are the least likely to receive adequate health care. WHO maintain that this is especially true for regions with low numbers of skilled health workers, such as Sub-Saharan Africa. According to the above report, while levels of antenatal care have increased in many parts of the world during the past decade, only 46 per cent of women in low-income countries benefit from skilled care during childbirth. This means that millions of births are not assisted by a midwife, a doctor or a trained nurse. In low-income countries including Nigeria, Just one third of all pregnant women have the recommended four antenatal care visits and only 31 per cent of all deliveries take place in a health care facility (WHO, 2012). A study conducted by WHO (2013) in northern Nigeria indicated that 25 per cent of all deliveries took place at home with no assistance or attendant present. The report further revealed that facilities including antenatal care, prenatal care, post-partum and obstetric care facilities in the country were generally in poor condition with chronic shortages of essential equipment, drugs and human resources. This problem has created an emergency need for programmes and policies aimed at accelerating progress towards addressing the menace. One of such programmes is Safe Motherhood Initiative.

Safe Motherhood Initiative (SMI) is a programme of activities directed towards ensuring that child-bearing mothers and their children do not face the risk of mortality or morbidity in pregnancies, child births, and post partum period. Daly, Azefor and Nasah (1993) defined SMI as a concerted set of interventions designed to reduce maternal mortality and to improve the reproductive health status of women. It is a means of saving the lives of women and improving the health of millions of others (Jatau, 2000). SMI has been conceptualized as a means of ensuring women's accessibility to needed care through antenatal programme in order to facilitate their safety and optimal health throughout pregnancy and child birth (Price, 2002). According to Ara and Islam (2013), SMI is a programme aimed at enhancing the quality and safety of women's lives through the adoption of a combination of health strategies which include: ensuring women's right to decide whether and when to have children by providing access to family planning services; increasing the numbers of healthcare providers (midwives, doctors, nurses and traditional birth attendants); and improving training for healthcare service providers. Definitions can go on but they have central conceptual focus: ensuring the safety and health of mothers and that

of their children during pregnancies and child birth. In the context of the present study, SMI is a programme while safe motherhood is the goal of the programme (SMI).

Safe motherhood may be described as actions taken by mothers, relatives and healthcare providers in order to make pregnancy and childbearing risk-free for mothers. Chinwuzie, Braimoh, Unigbe and Olumeko (1995) noted that safe motherhood included: family planning services to prevent unwanted pregnancies; safe abortions, where legal, and efficient management and treatment of complications of unsafe abortions; prenatal and delivery care at the community level with quick access to first-referral services for complications; and postpartum care, including family planning services, promotion of breastfeeding, immunization and nutrition services. Suffice it to say that when one practices the components of SMI, one is said to have practiced safe motherhood. In this study, safe motherhood means actions or roles taken by mothers, relatives and healthcare providers in order to make pregnancy and childbearing risk-free for mothers.

Safe Motherhood Initiative is achieved through a programme of inter-linked components which are pulled together to ensure the safety, health and happiness of child-bearing mothers. According to Partnership for Transforming Health Care System-PATHS (2005), and Ara and Islam (2013) SMI comprises pre-conception care; antenatal care; post-partum care; post-abortion care; emergency obstetric care/life saving skills; and care of the new born. PATHS (2005), Ara and Islam (2013), and the United Nationsø Fund for Population activities-UNFPA (2014) describe these components thus: Pre-conception care is the information and services (such as screening for and managing conditions which may complicate pregnancy, childbirth and health of the mother and child) given to an individual or couple who intend to biologically father or mother a child.

During pregnancy, it is very important that a mother takes good care of her own health and that of her unborn baby. This is known as antenatal care. Antenatal care is the care of the women during pregnancy (UNFPA, 2014). Other cares such as post-partum care, post-abortion care; emergency obstetric care/life saving skills are targeted towards saving the life and promoting the health of the mother and her child in the course of and after delivery (PATHS, 2005). UNFPA (2014) advise that since up to 50 per cent of maternal deaths occur after delivery, a midwife or a trained and supervised traditional birth attendant (TBA) should visit all mothers as soon as possible within the first 24-48 hours after birth. Ara and Islam (2013) advised that the midwife or TBA should assess the motherø general condition and recovery after childbirth and identify any special needs. This attention is particularly important especially when the woman is alone or as the head of the family.

A child-bearing mother and her child are supposed to benefit from SMI in a variety of ways. Daly, Azefor and Nasah (1993), and Jatau (2000) agree that the health risks that confront childbearing women especially teenage mothers are serious and they include: pre-eclamptic toxemia, anaemia, malnutrition, cephalopelvic disproportion, obstetric fistulae, obstructed labour, low birth weight and perinatal mortality. These complications and abnormalities according to the above report are preventable through valid motherhood programmes in maternal and child health (MCH) clinics. World Bank (2013) adds that SMI promotes family planning practice and ensures that unwanted or unplanned pregnancies which can interfere with women's social and economic activities and cause emotional and economic hardship not only to women but also to their families are avoided. WHO (2012) submits that SMI lessens the burden associated with frequent pregnancies, poor maternal health, pregnancy complications, and caring for sick children which drains the productive energy of women, jeopardizes their income-earning capacity, and contributes to their poverty. Jatau (2000) observes that SMI reduces the number of children who have drastically diminished prospects of leading a productive life following the death of a mother. In order to reduce life-threatening risks, mortality and morbidity among childbearing mothers, good quality maternal health services by trained health workers must be available and must be used by childbearing mothers.

A childbearing mother is a woman in her reproductive age (i.e. between puberty and menopause). Child-bearing age has been described as the period in a woman's life between puberty and menopause (Williams & Wilkins, 2006). Experts, as reported by Medical News Today-MNT (2005), advise that the best age for childbearing remains 20-35. Medical News Today (2005) warns that age-related fertility problems increase after 35 and dramatically after 40. Under-aged mothers also are at the high risk of pregnancy-related complication. WHO (2012) reports that young adolescents face a higher risk of complications and death as a result of pregnancy than older women. Studies like Jatau (2000), and Williams and Wilkins (2006) show that adolescent pregnancy is an exploding problem in Sub-Saharan Africa. Young women under age 20 in Africa are more likely to have a child than those in other regions (Daly, Azefor & Nasah, 1993). For example, by age 18 more than 40 percent of the women in Africa have given birth already (Senderwitz 1993). Daly, Azefor and Nasah (1993) reported that in Africa, 1 in 5 adolescent women would have a birth in a given year. They note that most of the births to teenagers are first births and women having their first child carry higher risk of serious medical complications. The above report further reveals that babies who are first births face a higher infant mortality rate than higher order births and this

risk is even greater among teenage mothers. Childbearing mother in this study is a woman who is in a period between her puberty and menopause. How the childbearing mothers would benefit from SMI depended on their attitude to it.

Attitude is a hypothetical construct that represents an individual's degree of like or dislike for something which in turn influences his/her behaviour to that thing. Hornby (2005) defined attitude as the way that you think and feel about somebody or something which influences the way you behave to the person or the thing. It is a mental position relative to a way of thinking or being (Looper, 2006). According to Wyohannes (2010), it is defined as an opinion or way of thinking which reflects in the person's behaviour. If childbearing mothers feel that safe motherhood is for their own good, they may develop positive attitude towards it and *vice-versa*. In the present work, attitude refers to childbearing mothers' feeling about safe motherhood which influences their behaviour towards it. Positive attitude to safe motherhood may make mothers to put it into practice.

Practice means doing a particular thing over and over again. According to Hornby (2005), practice means doing something regularly as part of one's normal behaviour. Merriam-Webster (2012) adds that to practice means to do or perform often, customarily, or habitually. In this study, practice refers to the habitual actions applied by childbearing mothers which are directed towards ensuring that they and their babies do not face the risk of mortality or morbidity in their pregnancies, child births, and post partum periods. According to Ara and Islam (2013), practice for safe motherhood may be interrupted by common problems in rural settings such as poverty, inadequate and/or poor quality health facilities and ill-equipment of the existing ones. Others are inadequate knowledge and lack of women education among families, poor utilization of available health services, negligence and attitude of health personnel, cultural practices, traditional values and belief system. This may be the case with Igbo-Eze South LGA. Part of the interest of the present work is to investigate the practice of safe motherhood among childbearing women in Igbo-Eze South LGA. Childbearing women's attitude to and practice for safe motherhood have been consistently reported to be influenced by a number of socio-demographic factors such as level of education, location, age, economic status among others.

Mother's level of education appears to wield strong influence on her attitude to and practice for safe motherhood. More educated mothers may acquire greater knowledge concerning health outcomes of their every action and this might make them to imbibe positive attitude to and consistent practice for safe motherhood. Becker, Peter, Gray, Gultiano and Blake (1993) note that mother's education may also act as a proxy variable of a number

of background variables representing women's higher socioeconomic status; thus, enabling her to seek proper medical care whenever she perceives it necessary. According to UNICEF (1997), education is positively associated with increased utilization of health services. Nisar and White (2003) observe that there are a number of explanations why education is a key determinant of demand. According to the authors, education is likely to enhance female autonomy; therefore, women develop greater confidence and capabilities to make decisions regarding their own health, as well as their children's health. The above report indicates that it is likely that more educated women seek higher quality services and have greater ability to use health care inputs to produce better health outcomes. That may be why Rossiter et al (2005) emphasize that formal education has the key to improved utilization of maternal and perinatal health services. Sharma and Sharma (2012) note that it is believed that women's education is important for understanding health messages and to be able to make decisions regarding their health and care.

Female literacy level and women's economic status appear closely interlinked with maternal attitude to and practices for safe motherhood as reported in most studies. For instance, WHO (1990) report that in all countries where female literacy rates and economic status have been high, the birth rates and reproductive mortality rates like MMR and IMR have been low. To buttress the relatedness of a mother's level of education and her economic status in increasing safe motherhood practices, Agarwal and Reddaiah (2005) recommend that it is very important to raise the status of women in terms of education and socio-economic status. From the foregoing, a woman's level of education has been shown to be strongly connected with her economic status in promoting positive attitude to and practice for safe motherhood. Irrespective of her level of education, a woman's level of income or economic status appears to be a strong determinant of her attitude to and practice for safe motherhood.

Women who have access to money are likely to have a positive attitude to and practices for safe motherhood. Elo, (1992), and Fosu, (1994) note that increased income has a positive effect on the utilization of modern health care services. Nisar and White (2003) find income level to be a significant factor affecting utilization of MCH services and they report that women of higher income were two times more likely to use antenatal services as compared to the lower income group. WHO (2012) note that poor women in remote areas are the least likely to receive adequate health care and that this is especially true for regions with low numbers of skilled health workers, such as Sub-Saharan Africa and South Asia. Those indicators were more adverse in rural areas.

Modern health facilities and services may be lacking in short supply or ill-equipped in the rural communities. Nigussie, Mariam and Mitike (2004) note that place of residence influences utilization of delivery services as urban women have more access to health care services than their rural counterparts. SIHFW (2008) report that rural women were far less likely to receive three ANC contacts (32%) compared to their urban counterparts (75%). SIHFW maintained that only 43 per cent of births in rural settings were attended to by a health professional, and urban women were more than twice as likely to seek such assistance. Utilization of MCHS may also depend on mother's age.

As years pass by, one naturally accumulates experiences. This means that as a mother grows older in her child-bearing life, her level of puerperal experiences also increases. An older or more experienced mother may utilize MCHS which will reduce her chances of exposure to pregnancy-related complications unlike young inexperienced mothers. Studies like Fiedler (1994) notes that mother's age may sometimes serve as a proxy for the women's accumulated knowledge of health care services, which may have a positive influence on the use of health services. Daly, Azefor and Nasah (1993) report that few adolescent mothers seek reproductive health services than older mothers because few teenagers are knowledgeable about sexual behaviour: few services are available for teenage mothers. The above report further revealed that because adolescents seek anonymity or do not have the money to pay for services, they conduct abortion by themselves or resort to unsafe abortion by people who have no medical training; therefore, they often delay seeking treatment for complications of illegal abortion for fear of revealing their identity and intention, or due to lack of access to health services.

Some studies argue that younger mothers may practice safe motherhood more than the older ones. Normon, Lopez, Carcamo and Galindo (1993) report that because of development of modern medicine and improvement in educational opportunities for women in recent years, younger women might have an enhanced knowledge of modern health care services and place more value upon modern medicine. This appears to be true especially when it has been reported in literature that the practice for safe motherhood is more among the educated mothers than the uneducated ones.

Some authors believe that one would naturally seek care irrespective of one's age. This means that mother's age has no connection with the attitude to and practice for safe motherhood. Igbokwe and Adama (2011) reported that age had no significant influence on child-bearing mother's practice of SMI components. The authors maintained that the age of

an individual does not necessarily influence the individual's capacity to effectively practice health-related behaviour which is of immense to the individual.

In addition to mother's age, other factors have been implicated to influence attitude to and practice for safe motherhood. Factors such as culture, parity and marital status have been reported to influence mother's attitude to and practice for safe motherhood (Daly, Azefor, Nasah, 1993; Nigussie, Mariam, and Mitike, 2004; WHO, 2012; Ara, S. & Islam, 2013). The aforementioned socio-demographic factors may also influence the attitude to and practices for safe motherhood in Igbo-Eze South LGA. These factors are rooted in some theories for better comprehension since every scientific research appears to be built on given theories.

Theories are constructs and postulations that guide or suggest a way in which individuals perceive phenomena and act or behave which in turn may influence the nature and the level of what they know or practice. Philips (1991) noted that the desire to effect change in behaviour for reducing the risk of future illness should be based upon theoretical models that identify predictors of behavioural change. According to Microsoft Encarta (2009), theory is an idea or belief about something arrived at through speculation or conjecture. Therefore, the present study will be anchored on the theory of Health Seeking-Behaviour and Theory of Attachment.

Igbo-Eze South is one of LGAs in Enugu State. It is a rural setting predominantly made up of farming communities. Some health-related harmful practices such as early marriages with attendant health risks, female genital mutilation, desire for many children, male children preference, and use of unhygienic objects for cord cutting and circumcision may still be observed in the area. These practices have negative health consequences on the mothers and their babies. There are numerous patent medicine shops and many herbal homes while formal health facilities are few. According to Igbo-Eze South LGA Ministry of Health-ISMH (2013), there are only 15 health facilities for the whole LGA. Judging from the proliferation of these herbal homes and chemist shops, it appears that Igbo-Eze people including child-bearing mothers rely so much on them than the formal health facilities for their health care. One wonders at the attitude to and practices for safe motherhood among these child-bearing women since no study, to the best of knowledge of the present researcher, has reported it. This calls for a research such as the present one to fill the backdrop in the literature.

Statement of the Problem

Safe motherhood was initiated so that pregnancy-associated complications among child-bearing mothers will be minimized or total avoided, thereby reducing the trend of maternal and child mortality and morbidity. Studies show that 74 per cent of maternal deaths could be averted if all women should engage in safe motherhood practices which address complications related to pregnancy and childbirth, especially emergency obstetric care. Following from this, it becomes necessary for child-bearing mothers to demonstrate positive attitude to and meticulous practice for safe motherhood in order to preserve their own health and life, and that of their infants.

In Igbo-Eze South LGA, some health-related harmful practices such as early marriages with attendant health risks, female genital mutilation, desire for many children, male children preference, and use of unhygienic objects for cord cutting and circumcision may still be observed. These practices have negative health consequences on the mothers and their babies. There are numerous patent medicine shops and many herbal homes while formal health facilities are few. There are only 15 health facilities for the whole LGA. Judging from the proliferation of these herbal homes and chemist shops, it appears that Igbo-Eze people including child-bearing mothers rely so much on them more than the registered health facilities for their health care.

This situation is bothersome. The problem is, what would the attitude to and practices for safe motherhood among the childbearing mothers in Igbo-Eze South LGA in the context of the above features? Since no study, to the best of knowledge of the present researcher, has been conducted to answer the above question, the present one poses to do so.

Purpose of the Study

The purpose of this study is to determine the attitude to and practices for safe motherhood among women of child-bearing age (WCBA) attending health facilities in Igbo-Eze South LGA of Enugu State. Specifically, this study will determine the:

1. attitude of WCBA to safe motherhood;
2. practice for safe motherhood among WCBA;
3. influence of age on WCBA's attitude for safe motherhood;
4. influence of age on WCBA's practices for safe motherhood;
5. influence of level of education on WCBA's attitude for safe motherhood;
6. influence of level of education on WCBA's practices for safe motherhood;
7. influence of level of income on WCBA's attitude for safe motherhood;

8. influence of level of income on WCBØ practices for safe motherhood.

Research Questions

The following research questions were posed to guide the present study.

1. What is the attitude of WCBA to safe motherhood initiatives?
2. What are the practices for safe motherhood initiatives among WCBA?
3. What is the influence of age on WCBØ attitude for safe motherhood initiatives?
4. What is the influence of age on WCBØ practices for safe motherhood initiatives?
5. What is the influence of level of education on WCBØ attitude for safe motherhood initiatives?
6. What is the influence of level of education on WCBØ practices for safe motherhood initiatives?
7. What is the influence of level of income on WCBØ attitude for safe motherhood initiatives?
8. What is the influence of level of income on WCBØ practices for safe motherhood initiatives?

Hypotheses

The following null hypotheses were postulated to guide the present study. Each of them was tested at .05 level of significance.

1. There is no significant difference in the childbearing womenØ attitude to safe motherhood initiative based on age.
2. There is no significant difference in the childbearing womenØ practices to safe motherhood initiative based on age.
3. There is no significant difference in the childbearing womenØ attitude to safe motherhood initiative based on educational level.
4. There is no significant difference in the childbearing womenØ practices to safe motherhood initiative based on educational level.
5. There is no significant difference in the childbearing womenØ attitude to safe motherhood initiative based on income level.
6. There is no significant difference in the childbearing womenØ practices to safe motherhood initiative based on income level.

Significance of the Study

The present study will generate data on the attitude to and practices for safe motherhood among women of child-bearing age attending health facilities in Igbo-Eze LGA of Enugu State. The findings of the study will be of immense benefit to the government at all levels, families, health educators, researchers, health care providers.

Findings from the attitude to components of SMI among WCBA will also be useful to the governments, UNICEF and WHO. If mothers are found to have negative attitude to SMI, the government, UNICEF and WHO may be prompted to strengthen their campaigns, workshops, adverts and every other programmes which will glamourize the essence of SMI. With this in place, the child-bearing mothers may be attracted and they may begin to develop positive attitude to SMI. The health educators will also find this an opportunity to educate mothers on the benefits of practices for safe motherhood. With this, mothers may begin to develop healthy attitude to safe motherhood.

Findings from the practices for safe motherhood among WCBA will be very important to governments, health educators, WHO and UNICEF who are interested in propagating the principles of safe motherhood. The government may strengthen the Free Maternal and Child Health Services (MCHS) so that more mothers will have access to health care and may be able to optimally practice safe motherhood. These findings may spur health educators to intensify the teaching of the benefits of practices for safe motherhood. WHO and UNICEF may use the findings to evaluate the SMI practices so far and then institute strategies for improvement.

The findings from the influence of age on WCBA's attitude to SMI will help the health educators to appropriately plan their teaching of tenets of SMI. Attention of those mothers who are at most risk of pregnancy-related complications like adolescent mothers and those approaching menopause will be drawn in order to make them develop positive attitude to safe motherhood. Attention may also be given to all mothers irrespective of age.

Data generated from the influence of age on WCBA's practice of SMI will be of immense benefits to the families, nurse and health educators. The health educators and the nurses may appreciate the need to intensify efforts towards teaching the principles and practice for safe motherhood to the mothers including their husbands and relations. This may make the mothers to practice safe motherhood. Even when they backslide in the practice of safe motherhood, their relations will reinforce them to continue because they have received scientific information about SMI through Health Education. With this, mother may unconsciously develop the habit of practicing safe motherhood.

The findings from the influence of level of education on WCBA's attitude to SMI will benefit various facilities. They may see the need for woman or girl-child education as often discouraged in the developing countries. This finding may make the health educators to extend their teachings beyond mothers to other members of society to see the need and benefits of girl child education. If a woman is educated, she is likely going to be positive about life. The findings will also help the curriculum planners to appropriately and compulsorily make the knowledge of SMI part of relevant subject in all levels of education.

The findings from the influence of level of education on WCBA's practice of SMI will be of immense benefit to the health educators, governments, WHO and UNICEF. They may grant free education to child-bearing mothers knowing that with education, a mother stands a better chance of appreciating the importance of SMI. Also, the health educators will find this an opportunity to educate mothers on the benefits of practices for safe motherhood. With this, mothers may begin to develop positive attitude to safe motherhood. As a result, she may see the need to practice safe motherhood.

The findings from the influence of level of income on WCBA's attitude to SMI will be of great benefit to the health educators, families and government. The health educators may as result of the findings educate families especially the husbands on the need to always support their wives financially as regards their medication and personal needs. The families especially the husbands may learn that it is very important to support their wives financially, or create for them income earning ventures so that they may be self dependent in terms of financing their health services. The government may also strengthen the free maternal and child health services knowing that it will promote positive attitude to safe motherhood among the child-bearing mothers.

Data generated from the influence of level of income on WCBA's practice of SMI may also benefit the health educators, government, WHO and UNICEF. Following from these findings, the health educators may consistently educate families on the need for women's financial autonomy. The government, WHO and UNICEF may be prompted by the findings to find a way of empowering women to be financially self sufficient so that they may improve in their practice of safe motherhood initiative.

Finally, the theory and model applied in this study will promote the understanding of the need for SMI among the WCBA. This will be tangential to the attitude to and practice of SMI among the WCBAs, the age, level of education notwithstanding. The theory and model have constructs and tenets that may guide thw WCBAs to break the barriers of demographic differences in order to attain the optimal realization and benefits associated with SMI. The

theories and models may therefore be used by researchers to make predictions or analysis of expected outcomes in related studies. More so, SMI planners and facilitators may utilize the theory or model in explaining some concepts of SMI that has to do with attitude and practice in order to promote attitudinal change and very high and consistent practices among WCBAs.

Scope of the Study

This study was delimited to Igbo-Eze South LGA of Enugu State. It focused on all the childbearing mothers attending health facilities in the LGA. It also investigated the attitude to and practices for safe motherhood among this population. The study covered level of education, age and level of income which were the socio-demographic factors that impinged on and influencing attitude to and practices for safe motherhood among childbearing mothers.

CHAPTER TWO

Review of Related Literature

This chapter presents the review of related literature on the attitude to and practices for safe motherhood (SM) among women of child-bearing age attending health facilities in Igbo-Eze South LGA of Enugu State. Literature on the subject abound. A few of them are from Nigeria while a great number of others are conducted elsewhere in foreign countries. The available literature has been organized and presented under the following headings:

Conceptual Framework

- Safe motherhood initiative.
- Components of safe motherhood.
- Benefits of safe motherhood.
- Attitude and practice.
- Women of childbearing age.
- Socio-demographic factors that influence attitude to and practice of SM.
- Measurement of attitude and practice

Theoretical Framework

- The health belief model (HBM).
- Theory of attachment.

Empirical Studies on Attitude to and Practices for SM

Summary of Literature Review

Conceptual Framework

This section will review the concepts of safe motherhood, attitude, practice, and child bearing mother. Numerous researchers have defined safe motherhood diversely. However, most of them have common conceptual focus.

Safe motherhood initiative.

Safe Motherhood Initiative (SMI) is a health programme directed towards reducing the rates of maternal and child mortality and morbidity resulting from pregnancy-and childbirth-related complications. According to UNFPA (2014), SMI is a set of programmes designed to reduce the high numbers of deaths and illnesses resulting from complications of pregnancy and childbirth. UNFPA added that these programmes seek to address the major causes of maternal deaths and illnesses like haemorrhage, complications of unsafe abortion, pregnancy-induced hypertension, sepsis and obstructed labour by undertaking related

activities which ensure women have access to comprehensive reproductive health services. Ara and Islam (2013) describe SM as a programme designed to ensure that women receive appropriate attention throughout their pregnancy and childbirth, providing pre-and postnatal care including care of the baby and breastfeeding support, and delivery care with referral for women with obstetric complications. The authors also note that SM is a programme aimed at enhancing the quality and safety of women's lives through the adoption of a combination of health and non-health strategies which include: ensuring women's access to health services; raising women's awareness of health services; promoting women's right to decide whether and when to have children by providing access to family planning services; increasing the numbers of healthcare providers (midwives, doctors, nurses and traditional birth attendants); and improving training for healthcare providers.

Safe motherhood does not depend only on what the government can do to reduce maternal and child mortality, it also requires the involvement of the actions of the child-bearing mother and that of her relatives. This may be why NPSM (2003) defined SM as a concerted collective efforts by a pregnant mother herself, her immediate and extended family members, her community and all health personnel at the primary, secondary and tertiary levels of healthcare system to ensure safety of a pregnant woman and her baby during pregnancy, delivery and after delivery. According to Sharma and Sharma (2012), safe motherhood means ensuring that all women receive the care they need to be safe and healthy throughout pregnancy and childbirth. Daly, Azefor and Nasah (1993) defined Safe Motherhood Initiative (SMI) as a concerted set of interventions designed to reduce maternal mortality and morbidity and to improve the reproductive health status of women and their new born babies. There are diverse definitions of SM. However, they all build on promoting the health and reducing mortality and morbidity among mothers and their new born babies. However, this study will adopt NPSM (2003)'s definition which conceived SM as a concerted collective efforts by a pregnant mother herself, her immediate and extended family members, her community and all health personnel at the primary, secondary and tertiary levels of healthcare system to ensure safety of a pregnant woman and her baby during pregnancy, delivery and after delivery. The introduction of Safe Motherhood Initiative (SMI) was as a result of the collaborative efforts to reduce the global maternal and child mortality and morbidity.

In 1987 the World Bank, in collaboration with WHO and UNFPA, sponsored a conference on safe motherhood in Nairobi, Kenya to help raise global awareness about the impact of maternal mortality and morbidity (Sharma & Sharma, 2012). According to Ara

and Islam (2013), the conference launched the Safe Motherhood Initiative (SMI), which issued an international call to action to reduce maternal mortality and morbidity by one half by the year 2000. In order to make motherhood safe for child-bearing mothers, countries adopt different strategies.

Developing countries use different strategies in ensuring motherhood among their child-bearing mothers and efficient management and treatment of complications of unsafe abortions, promoting antenatal care, delivery care at the community level with quick access to first-referral services for complications, postpartum care including family planning services to prevent unwanted pregnancies, improving essential obstetric care, addressing the reproductive health needs of adolescents, ensuring women's access to health services, and raising women's awareness of health services (Chiwuzie, Braimoh, Unigbe & Olumeko, 1995; Rossiter, Chong, Lister, Bano, Briggs, Kwempu & Memberr, 2005). Other strategies are promoting women's right to decide whether and when to have children, promotion of breastfeeding, immunization and nutrition services, increasing the numbers of healthcare providers (Midwives, doctors, nurses and traditional birth attendants), and improving training for healthcare providers (Daly, Azefor and Nasah, 1993; UNFPA, 2012). It is hoped that when these strategies are implemented, the rates of maternal mortality will drop. In too many countries, maternal mortality appears to be a leading cause of death for women of reproductive age.

Maternal mortality is the death of a mother following complications of pregnancy and/or child birth. According to Chinwuzie, Braimoh, Unigbe, and Olumeko (1995), maternal mortality is the death of a woman while pregnant or within 2 days after termination of pregnancy from any cause related to or aggravated by pregnancy or its management. Maternal Mortality Rate (MMR) therefore, is the annual number of women who die from pregnancy-or childbirth-related complications per 100,000 live births (Indexmundi, 2013). Daly, Azefor and Nasah, B. (1993) observe that the root causes of a woman's death begin before her birth, are perpetuated during childhood and adolescence and continue later in life. Maternal mortality has been consistently reported to be caused by a lot of factors.

When a woman becomes pregnant, her entire system seem to be reset to accommodate the implanted fetus's needs. These physiological changes may distort the woman's body harmony making it very difficult for her to cope with. The changes may result to complications accounting for 80 per cent of all maternal deaths (WHO, 2012). These complications include: severe bleeding (mostly bleeding after childbirth), infections (usually after childbirth), high blood pressure during pregnancy (pre-eclampsia and eclampsia), and

unsafe abortion (WHO, 2012; Ara & Islam, 2013; UNFPA, 2014). MSI (2004) reports that globally, an estimated 585,000 women die each year from obstetric complications such as preeclamptic toxemia, anaemia, malnutrition, cephalo pelvic disproportion, obstetric fistulae, and obstructed labour. Women also die because of their vulnerability to infections such as malaria, and AIDS during pregnancy (WHO, 2012).

The rate of maternal mortality is found to be associated with lifetime risk of maternal death among other factors. The joint report of WHO, UNICEF, UNFPA and the World Bank (2012) described lifetime risk as the probability that a woman would die from complications of pregnancy and childbirth over her lifetime; it takes into account both the maternal mortality ratio (MMR) and the total fertility rate (TFR) which is the probable number of births per woman during her reproductive years. World Bank (2012) reveals that in a high-fertility setting a woman faces the risk of maternal death multiple times, and her lifetime risk of death will be higher than in a low-fertility setting. UNFPA (2012) concluded that the lifetime risk of maternal death in the developing world in 2010 as a whole was 1 in 150, compared to industrialized regions with an estimated 1 in 4,700. Among the regions, women in sub-Saharan Africa face the highest lifetime risk of 1 maternal death in every 39 births (World Bank, 2012). Apart from maternal mortality, increased maternal morbidity has also been reported among the child-bearing mothers.

A great number of mothers who did not die out of childbirth-related conditions may suffer one form of morbidity or the other. In every single maternal death, an estimated 100 women survive childbearing but suffer from serious diseases, disabilities, or physical damage caused by pregnancy-related complications (Ara & Islam, 2013). Apart from maternal mortality, increased maternal morbidity has also been reported among the child-bearing mothers.

A great number of mothers who did not die out of childbirth-related conditions may suffer one form of morbidity or the other. In every single maternal death, an estimated 100 women survive childbearing but suffer from serious diseases, disability, or physical damage caused by pregnancy-related complications (Ara & Islam, 2013). WHO (1998) indicated that at least 20 million mothers suffer serious and long lasting illnesses or disabilities following pregnancy and childbirth. This data implies that pregnancy and childbirth is full of risks and for a mother to undergo pregnancy and have a safe delivery, she must embrace safe motherhood. Maternal health and that of her newborn seem to be closely linked together.

The health of a mother may influence that of her baby. According to Park (2006), a healthy mother brings forth a healthy baby with positive chances of survival. Requejo (2013)

notes that 43 per cent of child deaths occur during the first month of life, and this percentage is continuing to rise. More than three million newborn babies die every year, and an additional 2.6 million babies are stillborn (Cousens, Blencowe, Stanton, Chou, Ahmed, Steinhardt, Creanga, Tuncalp, Balsara, Gupta, Say & Lawn 2011). This trend is worrisome especially when interventions reaching these women and babies on time would have averted most of these deaths and morbidities.

If government at all levels, international or local organizations, non-governmental organizations (NGOs), and community members including child-bearing mothers themselves should earnestly pursue and embrace SM by putting each of its precepts into practice, the rates of maternal and child deaths and morbidities may have been reduced to the barest minimum. The State Institute of Health and Family Welfare-SIHFW (2008) noted that an estimated 63 percent of child mortality would be prevented with 99 percent coverage of effective and available interventions. SIHFW (2008) contend that mothers could also potentially fare much better when they are assisted with appropriate intervention. The World Bank (1993) has estimated that that 74 percent of maternal deaths could be averted if all women had access to interventions that address complications related to pregnancy and childbirth, especially emergency obstetric care. Accessing these interventions in order to reduce maternal and child morbidity and mortality depends so much on the child-bearing mothers' attitude to safe motherhood.

Components of safe motherhood initiative.

Safe motherhood Initiative is achieved through a programme of inter-linked components which are pulled together to ensure the safety, health and happiness of child-bearing mothers. UNFPA (2014) notes that safe motherhood includes antenatal care, delivery care (including skilled assistance for delivery with appropriate referral for women with obstetric complications) and postnatal care, including care of the baby and breastfeeding support. Sexually transmitted diseases (STD)/HIV/AIDS prevention and management, family planning services, and other Rhesus factor concerns. PATHS (2005), and Ara and Islam (2013) add that SMI also includes pre-conception care, post-abortion care, post partum care, and Life saving skills.

Family planning is a very important aspect of safe motherhood. PATHS (2005) described family planning as a way of thinking and living a life adopted voluntarily upon the basis of knowledge, attitude and responsible decision by individuals and couples in order to promote the health of family and thus contribute effectively to the social development of the

country. Family planning means helping the individuals and couples choose the number of children they will have (Derek, 1993). Nzeako and Anyi (1990) note that family planning helps in reducing maternal mortality, saving children's life, increasing child survival, and helps women to have healthier children. Family planning is important even during pre-conception care.

Pre-conception cares are health actions directed toward preparing a mother for a safe and a risky-free pregnancy and child-bearing. PATHS (2005), and Ara and Islam (2013) described pre-conception care as the information and services (such as screening for and managing conditions which may complicate pregnancy, childbirth and health of the mother and child) given to an individual or couple who intend to biologically father or mother a child. According to Holt (2008), pre-conception counseling may include assessment of lifestyle such as diet, exercise, consumption of alcohol or tobacco, and ways of dealing with stress, recommendation of vitamins; administration of necessary vaccinations; and general advice about maintaining healthy habits. Koblinsky and Corberff (1987) observe that the risk of maternal death is up to 15 times higher for women who do not receive pre-natal care than it is for those who do. Antenatal care is equally important for the welfare of the mother and her child.

Antenatal care is the care of the women during pregnancy. During pregnancy, it is very important that a mother takes good care of her own health and that of her baby. According to UNFPA (2014), the primary objective of antenatal care is to establish contact with women, and identify and manage current and potential risks and problems. UNFPA affirms that this creates the opportunity for the woman and her health care provider to establish a delivery plan based on her unique needs, resources and circumstances. Therefore, the delivery plan identifies her intentions about where and with whom she intends to give birth and contingency plans in the event of complications (transport, place of referral, etc). Park (2014) define antenatal care as the care which mothers receive from healthcare professionals during their pregnancies. Park asserts that the purpose of antenatal care is to monitor mothers' health, the babies' health and support facilities to make child-bearing plans which are right for them. After delivery, the mother needs a postpartum care.

A woman, in the course of childbirth may undergo enormous physiological and emotional stress. She needs to be cared for after delivery so that she may fully recover from the pains accompanying childbirth. This care is known as postpartum care. Adama (2008) defined postpartum care as the care given to mothers after delivery to recuperate from injuries associated with childbirth. This seems to reverse the physiological changes that

occurred during pregnancy and delivery, and to restore the body to its pre-pregnancy state. During this period, breastfeeding is established, and family planning is introduced to avert early occurrence of another pregnancy (Lucas & Gilles, 2003). A mother also needs a care after abortion.

Abortion means termination of pregnancy before the end of its term. It is the death or expulsion of the foetus either spontaneously or by induction before the 28th week of the pregnancy (Myles, 2009). According to Umar (1993), abortion involves the detachment, forcing out or expulsion of the incompletely developed foetus or embryo from the mother's womb before viability. Abortion always comes with complications making post-abortion care very necessary.

Post-abortion care means after-abortion care. This means care given to a woman following abortion. NPSM (2003) describes post-abortion as offering contraception to a woman who has experienced an abortion complication as a way of preventing subsequent abortion. NPSM recommended the need for administration of broad spectrum antibiotics, intravenous fluids, and blood transfusion to prevent infection, de-hydration and anaemia that may lead to maternal mortality and morbidity.

Emergency obstetric care and Life saving skills are cares given to a woman to ensure that risks of complications associated with pregnancy and delivery are prevented. Emergency obstetric care and Life saving skills are targeted towards saving the life and promoting the health of the mother and her child in the course of and after delivery (PATH, 2005). UNFPA (2014) advised that since up to 50 per cent of maternal deaths occur after delivery, a midwife or a trained and supervised Traditional Birth Attendant (TBA) should visit all mothers as soon as possible within the first 24-48 hours after birth. Ara and Islam (2013) advised that the midwife or TBA should assess the mother's general condition and recovery after childbirth and identify any special needs. This attention is particularly important especially when the woman is poor, uneducated, and lives in rural setting including Igbo-Eze LGA of Enugu State.

Benefits of safe motherhood initiative.

The child-bearing mothers and their children are expected to benefit from SMI in a variety of ways. Daly, Azefor and Nasah (1993), and Jatau (2000) concur that the health risks that confront child-bearing women are serious and they include: pre-eclamptic toxemia, anaemia, malnutrition, cephalopelvic disproportionate, obstetric fistulae, obstructed labour, low birth weight and perinatal mortality. These complications and

abnormalities according to the above report are preventable through valid motherhood programmes in maternal and child health (MCH) clinics. World Bank (2013) noted that investments in safe motherhood not only improved women's health and the health of her family, but also increased the labour supply, productive capacity and economic well-being of communities. All these ultimately have a positive impact on the economy. World Bank (2013) asserts that SM promotes family planning practice and ensures that unwanted or unplanned pregnancies which can interfere with women's social and economic activities and cause emotional and economic hardship not only to women but also to their families are avoided. WHO (2012) submits that SMI lessens the burden associated with frequent pregnancies, poor maternal health, pregnancy complications, and caring for sick children which drain the productive energy of women, jeopardizes their income-earning capacity, and contributes to their poverty. Maternal mortality and morbidity have far far-reaching consequences even to the wider society.

A mother's death carries profound consequences not only for her family, especially her surviving children, but also for her community and country. Area and Islam (2013) observe that in some developing countries, if the mother dies, the risk of death for her children under age 5 is doubled or tripled. In addition, if a woman dies, during her most productive years, her death has a strong social and economic impact because her family and community lose a productive worker and a primary care giver. Therefore, SMI aims at enhancing the quality and safety of women's lives to ensure that maternal mortality and morbidity do not occur (Ara & Islam, 2013). Jatau (2000) submits that safe motherhood reduces the number of children who have drastically diminished the prospects of leading a productive life following the death of a mother.

Exclusive breast feeding (EBF) which is a safe motherhood practice has been reported to promote and preserve the health of a mother in a variety of ways. According to Medela (2014), when mothers breastfeed their children, they reduce the risk of urinary tract infection; pre-and post-menopausal breast cancer; ovarian cancer; and osteoporosis. The report further indicates that from 3 to 12 months postpartum, breastfeeding increases the rate of weight loss in most nursing mothers and offers some protection against the early return of fertility. By this, EBF become a tool for checking obesity and birth control. Nwagu (2006); Igbokwe (2012); and Medela (2014) agree that EBF saves mother's money and time. This is because breastfed babies are healthier; their mothers miss less work and spend less time and money on pediatric care. Most of the reported benefits of practicing safe motherhood hover around making child-bearing safe for mothers. However, reports according to WHO

indicated that the child bearing mothers' attitude to and practice for SM is still low especially in developing countries including Nigeria. However, for a mother to reap the benefits of safe motherhood, she should have a positive attitude to it by practicing it correctly and consistently.

Attitude and practice.

Attitude has been a difficult concept to define adequately, primarily because it has been defined by so many, and also because of the word's differing lay uses and connotations. Attitude is the way one feels about something or somebody that makes one behave in a particular way towards the thing or the person. Attitudes is an evaluative statement favorable or unfavorable related to person, object or event which reflects how one feels about something or somebody (Blurtit. com, 2011). Attitude is a hypothetical construct that represents an individual's degree of like or dislike for something which in turn influences his/her behaviour towards that thing. Attitude, according to Microsoft Encarta (2009) is an opinion or general feeling about something. It is mental position relative to a way of thinking or being (Looper, 2006). Wyohannes (2010) defines it as an opinion or way of thinking which reflects in the person's behaviour. Attitudes are generally positive or negative views of a person, place, thing, or event. Sometimes, people may also be conflicted or ambivalent toward an object, meaning that they simultaneously possess both positive and negative attitudes toward the item in question, or they may not even have any feeling whatsoever about the item. Hornby (2005) defines attitude as the way that a person thinks and feels about somebody or something which influences the way you behave to the person or the thing. If the child-bearing mothers feel that safe motherhood is for their own good, they may develop positive attitude towards it. However, in the present work, attitude refers to child-bearing mothers' outlook or feeling about safe motherhood which influences their behaviour toward it. Attitude is also related to practice.

Practice means doing a particular thing over and over again. Merriam-Webster (2012) defined practice as performing often, customarily, or habitually. Brown (1993) conceived the term practice as performing an act habitually or consistently. According to Hornby (2005), practice means doing something regularly as part of one's normal behaviour. Practice is the continuity of an action. Robinson and Davidson (1998) described practice as a habitual activity, procedure or custom. In this study, practice refers to the habitual actions engaged in by child-bearing mothers which are directed towards ensuring that they do not face the risk of mortality or morbidity in their pregnancies, child births, and post partum

periods. This study will focus on practice as it relates to health which has been described by Bucher (1994) as health practice. According to Bucher, health practice is the application of good health actions to one's daily living. Health practice in this study means adopting a safe motherhood lifestyle. Practices for safe motherhood have been proven a sure way of reducing mortality and morbidity among women of child-bearing age.

Woman of childbearing age.

A woman of child-bearing age (WCBA) is one in her reproductive age (i.e. between puberty and menopause). She is that woman who has the natural capability to conceive and give birth. Child-bearing age has been described as the period in a woman's life between puberty and menopause (Williams & Wilkins, 2006). Experts, as reported by Medical News Today-MNT (2005), advise that the best age for childbearing remains 20-35. MNT (2005) warns that age-related fertility problems increase after 35 and dramatically after 40. Under-aged mothers also are at the high risk of pregnancy-related complication. WHO (2012) reports that young adolescents face a higher risk of complications and death as a result of pregnancy than older women. Studies like Jatau (2000), and Williams and Wilkins (2006) show that adolescent pregnancy is an exploding problem in Sub-Saharan Africa. Young women under age 20 in Africa are more likely to have a child than those in other regions (Daly, Azefor & Nasah, 1993). For example, by age 18 more than 40 percent of the women in Africa have given birth already (Senderwitz 1993). In clarifying this, Daly, Azefor and Nasah (1993) report that in Africa, 1 in 5 adolescent women will have a birth in a given year. They note that most of the births to teenagers are first births and women having their first child carry higher risk of serious medical complications. The above report further reveals that babies who are first births face a higher infant mortality rate than higher order births and this risk is even greater for teenage mothers. However, a WCBA in this study is a woman who is in a period between her puberty and menopause. There appears to be factors that influence the attitude to and practice for safe motherhood among women of childbearing age.

Socio-demographic factors that influence attitude to and practices for safe motherhood initiative.

The benefits of SMI have taken a fore-front stage in various political, and research cum academic discourses. It has been found that practicing safe motherhood is influenced by some socio-demographic factors among the child-bearing mothers. One of such factors is maternal education.

Mothers who are educated may have more knowledge of the benefits of safe motherhood than their uneducated counterparts. Therefore, they are likely to have a better attitude to and consistent practice for safe motherhood than their uneducated folks. WHO (1996b) has clearly stated that knowledge is prerequisite for any health action. According to WHO, many of the ailments people suffer from are to a large extent, self inflicted by anti-health practices due to lack of knowledge (education). Vanden, DeMey, Buddingh and Bots (1999), and Okereke, Aradeon, Akerele, Tanko, Yisa and Obonyo (2013) report that acquiring some level of education is strongly associated with the knowledge of safe pregnancy practices among some women in rural communities. The reports specified that attending school by a respondent increased the likelihood of knowing maternal danger signs by threefold. Ogbonna, Okolo and Ezeogu (2000), Chudasama, Patel and Kavishwar (2008), and Tiwari, Mahajan and Lahariya (2009) reported that mothers' education is significantly associated with higher probability of EBF practices. The report indicated that those who are educated appreciate the need for exclusively breastfeeding their babies more than the uneducated. This finding may be realistic in other safe motherhood practices. Nitai, Islam, Chowdhury, Bari and Akhter (1993) found that female education has a net effect on maternal health service use, independent of other background characteristics. The report further indicated that the percentage of women who sought care from qualified medical personnel for treating complications increases from 26.5 per cent among illiterate women to 34.6 per cent among women with secondary or higher education.

The level of mother's education is also associated with a child health. Govindasamy and Ramesh (1997) report that a higher level of maternal education results in improved child survival because health services that effectively prevent fatal childhood diseases are used to a greater extent by mothers with higher education than by those with little or no education. The study concluded that the benefits of maternal education persist even when other socioeconomic factors are taken into account. Okereke et al (2013) also report that knowledge of safe pregnancy practices among some women in rural communities is strongly associated with acquiring some level of education.

It seems mother's level of education and her economic status are closely linked together. To bolster the relatedness of mother's level of education and economic status in increasing safe motherhood practices among mothers, Agarwal and Reddaiah (2005) recommended that it is very important to raise the status of women in terms of education and socio-economic status. From the foregoing, a woman's level of education has been shown to

be strongly connected with her economic status in promoting positive attitude to and practice for safe motherhood.

Wealthy mothers may likely have a better attitude to and consistent practice for safe motherhood because they can afford the medical bills and associated hospital expenses compared to poorer ones. Alemayehu, Haidar and Habte (2009) report that wealth index is closely associated with health practices. Nitai, Islam, Chowdhury, Bari and Akhter (1993) submit that about 35.4 per cent of women who worked for cash went to some qualified medical personnel for treatment, compared with only 25.3 per cent of those who did not work. Similarly, Vanden, DeMey, Buddingh, and Bots (1999) report that unemployment is associated with deliveries outside the hospital. This is risky since most deliveries outside the hospital may not be assisted by a skilled birth attendant, although, this may be blamed on poverty.

Poverty may limit mothers' access to maternal healthcare services. Kiwanuka, Ekirapa, Peterson, Okui, Rahman, Peters and Pariyo (2008) indicate that the poor and vulnerable experience a greater burden of disease but have lower access to health services than the less poor. This is because of lack of money for transport and hospital fee (Mwaniki, Kabiru & Mbugua, 2002). Oxaal and Baden (1996) note that the introduction of user fees has discouraged some women from seeking maternity care. Hutton (2002) added that the introduction of user fees tends to dissuade the poor more than the rich from using health services and tends to dissuade the poor more than the rich from using health services and also tends to delay care and shift people to self-medication and informal care. Okafor, Obi and Ugwu (2011) also find that unaffordable medical bills is a major barrier to utilization of maternal and child healthcare services leading to a very high maternal and perinatal mortality and the inability to attain the MDG4 and MDG5 in many developing countries. Nanda (2002) reports that the introduction of user fees resulted to rise in maternal deaths by 56 per cent in Zaria along with decline by 46 per cent in the number of deliveries in the main hospitals. In addition to economic status, parity appears to influence safe motherhood attitude and practice.

Parity has been described as number of births a mother has had and the order of such childbirths. Maternal health may be higher in first order births. According to Navaneethan and Dharmalingham (2000), care during delivery would be higher in first order pregnancies and is expected to decline as order of birth increases. Suffice this to say that as the number of births increase, delivery case among mothers diminishes. Similarly, Health Promotion International-HPI (2001) notes that because of the perceived health risks associated with first

pregnancy, a woman is more likely to seek maternal health care services for first order than higher order births. Nitai, Islam, Chowdhury, Bari and Akhter (1993) reported that the percentage of women who sought care from a doctor or nurse to treat any complications decreased from 29 per cent in women with no previous pregnancies to 26.1 per cent in mothers with one to four previous pregnancies and increased again to 35.1 per cent in women with five or more previous pregnancies. Mwaniki, Kabiru and Mbugua (2002) also note that utilization of health facilities for maternity services was significantly influenced by number of children. Safe motherhood attitude and practice also depends on mothers' age.

Maternal age may be considered as a potential factor affecting attitude to and practice for safe motherhood. As years pass by, one naturally accumulates experiences. This means that as a mother grows older in her child-bearing life, her level of puerperal experiences also increases. An older or more experienced mother may have a better attitude to and practice for safe motherhood which would reduce her chances of exposure to pregnancy-related complications unlike young inexperienced mothers. Studies like Fiedler (1981), Elo (1992), Normon Lopez, Carcamo and Galindo (1993), and Fosu (1994) have recognized that women's age plays an important role in the utilization of medical services. Fosu (1994) notes that mother's age plays may sometimes serve as a proxy for the women's accumulated knowledge of health care services, which may have a positive influence on the use of health services. Daly, Azefor and Nasah (1993) reported that few adolescent mothers seek reproductive health services than older mothers because: (i) few teenagers are knowledgeable about sexual behaviour; (ii) few services are designed to meet the needs of adolescents at a cost affordable to them; (iii) health providers are not trained to provide counseling and services to adolescents; and (iv) government policies and legislation often work at odds with promoting family planning and reproductive health services and education programmes for adolescents. The above report further revealed that because adolescents seek anonymity or do not have the money to pay for services, they abort themselves or resort to unsafe abortion by people who have no medical training; therefore, they often delay seeking treatment for complications of illegal abortion for fear of revealing their identity and intention, or due to the lack of access to health services.

Some studies argue that younger mothers may practice safe motherhood more than the older ones. Normon, Lopez, Carcamo and Galindo (1993) report that because of development of modern medicine and improvement in educational opportunities for women in recent years, younger women might have an enhanced knowledge of modern health care services and place more value upon modern medicine. This appears to be true especially when it has

been reported in literature that the practice for safe motherhood is more among the educated mothers than the uneducated ones.

Some authors believe that one would naturally seek care irrespective of one's age. This means that mother's age has no connection with the attitude to and practice of safe motherhood. Igbokwe and Adama (2011) reported that age had no significant influence on child-bearing mother's practice of SMI components. The authors contend that the age of an individual does not necessarily influence the individual's capacity to effectively practice health-related behaviour most especially when the behaviour is of immense benefit to the individual. Marital status is another strong predictor of safe motherhood attitude and practice.

Husbands may be a source of moral and financial assistance to mothers in terms of practices for safe motherhood. Vanden, DeMey, Buddingh, and Bots (1999) note that being without a husband was associated with deliveries outside the hospital. Single adolescents may hide their pregnancies and may not seek care because of shame or lack of financial support. SIHFW (2008) reported that adolescent mothers were more constrained than adult mothers with regard to maternal health care seeking and they were less likely than adult mothers to have had the recommended number of antenatal check-ups (43% versus 63%), experienced institutional delivery (31% versus 55%) or received a postpartum check-up (19% versus 32%). Alemayehu, Haidar and Habte (2009) report that marital status was found to influence the practice of EBF. Another factor associated with safe motherhood attitude and practice is location. Location will be discussed in terms of the distance from mother's residence to a health facility, and in terms of setting where a mother lives whether rural or urban.

The distance of a mother's home to a health facility may influence her attitude to and practice for safe motherhood. Nitai, Islam, Chowdhury, Bari and Akhter (1993) report that the respondents residing in close proximity to health care services are more likely to use them. Similarly, Kiwanuka, Ekirapa, Peterson, Okui, Rahman, Peters and Paroiyo (2008) observe that distance to service points is key determinants of health care utilization among mothers. Mwaniki, Kabiru and Mbugua (2002) report that utilization of health facilities for maternity services was significantly influenced by distance. The study indicated that mothers living less than 5 kilometre (km) to a health facility utilized the services better than those living 5 km and beyond. Also, living in a rural or urban area may influence safe motherhood attitude and practice among child-bearing mothers.

Mothers who live in a rural setting may not have access to health facilities like their urban counterparts. This is because modern health facilities and services may be lacking, in short supply or ill-equipped in rural communities. Again, rural women may be less educated

and poorer compared to their counterparts in urban centres. WHO (2012) observes that poor women in remote areas are the least likely to receive adequate health care because they have low numbers of skilled health workers. Nigussie, Mariam and Mitike (2004) note that the place of residence influences utilization of delivery services as urban women have more access to health care services than their rural counterparts. SIHFW (2008) reports that rural women were far less likely to receive three ANC contacts (32%) compared to their urban counterparts (75%). SIHFW maintained that only 43 per cent of births were attended to by a health professional and urban women were more than twice as likely to seek such assistance. Ara and Islam (2013) reported that in rural Mozambique, women's fear for witchcraft encourages them to hide pregnancies and delay prenatal care to protect themselves and their children. They also reported that in rural Nigeria, women do not seek prenatal care because of lack of financial resources.

Various factors which influence safe motherhood like attitude and practice have been discussed. However, the present study will concentrate on the influence of mothers' attitude to and practice for safe motherhood in Igbo-Eze South LGA of Enugu State.

Measurement of attitude and practice.

Measurement means establishing the worth of an item. The International Knowledge Measurement-IKM (2011) states that managing information begins with measuring it. Measurement is conducted using instruments such as scale or a text (Nwachukwu, 2007). Stevens (1946) note four types of measurement for variables: nominal, ordinal, interval and ratio. Stevens noted that in assigning numerals to objects or events, one must be able to differentiate objects on a given aspect, attribute or property. Such differentiation may be rough or crude or may be refined and specific. It may, for instance, be just to classify objects, persons or responses into different categories. For this purpose, a nominal scale may suffice. In this scale the numbers are just identification names. They are not amenable to mathematical operations like calculations of means, coefficients of correlation and so on. One of course can count the number of subject under each table (numeral or verbal) and find the modal category in which the highest number of individual falls. Test of association can be performed if the subjects are categorized to two (or more) categories.

Stevens (1946) states that in determining the relative positions of persons or objects with respect to a characteristic, one needs an ordinal scale, in which individuals or objects are ranked as first, second, third and so on, depending on the more or less of the attribute

possessed by the individuals or objects. The ordinal scale can state who has more or less of the attribute under study, but not how more or how much less.

Another scale of measurement is an interval scale. This scale tells us whether P is as much higher than Q as Y is than Z on a particular attribute. In other words, in an interval scale, the difference between any two adjacent positions is the same as the one between any other adjacent positions (Nwachukwu, 2007). The interval scale is an improvement over the ordinal scale, even as the latter is over the normal scale.

There is another type of scale, called the ratio scale, which is commonly used in the physical sciences. To have a ratio scale, the absolute zero point needs to be determined. A one centimeter rod can be said to be exactly twice as long as a two-centimeter one, because both rods share a common starting point, namely, the real zero point. But in the subject matter of the social sciences, including health education, the zero point is arbitrary and, therefore, we cannot express the relationship in terms of strict ratio. However, attitude and practice will be measured in the present study.

Attitude measurement is necessary in education as well as in the world of science. Attitude has been a difficult concept to define adequately, primarily because it has been defined by so many, but also because of the word's differing lay uses and connotations. One of the earliest definitions of attitude was proposed by Thomas and Znaniecki (1918). They define attitude as a mental and neural state of readiness, organized through experience, exerting a directive or dynamic influence upon the individual's response to all objects and situations with which it is related. Attitudes are latent and not directly observable in themselves, but they act to organize or provide direction to actions and behaviours that are observable. Attitudes vary in direction (either positive or negative), in degree (the amount of positiveness or negativeness), and in intensity (the amount of commitment with which a position is held; (Smith, 1982). Educators have been interested in attitudes because of their possible impact on learning, and while attitudes have not been convincingly linked to achievement, they have been long considered an important component of the most important outcome of education: learning. Researchers believe that attitude should be measured.

Measurement of attitude means determining someone's feeling toward something. According to Enyi (2006) measurement of attitude is usually based on the subjected self-reports. He further stated that the instrument used to measure attitude is always referred to as attitude scale. Osuala (2005), and Enyi (2006) agreed that the likert scale commonly used for the statement is assigned numerical values thus: strongly agree (5), Agree (4), undecided (3), disagree (2) and strong disagree (1). Nworgu (2006) states that the statement formed should

be such that half are positive and the other half are negative, and be placed in alternated positions. He went further to say that the score should be in such a way that a higher value indicates more positive responses or attitude for example strongly agree (SA) 5, Agree (A) (4), undecided (U) (3), Disagree (D) (2) and strongly Disagree (SD) (1), while for negative items, the weighing is reversed as strongly agree (1), agree (2), undecided (3), Disagree (4), and strongly Disagree (5). The likert attitude measurement scale was modified by Osuaala (2005), Enyi (2006) and Nworgu (2006) on a four point scale as strongly Agree (SA) (4), Agree (A) (2), Disagree (D) (3), and strongly disagree (SD) (1), on the positive side. On the negative side it is strongly Agree (SD) (1), Agree (A) (2), Disagree (D) (3), and strongly Disagree (SD) (4). This modified attitude measurement scale by Osuala (2005), Enyi (2006) and Nworgu (2006) will be used in the present study to measure the child-bearing mothers' attitude for safe motherhood.

Another way attitude can be measured is by using response like 'yes' to a practice (attitude) that has taken place or 'no' to an action or behaviour that the individual does not adopt (Enenta, 2005). Okafor (1991) noted that measurement of attitude in health education is always very difficult because attitude is concerned with one's feeling towards an object, person or thing. In the words of Adenuwagun et al, (2002) attitude is best viewed as a set of affective reactions towards an object that predisposes the individual to behave in a certain manner towards the object. It then follows that the quality of one's attitude is judged from the observable evaluative responses one tends to make, in this case towards safe motherhood. Attitude as earlier observed, has the tendency to determine practices in some cases (Opera, 1993). For instance, positive attitude to safe motherhood can improve its practice. In the context of the present study, attitude refers to child-bearing mothers' feeling about safe motherhood which influences their behaviour towards it. This feeling may positively or negatively influence the practice of safe motherhood. Practice can also be measured.

Practice has been described as the continuity of an action. Several tools can be used to measure practice. Gemson (2011) stated that the rating scale 'Large Extent' (LE), to 'Some Extent' (SE), and 'Never' (N) can be used to measure the practice of safe motherhood among child-bearing mothers in Igbo-Eze South LGA of Enugu State.

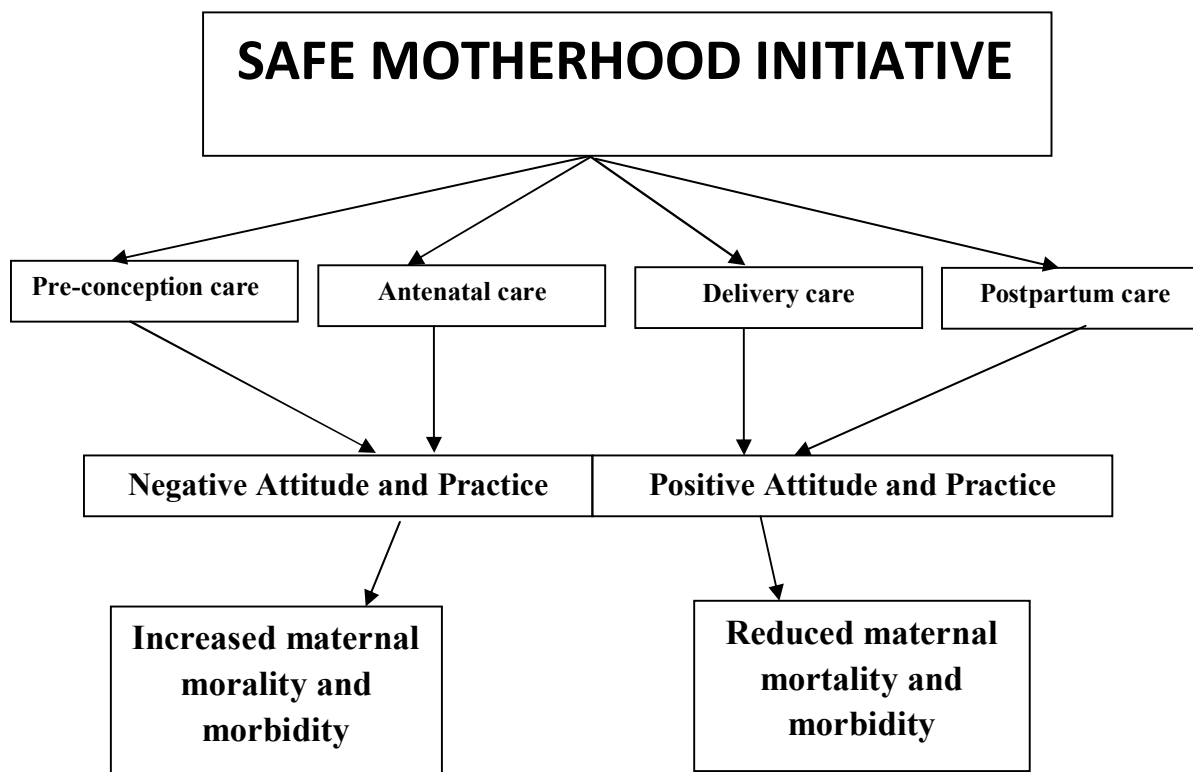


Figure 1. Researcher generated conceptual frame work: Attitude to and practice for safe motherhood among child-bearing mothers.

Figure 1 above is a conceptual framework used in the description of attitude to and practice for safe motherhood among child-bearing mothers in Igbo-Eze South LGA of Enugu State. The Framework indicates that positive attitude to and practice of the components for safe motherhood initiative will lead to reduced maternal mortality and morbidity while reverse is the case with negative attitude to and practice of the components of safe motherhood initiative.

Theoretical Framework

Theories are constructs and postulations that guide or suggest a way in which individuals perceive phenomena and act or behave which in turn may influence the nature and the level of what they know or practice. The desire to effect change in behaviour for reducing the risk of future illness according to Philips (1991) should be based upon theories that identify predictors of behaviour change. Some of these theories emphasize the importance of volitional decisions by individuals about perceived utility of their action (Adama, 2011). This study will therefore be anchored on the theory of health seeking-

behaviour and theory of attachment in explaining the attitude to and practice for safe motherhood among WCBA in Igbo-Eze South LGA of Enugu State.

Theory of health seeking-behaviour.

Theory of health seeking-behaviour was developed by Anderson and Newman (1973). The theory proposed that the use of health care services is a function of three sets of individual characteristics which include: individual predisposing factors, need factors, and enabling factor.

Individual predisposing factors include the demographic characteristics of age and sex as biological imperative, social factors such as education, occupation, ethnicity and social relationships (e.g., family status), and mental factors in terms of health beliefs (e.g., attitudes, values, and knowledge related to safe motherhood and other health services). These factors may hinder or promote practice for safe motherhood among child-bearing mothers. In relation to the present study, the relevant predisposing factors are maternal age, level of education and occupation. These factors determine the attitude to and practices for safe motherhood initiative among the childbearing mothers.

Need factors may also determine the use of health services. At the individual level, there is difference between perceived need and evaluated need. Perceived need for health services implies how people (child-bearing mothers) view and experience their own general health, functional state and illness symptoms. On the other hand, evaluated need or real need is professional assessments and objective measurements of patients' health status and need for medical care. A pregnant woman may think she needs to work hard so as to make the unborn baby strong (perceived need) while the doctor might find out that she needs bed rest (evaluated or real need).

Enabling factor can also influence the practice of safe motherhood among child-bearing mothers. Financing and organizational factors are considered to serve as conditions enabling services utilization. Individual financing factors involve the income and wealth at an individual's disposal to pay for health services and the effective price of health care which is determined by the individual's health insurance status and cost-sharing requirements. Organizational factors entail whether an individual has a regular source of care and the nature of that source. They also include means of transportation, travel time to and waiting time for health care. Financing encompasses the resources available to the child-bearing mother for the effective practice for safe motherhood. Organizational factor refers to the amount, varieties, locations, structures and distribution of health services facilities and personnel. It

also involves physician and hospital density, office hours, provider mix, quality management oversight, and outreach and education programmes. However, their theory will be used in the present work to explore various biological, socio-economic and environmental factors that determine the attitude to and practices for safe motherhood among the childbearing mothers in Igbo-Eze South LGA.

Attachment theory.

Attachment theory focuses on the relationships and bonds between people, particularly long-term relationships including those between a patient and health-care provider. Attachment is an emotional bond to another person (Cherry, 2013). According to Ciechanowski, Walker, Katon and Russian (2002), theory of attachment is a framework of ideas that attempts to explain attachment, the almost universal human tendency to prefer certain familiar companions over other people, especially when ill, injured, or distressed. A psychologist, Bowlby (1969), was the first attachment theorist to describe attachment as a lasting psychological connectedness between human beings. Bowlby believed that the earliest bonds formed by children with their caregivers have a tremendous impact that continues throughout life. He suggested that attachment also serves to keep the infant or patients close to the mother or healthcare provider respectively, thus improving the child's/patient's chances of survival.

The central theme of attachment theory is that primary caregivers who are available and responsive to a person's needs allow the person to develop a sense of security (Cherry, 2013). The infant knows that the caregiver is dependable, which creates a secure base for the child to then explore the world. This analogy can be extended to the mother and the health provider relationship at the instance of attitude to and practices for safe motherhood. People (child-bearing mothers) get attached to health providers who give them sense of health security. More so, this is why a patient prefers one doctor or nurse to the other(s). In this instance, if the doctor encourages the child-bearing mother to engage in practices for safe motherhood, she would unreservedly practice it. If her doctor or nurse is no longer at the health facility (may be transferred), she may find it difficult to continue using the health service in that facility. Moreover, a patient may have the same attachment to a particular hospital just as an infant if she feels that its care-giver is dependable. It may make her to develop positive attitude to safe motherhood. She believes that the hospital has genuine drugs, trained health personnel among other reasons.

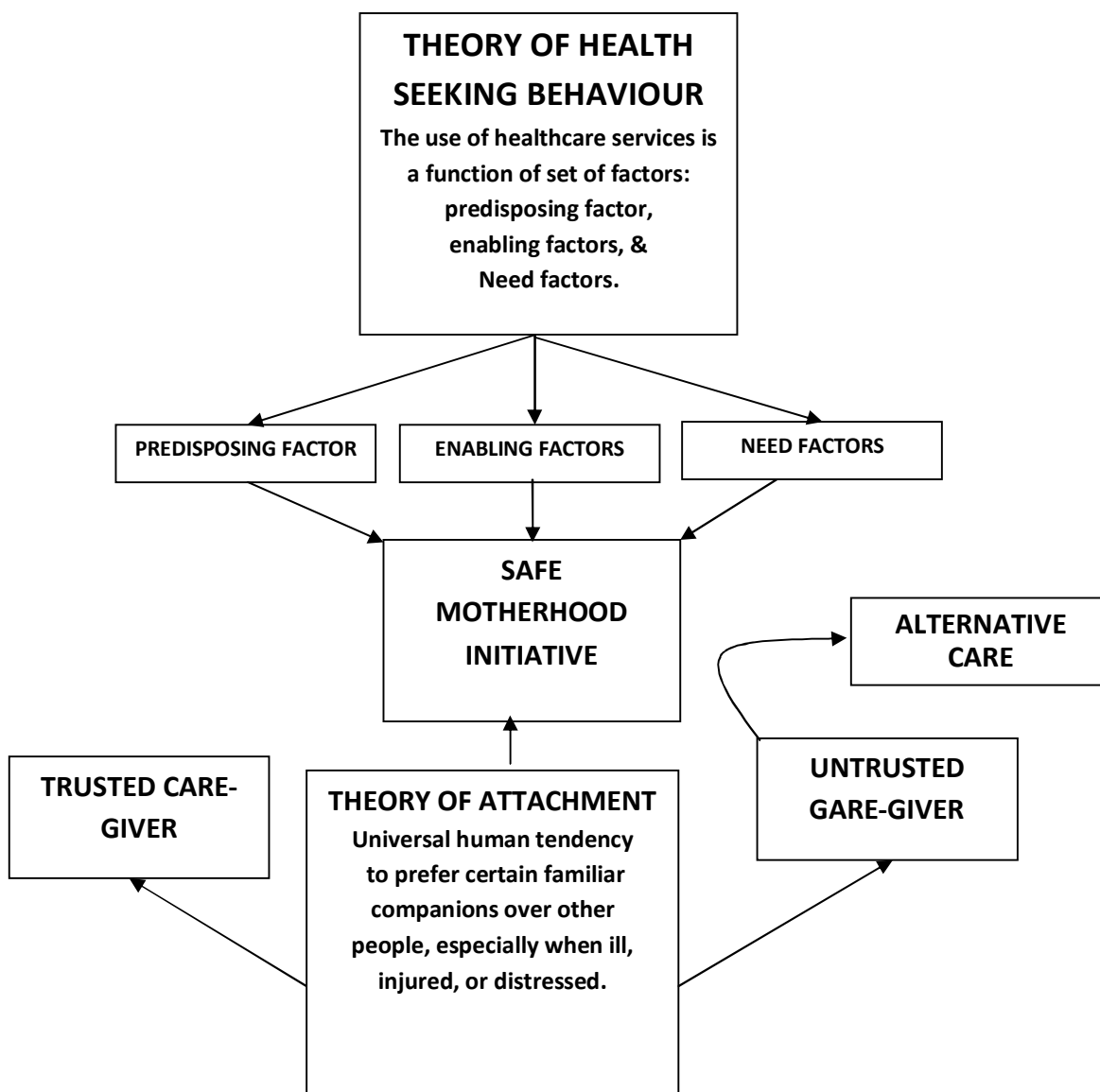


Figure 2.: The researcher generated theoretical framework of attitude to and practice of safe motherhood among the women of child-bearing age in Igbo-Eze South LGA of Enugu

Figure 2. above explains the interaction of factors which determine the attitude to and practice for safe motherhood among women of child-bearing. These factors have been identified by the theories of Attachment, and Health-Seeking behaviour. Attachment theory holds that if a mother feels that a certain healthcare giver is trustworthy and dependable, her attitude to safe motherhood will become positive. Her practice of safe motherhood will also increase. Likewise, if her trusted friend or a relation professes safe motherhood, her attitude to and practice of it will change for the better. Refer to the arrow moving from the attachment Theory to trusted care-giver, then, to health facility. Conversely, if her healthcare-giver,

friend or relation that informs her about SMI is not perceived as dependable, she may turn down the practice of safe motherhood.

Empirical Studies on Attitude to and Practice for Safe Motherhood Among Women of Child-Bearing Age

This section will explore studies conducted in the area of attitude to and practices for safe motherhood among child-bearing mothers attending health facilities. Nitai, Islam, Chowdhury, Bari and Akhter (1993) examined the factors that influence the use of maternal health care services in Bangladesh. Prospective data obtained from the survey on Maternal Morbidity in Bangladesh, which was conducted by the Bangladesh Institute of Research for Promotion of Essential and Reproductive Health and Technologies (BIRPERHT) was used. Data collection spanned the period from November 1992 to December 1993. The study had two designs: cross-sectional and prospective. The paper employed data from the prospective component. Multi-state random sampling was employed to collect data on maternal morbidity. One district from each of four divisions was selected in the first stage. In the second stage, one thana (a thana contains several 'unions' comprising a population size of 0.2-0.25 million) from each selected district was selected randomly. Finally, two unions (unions consist of several 'wards' which are small geographical boundaries comprising villages in rural areas) from each selected thana were considered study areas. For the prospective study, 1020 pregnant women (pregnant for <6 moths) were interviewed. 993 pregnant women out of 1020 who had at least one antenatal follow-up were selected. The results from bivariate analysis suggest that older women are more likely to seek maternal health-care services than younger women. The percentage of women who sought care from qualified medical personnel, i.e. a doctor, nurse or FWV, to treat complications decreases from 30.3 per cent in women with less than four family members to 23.2 per cent among mother with four to six family members, and increases again to 33.6 per cent in women with seven or more family members. The use of traditional and other health services does not show a similar pattern in relation to family size. The results indicate that female education has a net effect on maternal health service use, independent of the background characteristics, household socioeconomic status and access to health care services.

Govindasamy and Ramesh (1997) conducted a study to ascertain the relationship between maternal education and the utilization of maternal and child health services in India. Using data from the National Family Health Survey 1992-93, they examined the relationship between maternal education and factors known to reduce the risks of maternal and child

mortality, namely, healthcare practices, for some selected northern and southern states in India. They hypothesized that the practices of educated women are quite different from those of uneducated women with regard to pregnancy, childbirth, immunization, and management of childhood diseases such as diarrhea and acute respiratory infection (ARI). However, there exists a number of confounding factors such as socioeconomic status that are associated with the study of the impact of maternal education on health-care utilization. The hypothesis that the relationship between mother's education and healthcare practices might be the result of other variables was tested, and regression analysis on several of these variables was carried out. It was evident that a higher level of maternal education results in improved child survival because health services that effectively prevent fatal childhood diseases were used to a greater extent by mothers with higher education than by those with little or no education. The study concluded that the benefits of maternal education persisted even when other socioeconomic factors were taken into account.

Vanden, DeMey, Buddingh, and Bots (1999) conducted a research which aimed at determining the coverage of antenatal and delivery care and the determinants of non-compliance in a rural area of Zimbabwe in order to improve the quality and efficiency of maternal health care services. A community-based, cross-sectional study was carried out in the catchment area of Gutu Mission Hospital, in rural Zimbabwe, from January to June 1996. Two hundred and thirty-five women, aged 16 to 54 years, who had delivered a child in the past three years, were interviewed on general characteristics (age, marital status, religion, education, and work), obstetric history, use of family planning, pregnancy complications, number of antenatal visits, obstetric history, use of family planning, pregnancy complications, number of antenatal visits, and use of maternity waiting shelters. Associations of these factors to non-use of antenatal care facilities and hospital delivery were studied. In the Gutu district, guidelines exist to identify women at high risk of complications during pregnancy and to indicate where women should give birth (hospital, rural clinic or at home). The study evaluated which factors were important for non-compliance to these guidelines. The analyses were performed using a logistic regression model. The results show that 97 per cent of the pregnant women attended the antenatal care facilities at least once. 73 per cent came at least five times or more. The level of mother's education influenced health care utilization. Belonging to certain religious groups proved to be the strongest explanation for not attending antenatal care facilities. Use of maternity waiting shelters and complications during the pregnancy were important factors for hospital delivery, whereas unemployment and being without a husband were associated with deliveries outside the hospital.

Identification as high risk of a complicated pregnancy by application of the existing guidelines was not associated with place of delivery. Delivery at a location that did not conform to the existing guidelines was associated with non-use of maternity waiting shelters, unemployment or being without a husband and use of traditional care.

Mwaniki, Kabiru and Mbugua (2002) researched on utilization of antenatal and maternity services by mothers seeking child welfare services in Mbeere District, Eastern Province of Kenya. The Cross-sectional, descriptive research design was employed in the study. Two hundred mothers bringing their children aged one year and below to the child welfare clinic between September and December 2000 were studied. The study revealed that the proportion of mothers who utilized health facilities for antenatal and maternity services was 97.5 per cent and 52 per cent, respectively. Utilization of health facilities for maternity services was significantly influenced by number of children and distance to health facility in that, as number of children increased, utilization of maternity services reduced ($\chi^2=8.99$; $p=0.07$; $df=1$). Mothers living less than 5 km to a health facility utilized the services better than those living 5 km and beyond ($\chi^2=7.57$; $p=0.0059$; $df=1$). Among the reasons given by the mothers (individual respondents and through Focus Group Discussions) regarding dissatisfaction with the services offered included shortage of drugs and essential supplies, lack of commitment by staff, poor quality of food and lack of cleanliness in the health facilities. Coverage for antenatal services was high among mothers during their last pregnancy. However, only about half of the mothers interviewed utilized health facilities for maternity services (labour and delivery). The major constraints experienced by the mothers as they sought for the services (as reported by individual respondents are through Focus Group Discussions) include lack of transport, lack of money for transport and hospital feed and delay in admission to health facility once mothers report in labour.

Alam, Qureshi, Adil and Ali (2005) conducted a study which compared the knowledge, attitude and practices among antenatal care facilities utilizing and non-utilizing women, aged 15-49 years. A Cross-sectional survey was conducted between October 2003 and April 2004, including 200 married women in the age range 15-49 years. Knowledge, attitude and practices of women utilizing and not utilizing antenatal care facilities during their previous pregnancy were compared by calculating odds ratios and 95 per cent confidence intervals. P values were obtained by doing chi-square test. Pallor was significantly lower among women utilizing antenatal care (57%) as compared to those who were not (77.6%). (O.R 0.38 95% CI (0.18-0.81) p value 0.02). Tetanus toxoid coverage was higher among women utilizing antenatal care (92% compared to those who were not (59.2%) (O.R 10.8

95% CI (4.5-26.2). knowledge about danger signals in pregnancy and realization of the importance of eating a healthy diet during pregnancy was significantly higher among women utilizing antenatal care. It was concluded that lesser prevalence of anaemia and better tetanus toxoid coverage was seen among women attending antenatal care facilities. Identification of danger signals in pregnancy and recognition of nutritional demands of pregnancy were better understood by women utilizing antenatal care facilities.

Alhilfy and Esaa (2007) evaluated the mothers' knowledge, practice and attitude towards childhood survival in Iraq. A cross sectional cohort study on randomly selected samples of mothers having children less than 2 years, attending the primary health care centers (PHCCs) in Tikrit city from October 2004 to the end of June 2005 was included in this study. Questionnaire and interviewing were the instrument for data collection. The results showed that the majority of mothers were housewives (82.3%), their age group mainly between 25-34 years (86.9%). Only about 31 per cent were highly educated. Most sampled mothers believe that breast milk is the best food for their infants, and recognize that breast milk has many advantages for infants, mothers and their facilities. Only about 45 per cent of these mothers had a positive practice towards breast-feeding. Exclusive breast-feeding was low among breast-feeding mothers (28.9%). About 35.2 per cent of mothers have no idea about what complementary food should be added in the various child age groups. The children who had no growth-monitoring card numbered 24.2 per cent and only 49.2 per cent of the mothers had maternal cards. About 82.8 per cent of mothers under study were delayed beyond the appointment given by PHC workers for their routine visits, which reflects their poor interest and indifference of these mothers to PHC services. Knowledge and practice of mothers was, generally, not satisfactory towards diarrhoeal disease and ante-natal care, while the knowledge of mothers about ARI risk signs were around 65 per cent. These results recommended the promotion of breast feeding and educating mothers about correct knowledge and practice regarding perinatal care and diarrhoeal diseases for children.

Kiwanuka, Ekirapa, Peterson, Okui, Rahman, Peters and Pariyo (2008) conducted a systematic review of socio-economic differences in morbidity and access to health care in Uganda. It includes published studies from electronic databases and official reports from surveys done by government, bilateral and multilateral agencies and universities. The outcome measures studied were: the distribution of HIV/AIDS; maternal and child morbidity; and access to and utilization of health services for people belonging to different socio-economic and vulnerability groups. Forty-eight of 678 identified studies met the inclusion criteria of the study. Results indicate that the poor and vulnerable experience a greater burden

of disease but have lower access to health services than the less poor. Barriers to access arise from both the service providers and the consumers. Distance to service points, perceived quality of care and availability of drugs are key determinants of utilization. Other barriers are perceived lack of skilled staff in public facilities, late referrals, health worker attitude, costs of care and lack of knowledge. The result showed that the overall rates of exclusive and full breastfeeding were 49.0 per cent and 68.2 per cent respectively. Maternal education, marital status, wealth index and age of the child were closely associated with EBF practice, nonetheless, in the hierarchical analysis; being not married, middle/richer/richest wealth index, and child age 0-1 and 2-3 months were retained as the predictors EBF ($P < 0.05$). A range of maternal and child health attributes such as marital status, economical status and child's age were found to influence the practice of EBF in Ethiopia.

Igbokwe and Adama (2011) investigated the knowledge and practice of safe motherhood initiative among childbearing mothers attending maternal and child health clinics in Nsukka Health District. The study utilized a survey design while, data were collected using self-designed childbearing mother knowledge and practices for safe motherhood questionnaire (CMKPSQ). The 363 childbearing mothers that participated in the study were randomly selected in the study area. Data collected were analyzed using percentage, t-test and chi-square statistical tools. Results showed that while some childbearing mothers practiced prenatal care, others had high knowledge of SMI. The two null hypotheses tested revealed that age has no statistical significant influence on childbearing mothers and the knowledge of SMI and age at pregnancy had no significant influence on childbearing mothers' practice of SMI components. The study advocated that Health Education programmes should be intensified at the grass-root level to increase and promote the utilization of MCH services among childbearing mothers.

Sharma and Sharma (2012) conducted a study to determine the knowledge, attitude and beliefs about safe motherhood practices amongst pregnant women residing in the urban slum city of Jaipur, India. The study recruited 100 pregnant women from one of the urban slums of a selected district. A pre-tested questionnaire was administered on the selected sample. Overall, the results show low levels of awareness among rural pregnant women. Two major axes of investigation used were age and education. In both instances, no significant differences for knowledge levels were found amongst pregnant women. The findings indicate most vulnerable section of society, especially through health education campaigns, in order to have a constructive outcome in the near future.

Okereke, Aradeon, Akerele Tanko, Yisa and Obonyo (2013) conducted a study which examined the knowledge of safe motherhood among women in selected rural communities in northern Nigeria. This was a cross-sectional study carried out in two states (Kaduna and Kano States) within northern Nigeria. Pretested, interviewer-administered questionnaires were applied by female data collectors to 540 randomly selected women who had recently delivered within the study site. Chi-square tests were used to determine possible association between variables during bivariate analysis. Variables significant in the bivariate analysis were subsequently entered into a multivariate logistic regression analysis. The degree of association was estimated by odds ratio (OR) and 95 per cent confidence interval (CI) between knowledge of maternal danger signs and independent socio-demographic as well as obstetric history variables which indicated significance at $p < 0.05$. Results reveal that over 90 per cent of respondents in both states showed poor knowledge of the benefits of health facility delivery by a skilled birth attendant. More than 80 per cent of respondents in both states displayed poor knowledge of the benefits of ANC visits. More than half of the respondents across both states had poor knowledge of maternal danger signs. According to multivariate regression analysis, ever attending school by a respondent increased the likelihood of knowing maternal danger signs by threefold (OR 2.63, 95% CI: 1.2-5.8) among respondents in Kaduna State, while attendance at ANC visits during most recent pregnancy increased the likelihood of knowing maternal danger signs by twofold among respondents in Kano State (OR 2.05, 95% CI: 1.1-3.9) and threefold among respondents in Kaduna State (OR 3.33, 95% CI: 1.6-7.2). The study also found a generally poor knowledge about safe motherhood practices among female respondents within selected rural communities in northern Nigeria. Knowledge of safe pregnancy practices among some women in rural communities is strongly associated with attendance at ANC visits, being employed or acquiring some level of education. Increasing knowledge about safe motherhood practices should translate into safer pregnancy outcomes and subsequently lead to lower maternal mortality across the developing world.

Summary of Literature Review

This chapter reviewed the attitude to and practices for safe motherhood among women of child-bearing. Safe motherhood was defined as a concerted set of interventions designed to reduce maternal mortality and morbidity and to improve the reproductive health status of women. The components of safe motherhood were named. They include pre-conception care; antenatal care; post-partum care; post-abortion care; emergency obstetric

care/life saving skills; and care of the new born. Benefits of safe motherhood to both the mother and her child were reviewed.

Child-bearing mother, attitude, and practice are other concepts reviewed in this study. The study reviewed various socio-demographic factors that can influence the attitude to and practice for safe motherhood among child-bearing mothers. Prominent among these factors were: location, economic status, maternal level of education, maternal age, marital status, and parity. Some empirical studies on the attitude to and practice for safe motherhood among women of child-bearing were reviewed.

Theories were described as constructs and postulations that guide or suggest a way in which individuals perceive phenomena and act or behaviour which in turn may influence the nature and level of what they know or practice. The theories of anchor in the present study are the theory of health-seeking behaviour and attachment theory. Theory of health-seeking behaviour hold that the use of health care services is a function of three sets of individual characteristics which include: Individual predisposing factors, need factors and enabling factor. Attachment theory proposes that primary caregivers who are available and responsive to a person's needs allow the person to develop a sense of security.

There are so many studies conducted on the attitude to and practice for safe motherhood among women of child-bearing age globally. Even in Nigeria, studies have also been conducted on the subject matter. However, no study to the best of the knowledge of the present researcher has been conducted to determine the attitude to and practice for safe motherhood among women of child-bearing age in Igbo-Eze South LGA of Enugu State; thus the present study, opens new vistas for further research.

CHAPTER THREE

Method

This chapter presents the research design, area of the study, population for the study, sample and sampling techniques. It also presents instrument for data collection, validity of the instrument, reliability of the instruments, method of data collection and method of data analysis used in this study.

Research Design

A cross sectional survey research design was used for the study. The Institute for Work and Health-IWH (2009) described cross sectional survey research design as observational study where the researches record information about their subjects without manipulating the study environment. The author added that this design compares different variables within a population at a single point in time. The Public Health Action Team-PHAST (2011) noted that a cross-sectional study examines a relationship between disease (or other health-related state) and other variables of interest as they exist in a defined population at a single point in time. According to Cherry (2014), cross-sectional design is a type of study design that utilizes different groups of people who differ in the variable of interest such as socio-economic status, educational background, and ethnicity, but share other common characteristics.

This design was used successfully by Igbokwe and Adama (2011) who investigated the knowledge practice of safe motherhood initiative among childbearing mothers attending maternal and child health clinics in Nsukka Health District. The design is therefore considered appropriate for use in the present study.

Area of the Study

The area of study is Igbo-Eze South LGA of Enugu State. Igbo-Eze South is one of the rural LGAs created from Nsukka LGA in Enugu State. The researcher observes that there is widespread poverty and illiteracy among the people particularly the child-bearing mothers. The major source of income among the women is broom making, petty trading, and subsistence farming due to infertile soil. Very few are engaged in civil service probably because of lack of education. Igbo-Eze people glower at girl-child education. They are typically culture adherent people who believe in large family size norm and early marriage. Young girls are given out in marriage early or sent out to make money for the family.

There are numerous patent medicine shops and many herbal homes while formal health facilities are few (only 15 for the whole LGA). Judging from the proliferation of these herbal homes and chemist shops, it appears that Igbo-Eze people including child-bearing mothers rely so much on them more than the registered health facilities for their health care. One wonders what the attitude to and practice for safe motherhood among these child-bearing women would be like since no study, to the best of knowledge of the present researcher, has reported it. This called for a research such as the present one.

Population for the Study

The population for the study consisted of all the 720 registered child-bearing mothers who attend health facilities in Igbo-Eze South LGA of Enugu State (ISMH, 2013).

Sample and Sampling Techniques

The sample for the study consist of 144 childbearing mother which represented 20 percent of the population under study. The 20 per cent of population chosen is in line with Nwanaø (1990) rule of thumb which stated that when the population under study is in a few hundreds, the sample size should be 20-50 per cent. If there are many hundreds, 20 per cent of the population should be the sample size. The population of all the mothers in the present study is in many hundreds (720) and the researcher has chosen 20 per cent (144) as the sample size.

Multi stage sampling procedure was used in drawing sample for the study. The first stage will involve stratified sampling technique where the health facilities will be stratified into government and private health facilities. The second stage involved the use of simple random sampling of balloting without replacement to draw 50 per cent from each of the strata: government and private health facilities as there are a total of 15 health facilities (4 private; and 11 government owned), six government and two private health facilities was selected. This brought it to a total number of 8 health facilities which were studied. The number representing 50 per cent was obtained by writing numbers 1-11 against each of the government health facilities, and 1-4 against each of the private health facilities on slops of papers. Each slip was rolled into a paper ball, then mixed thoroughly in two different trays (i.e. government and private health facilities). The first 6 paper balls picked from government health facility tray and the first two balls picked from the private health facility tray were used for the study.

The third stage involved the use of systematic random sampling technique in selection of 41 respondents from each of the eight selected health facilities. If the researcher does not get up to 41 respondents in any of the facilities, the researcher would get the corresponding number from other facilities with greater number of the respondents. If the shortfall is in a private facility, the research will complete the number from the private facilities with more respondent. The same applies for the public facilities.

Instrument for Data Collection

Safe Motherhood Attitude and Practice Questionnaire (SMA PQ) constructed by the researcher were used for data collection. It was a 27-item questionnaire designed to investigate the attitude to and practice of safe motherhood among women of child-bearing age in Igbo-Eze South LGA. The questionnaire consists of three sections. Section A which has three socio-demographic variables (age, level of education and level of income) was designed to elicit information on the bio-data of the respondents. Section B has twelve items posed to ascertain the child-bearing mothers' attitude to safe motherhood initiative. Specifically, this section elicited information on attitude to prenatal care (ATPNC, 3 items), antenatal care (ATANC, 3 items), delivery care (ATDC, 3 items) and postpartum care (ATPPC, 3 items). The scale for each sub section was placed on a likert type scale ranging from strongly agree (4 points) to SD (1-point) which are premised on the literature. A composite score of each sub scale indicates the general child-bearing mothers' attitude to the sub scale. The lowest and highest score one can have for ATPNC and ATANC is 3 and 12 respectively while for ATDC we have 6 and 24 respectively.

Section C has four sub-sections with three items each that have a YES/NO response format and designed to find out the respondents' practice of prenatal care (POPNC); practice of antenatal care (PANC); practice of delivery care (PODC); and practice of postpartum care (PPPC). Each yes response has 2 points and a no response has 1 point. Thus, for each sub scale the lowest score is 3 while the highest score is 6. The composite score for each sub scale shows the practice level for that sub scale.

Validity of the instrument.

The face validity of the research instrument was established by giving the draft copy of the SMA PQ questionnaire, the specific purposes, the research questions and the hypotheses of the study to five experts in the Human Kinetics and Health Education Department, University of Nigeria, Nsukka. Their main task was to critically examine the

questionnaire and to ascertain that the content and language of the instrument was appropriate and cover the objectives of the study. They were also requested to check the appropriateness of each item and make corrections as they deem fit. Their criticisms and suggestions were used to produce the final version of the instrument that was used for data collection.

Reliability of the instrument.

The split half method was used to establish the reliability of the instrument. Twenty copies of the structured questionnaire were administered to twenty child-bearing mothers who attend health facilities in Igbo-Eze North LGA of Enugu State. The child-bearing mothers of Igbo-Eze North LGA possess the same characteristics with the respondents of the present study. The questionnaire were collected, numbered and then split into odd and even numbers. The responses of each half were calculated for degree of internal consistency using Pearson Product Moment Correlation Coefficient (PPMCC). A coefficient of .77 was generated from the analysis. According to Zikmund and Babin (2012), scales with coefficient between 0.70 and 0.80 are considered to have good reliability. This criterion will apply to the present study.

Method of Data Collection

A letter of introduction was obtained from the Head, Department of Health and Physical Education, University of Nigeria, Nsukka with which the researcher got permission to carry out research on attitude to and practices for safe motherhood among the child-bearing mothers who attend health facilities in Igbo-Eze South LGA of Enugu State. The letter was presented to the management of each selected health facility. The SMAPQ questionnaire was administered to the respondents on the immunization days when majority of the respondents were met. The researcher repeated visits until the sample size was met. Data was collected on the spot to ensure maximum return rate.

Method of Data Analysis

The returned copies of the questionnaires were properly cross-checked for completeness of information. All the copies were duly completed and therefore were used during data analyses. The information from the questionnaires were coded according to scores using the Statistical Package for Social Sciences (SPSS). Means were used to answer research questions 1, 3, 5, and 7 (attitude) while frequencies and percentages were used to answer research questions 2, 4, 6, and 8 (practices). One-way analysis of variance (ANOVA) and t-test were used for data analysis. The null hypotheses 1,2,5,6 were tested with ANOVA

because they have more than two categories while hypotheses 3 and 4 were tested with t-test. All the hypotheses were verified at .05 level of significance and at appropriate degrees of freedom.

CHAPTER FOUR

Results and Discussion

This chapter presents the results and discussion of results on attitude to and practices for safe motherhood among women of childbearing age attending health facilities in Igbo-Eze South L.G.A. of Enugu state, Nigeria. Presentation of the result section is in two parts: the first is the data answering the research questions and the second is testing of stated hypotheses.

Results

The findings of the study are presented in tables according to data answering research questions, and data testing the hypotheses.

Research question one.

What is the attitude of WCBA to safe motherhood initiatives? Data answering this research question are indicated in Table 1.

Table 1

Attitude of WCBA to Safe Motherhood Initiatives (n=144)

S/n	Attitude of safe motherhood initiatives	\bar{x}	Remark
	Attitude to prenatal care		
1	It is necessary to visit a doctor to ensure that you are fit for pregnancy before conception.	2.68	Positive
2	There is need to ensure that you are medically certified infection-free before conception.	2.53	Positive
3	There is need to seek medical advice on the type food and drug consumption prior to pregnancy.	2.55	Positive
	Cluster \bar{x}	2.59	Positive
	Attitude to antenatal care		
4	Antenatal care is necessary for the health of the mother and the unborn child	3.43	Positive
5	Antenatal care is for the weakling.	2.46	Negative
6	It is a waste of time and resources to attend antenatal care	2.55	Positive
	Cluster \bar{x}	2.51	Positive
	Attitude to delivery care		
7	Delivery in the care of traditional birth attendant (TBA) is better than hospital delivery.	3.0	Positive
8	Home delivery is better because strong women do not need assistance during labour and delivery	2.35	Negative
9	I do not have to wait until the labour is at the peak before seeking assistance	3.26	Positive
	Cluster \bar{x}	2.87	Positive
	Attitude to postpartum care		
10	A mother and her newborn should not leave the hospital after delivery until the care provider certifies them fit to be discharged	3.43	Positive
11	Mothers and newborns should regularly visit hospital for medical checkup and immunization respectively as and when due	3.43	Positive
12	People who practice exclusive breastfeeding are those who cannot afford formula milk	2.45	Negative
	Cluster \bar{x}	3.10	Positive
	Overall \bar{x}	2.84	Positive

Table 1 shows an overall mean attitude of WCBA to SMI in Igbo-Eze LGA of Enugu State. All the three positive statements on attitude to parental care were positive with a positive cluster mean of 2.59. Attitude to antenatal care had one positive statement with a mean positive response and two negative statements with one negative response. This implies that the negative statement with a mean positive response indicates a negative attitude (item 6, \bar{x} = 2.55). Attitude to delivery care had two negative statements and a positive statement with corresponding one positive and one negative mean responses respectively. WCBA have positive attitude to postpartum care as all the positive statements have mean positive responses, while the negative statement have a mean negative response.

Research question two.

What are the practices for safe motherhood initiatives among WCBA? Data answering this research question are indicated in Table 2.

Table 2

Practices of WCBA to Safe Motherhood Initiatives (n=144)

S/n	Practice of safe motherhood components	f	%	Remark
Practice of prenatal care				
1	Do you visit the hospital to find out if you are fit pregnancy before you conceive?	29	20.14	LP
2	Do you visit the hospital to find out if you are have any infection which can be transmitted to the unborn child with the intonation of preventing it?	67	46.53	MP
3	Are there some diets or practices you curtail because you are expecting a pregnancy?	105	72.92	HP
	Cluster ☒	67	46.53	MP
Practice of antenatal care				
4	Do you observe the minimum of 4 antenatal visits as recommended by WHO?	140	97.22	VHP
5	When pregnant, do you take your routine drugs and exercises as and when due?	113	78.47	HP
6	Do you take adequate and purposeful diets and rest during pregnancy?	119	82.64	VHP
	Cluster ☒	124	86.11	VHP
Practices of delivery care				
7	Do you go to hospital for delivery?	100	69.44	HP
8	Do you make conscious efforts to ensure that you avoid unassisted delivery?	139	96.53	VHP
9	Do you wait until the peak of labour before you seek assistance?	80	55.55	MP
	Cluster ☒	106	73.61	HP
Practice of postpartum care				
10	Do you wait in the hospital after delivery until the medical personnel certifies you and your baby (ies) fit to be discharged?	142	98.61	VHP
11	Do you observe regular checkup and routine immunization for you and your baby respectively?	142	98.61	VHP
12	Do you practice exclusive breastfeeding?	116	80.55	VHP
	Cluster ☒	133	92.36	VHP
	Overall ☒	108	75.0	HP

Table 2 shows a high extent of practice (75%) for SMI among WCBA in Igbo-Eze South LGA of Enugu State. During prenatal periods, majority (72.9%) of WCBA curtail consumption of some foods due to pregnancy. During delivery, 96.5 per cent of WCBA make conscious effort to avoid unassisted delivery. Table 2 also shows that almost all the WCBA (97.2%) in Igbo-Eze South observe the minimum of four antenatal visits as recommended by

WHO. The WCBA also have very high practice (92.4%) regarding practice of postpartum care.

Research question three.

What is the influence of age on WCBø's attitude for safe motherhood initiatives? Data answering this research question are indicated in Table 3.

Table 3

Influence of Age on WCB's Attitude to Safe Motherhood Initiatives (n=144)

S/ N	Attitude to safe motherhood components	15-25 years (n=35)		26-39 years (n=90)		40years/ above (n=19)	
		\bar{x}	R	\bar{x}	R	\bar{x}	R
	Attitude to prenatal care						
1	It is necessary to visit a doctor to ensure that you are fit for pregnancy before conception.	1.57	-	3.00	+	3.47	+
2	There is need to ensure that you are medically certified infection-free before conception.	1.28	-	2.30	-	4.00	+
3	There is need to seek medical advice on the type food and drug consumption prior to pregnancy.	1.43	-	2.27	-	3.95	+
	Cluster \bar{x}	1.43	-	2.52	+	3.81	+
	Attitude to antenatal care						
4	Antenatal care is necessary for the health of the mother and the unborn child	2.71	+	3.58	+	4.00	+
5	Antenatal care is for the weakling.	1.31	-	2.18	-	3.89	+
6	It is a waste of time and resources to attend antenatal care	1.91	-	2.12	-	3.63	+
	Cluster \bar{x}	1.98	-	2.63	+	3.84	+
	Attitude to delivery care						
7	Delivery in the care of traditional birth attendant (TBA) is better than hospital delivery.	1.28	-	2.56	+	4.00	+
8	Home delivery is better because strong women do not need assistance during labour and delivery	1.00	-	2.06	-	4.00	+
9	I do not have to wait until the labour is at the peak before seeking assistance	2.25	-	3.54	+	4.00	+
	Cluster \bar{x}	1.51	-	2.72	+	4.00	+
	Attitude to postpartum care						
10	A mother and her newborn should not leave the hospital after delivery until the care provider certifies them fit to be discharged	2.74	+	3.56	+	4.00	+
11	Mothers and newborns should regularly visit hospital for medical checkup and immunization respectively as and when due	2.54	+	3.76	+	4.00	+
12	People who practice exclusive breastfeeding are those who cannot afford formula milk	1.42	-	2.16	-	3.78	+
	Cluster \bar{x}	2.23	-	3.16	+	3.93	+
	Overall \bar{x}	1.79	-	2.76	+	3.90	+

Keys: (-) = negative; (+) = positive; R = Remark; \bar{x} = mean, $\times 2.50 = (+)$, $< 2.50 = (-)$

Table 3 shows that the higher the age of WCBA, the higher their attitude (40years/Above= \bar{x} =3.9 > 26-39 years= \bar{x} = 2.76 > 12-25 years= \bar{x} = 1.79). The entire cluster means of WCBA aged 40 years and above and 26-39 years show positive attitude while all the cluster means of 15-25 years show negative attitude using criterion mean of 2.5.

Research question four.

What is the influence of age on WCB's practices for safe motherhood initiatives?

Data answering this research question are indicated in Table 4.

Table 4

Influence of Age on WCB's Practices to Safe Motherhood Initiatives (n=144)

S/ N	Practice of safe motherhood components	15-25 years (n=35)			26-39 years (n=90)			40years/ above (n=19)		
		f	%	R	f	%	R	f	%	R
	Practice of prenatal care									
1	Do you visit the hospital to find out if you are fit pregnancy before you conceive?	11	31.4	L	4	4.4	VL	14	74.0	H
2	Do you visit the hospital to find out if you are have any infection which can be transmitted to the unborn child with the intonation of preventing it?	20	57.1	M	31	34.4	L	16	84.2	VH
3	Are there some diets or practices you curtail because you are expecting a pregnancy?	9	26.0	L	78	87.0	VH	18	95.0	VH
	Cluster 2	13	37.1	LP	38	42.2	M	16	84.2	VH
	Practice of antenatal care									
4	Do you observe the minimum of 4 antenatal visits as recommended by WHO?	32	91.4	VH	89	99.0	VH	19	100	VH
5	When pregnant, do you take your routine drugs and exercises as and when due?	29	83.0	VH	71	79.0	H	13	79.0	H
6	Do you take adequate and purposeful diets and rest during pregnancy?	30	86.0	VH	71	79.0	H	18	95.0	VH
	Cluster 2	30	85.7	VH	77	85.6	VH	17	89.5	VH
	Practices of delivery care									
7	Do you go to hospital for delivery?	28	80	VH	58	64.4	H	14	74.0	H
8	Do you make conscious efforts to ensure that you avoid unassisted delivery?	32	91.4	VH	88	98.0	VH	19	100	VH
9	Do you wait until the peak of labour before you seek assistance?	15	43.0	M	48	53.3	M	17	89.4	VH
	Cluster 2	25	71.4	H	65	72.2	H	17	89.4	VH
	Practice of postpartum care									
10	Do you wait in the hospital after delivery until the medical personnel certifies you and your baby (ies) fit to be discharged?	34	97.1	VH	89	99.0	VH	19	100	VH
11	Do you observe regular checkup and routine immunization for you and your baby respectively?	34	97.1	VH	89	99.0	VH	19	100	VH
12	Do you practice exclusive breastfeeding?	24	69	H	79	89.0	VH	13	68.7	H
	Cluster 2	31	91.2	VH	86	95.6	VH	17	89.5	VH
	Overall 2		70.7	H		73.9	H		88.2	VH

KEY: H=High, VH=Very High, L=Low, M= Moderate

Table 4 shows that as age increases, the WCBø practices for SMI also increase. Age is directly proportional to WCBAø practices for SMI. WCBA within the age range of 40 years and above have very high extent of practice of SMI, 26-39 years have moderate practice (42.2%), while others have low practice (15-25 years=37.1%) of prenatal care. For antenatal care, all ages have very high practice of antenatal care. The table also shows that WCBA between before the age of 40 years have high practice of delivery care while those above 40 years have very high extent of practice (89.4%). Very high practice was reported by WCB of all age ranges.

Research question five.

What is the influence of level of education on WCBø attitude for safe motherhood initiatives? Data answering this research question are indicated in Table 5.

Table 5

Influence of Level of Education on WCB's Attitude to Safe Motherhood Initiatives (n=144)

S/N	Attitude to safe motherhood components	OND/Below (n=60)		NCE/Above (n= 84)	
		\bar{x}	R	\bar{x}	R
	Attitude to prenatal care				
1	It is necessary to visit a doctor to ensure that you are fit for pregnancy before conception.	2.74	+	3.31	+
2	There is need to ensure that you are medically certified infection-free before conception.	2.22	-	2.72	+
3	There is need to seek medical advice on the type food and drug consumption prior to pregnancy.	1.50	-	3.62	+
	Cluster \bar{x}	2.15	-	3.20	+
	Attitude to antenatal care				
4	Antenatal care is necessary for the health of the mother and the unborn child	1.00	-	2.01	-
5	Antenatal care is for the weakling.	1.40	-	3.58	+
6	It is a waste of time and resources to attend antenatal care	1.72	-	2.39	-
	Cluster \bar{x}	1.37	-	2.66	+
	Attitude to delivery care				
7	Delivery in the care of traditional birth attendant (TBA) is better than hospital delivery.	1.37	-	2.39	-
8	Home delivery is better because strong women do not need assistance during labour and delivery	1.43	-	2.58	+
9	I do not have to wait until the labour is at the peak before seeking assistance	1.04	-	2.48	-
	Cluster \bar{x}	1.28	-	2.48	-
	Attitude to postpartum care				
10	A mother and her newborn should not leave the hospital after delivery until the care provider certifies them fit to be discharged	1.00	-	4.00	+
11	Mothers and newborns should regularly visit hospital for medical checkup and immunization respectively as and when due	2.60	+	2.72	+
12	People who practice exclusive breastfeeding are those who cannot afford formula milk	1.24	-	3.51	+
	Cluster \bar{x}	1.61	-	3.41	+
	Overall \bar{x}	1.60	-	2.97	+

Table 5 shows that the overall mean attitude of WCBA for SMI is negative for OND/below and positive for NCE/Above. All WCBA with NCE and above had positive attitude for SMI except in delivering care (\bar{x} =2.48), while all WCBA with OND/Below have negative attitude to SMI based on cluster mean.

Research question six.

What is the influence of level of education on WCB's practices for safe motherhood initiatives? Data answering this research question are indicated in Table 6.

Table 6

Influence of Level of Education on WCB's Practices for Safe Motherhood Initiatives (N=144)

	Practice of safe motherhood components	OND/Below (n=60)			NCE/Above (n= 84)		
		f	%	R	f	%	R
	Practice of prenatal care						
1	Do you visit the hospital to find out if you are fit for pregnancy before you conceive?	35	58.3	M	69	82.1	VH
2	Do you visit the hospital to find out if you are have any infection which can be transmitted to the unborn child with the intonation of preventing it?	28	47.0	M	78	93.0	VH
3	Are there some diets or practices you curtail because you are expecting a pregnancy?	15	25.0	L	81	96.4	VH
	Cluster ☒	26	43.3	M	76	90.5	VH
	Practice of antenatal care						
4	Do you observe the minimum of 4 antenatal visits as recommended by WHO?	50	83.3	VH	84	100	VH
5	When pregnant, do you take your routine drugs and exercises as and when due?	49	82.0	VH	75	89.3	VH
6	Do you take adequate and purposeful diets and rest during pregnancy?	40	67.0	H	80	95.2	VH
	Cluster ☒	46	76.7	H	80	95.2	VH
	Practices of delivery care						
7	Do you go to hospital for delivery?	31	52	M	80	95.2	VH
8	Do you make conscious efforts to ensure that you avoid unassisted delivery?	55	92	VH	82	98.0	VH
9	Do you wait until the peak of labour before you seek assistance?	17	28.3	L	30	36.0	L
	Cluster ☒	34	56.7	M	64	79.2	H
	Practice of postpartum care						
10	Do you wait in the hospital after delivery until the medical personnel certifies you and your baby (ies) fit to be discharged?	50	83.3	VH	83	99.0	VH
11	Do you observe regular checkup and routine immunization for you and your baby respectively?	48	80.0	VH	82	98.0	VH
12	Do you practice exclusive breastfeeding?	31	52.0	M	78	93.0	VH
	Cluster ☒	43	71.7	H	81	96.4	VH
	Overall ☒		62.1	H		89.6	VH

Table 6 shows that the overall mean percentage of WCBA with NCE and higher degrees is higher than the overall mean percentage of WCBA with OND or lesser certificates. The cluster mean percentage of the SMI among WCBA with NCE and higher certificates is very high except for delivery care which has a high extent of practice (79.2%). The Table also shows that WCBA with OND and lesser qualifications has high extent of practice for postpartum care and antenatal care, delivery care and prenatal care has moderate extent of practice at 56.7 and 43.3 per cents respectively.

Research question seven.

What is the influence of level of income on WCBø's attitude for safe motherhood initiatives? Data answering this research question are indicated in Table 7.

Table 7

Influence of Level of Income on WCB's Attitude for Safe Motherhood Initiatives (n=144)

S/N	Attitude to safe motherhood components	₦20000/ Below (40)		₦ 21000/ 60000 (75)		₦ 61000/ Above (29)	
		Mean	R	Mean	R	Mean	R
1	Attitude to prenatal care						
	It is necessary to visit a doctor to ensure that you are fit for pregnancy before conception.	1.75	-	3.00	+	3.31	+
2	There is need to ensure that you are medically certified infection-free before conception.	1.37	-	2.21	-	3.68	+
3	There is need to seek medical advice on the type food and drug consumption prior to pregnancy.	1.50	-	2.19	-	3.62	+
	Cluster Mean	1.54	-	2.47	-	3.54	+
	Attitude to antenatal care						
4	Antenatal care is necessary for the health of the mother and the unborn child	2.75	+	3.57	+	4.00	+
5	Antenatal care is for the weakling.	1.40	-	2.09	-	3.58	+
6	It is a waste of time and resources to attend antenatal care	1.92	-	2.01	-	3.41	+
	Cluster Mean	2.02	-	2.56	+	3.66	+
	Attitude to delivery care						
7	Delivery in the care of traditional birth attendant (TBA) is better than hospital delivery.	1.37	-	2.41	-	4.00	+
8	Home delivery is better because strong women do not need assistance during labour and delivery	1.00	-	1.93	-	3.36	+
9	I do not have to wait until the labour is at the peak before seeking assistance	2.35	-	3.52	+	4.00	+
	Cluster Mean	1.57	-	2.62	+	3.79	+
	Attitude to postpartum care						
10	A mother and her newborn should not leave the hospital after delivery until the care provider certifies them fit to be discharged	2.77	+	3.54	+	4.00	+
11	Mothers and newborns should regularly visit hospital for medical checkup and immunization respectively as and when due	2.60	+	3.78	+	4.00	+
12	People who practice exclusive breastfeeding are those who cannot afford formula milk	1.50	-	2.06	-	3.51	+
	Cluster Mean	2.29	-	3.13	+	3.84	+
	Overall Mean	1.86	-	2.70	+	3.71	+

Table 7 shows that the overall mean attitude of WCBA whose monthly income is ₦20000 or less is negative, while those that earns more than ₦20000 are positive. This implies that the higher the income, the more positive the attitude of WCBA to SMI. The cluster means of the WCBA with monthly income of ₦20000 attitude to SMI are all positive.

WCBA that earns between N21000-N60000 have positive cluster means except for attitude to prenatal care ($x=2.47$). On the other hand, all WCBA that earns from N61000 or more have cluster means on all the SMI components that are all positive.

Research question eight.

What is the influence of level of income on WCBs practices for safe motherhood initiatives? Data answering this research question are indicated in Table 8.

Table 8

Influence of Level of Income on WCB's Practices for Safe Motherhood Initiatives (n=144)

S/ N	Practice of safe motherhood components	₦20000/Below (40)			₦ 21000/ ₦60000 (75)			₦ 61000/ Above (29)		
		f	%	R	f	%	R	f	%	R
	Practice of prenatal care									
1	Do you visit the hospital to find out if you are fit pregnancy before you conceive?	11	28.0	L	48	64	H	20	69	H
2	Do you visit the hospital to find out if you are have any infection which can be transmitted to the unborn child with the intonation of preventing it?	8	20.0	L	32	43	M	26	89.6	VH
3	Are there some diets or practices you curtail because you are expecting a pregnancy?	20	50.0	M	65	87	VH	28	97	VH
	Cluster 2	13	32.5	L	48	64	H	25	86.2	VH
	Practice of antenatal care									
4	Do you observe the minimum of 4 antenatal visits as recommended by WHO?	28	70.0	H	70	93.3	VH	29	100	VH
5	When pregnant, do you take your routine drugs and exercises as and when due?	31	78.0	H	68	91	VH	22	76	H
6	Do you take adequate and purposeful diets and rest during pregnancy?	18	45.0	M	45	60	H	25	86.2	VH
	Cluster 2	26	65.0	H	61	81.3	VH	29	86.2	VH
	Practices of delivery care									
7	Do you go to hospital for delivery?	12	30.0	L	65	87	VH	29	100	VH
8	Do you make conscious efforts to ensure that you avoid unassisted delivery?	38	95.0	VH	73	97.3	VH	28	97	VH
9	Do you wait until the peak of labour before you seek assistance?	38	95.0	VH	18	24	L	12	41.3	M
	Cluster 2	29	72.5	H	52	69.3	H	23	79.3	VH
	Practice of postpartum care									
10	Do you wait in the hospital after delivery until the medical personnel certifies you and your baby (ies) fit to be discharged?	19	48.0	L	67	89.3	VH	29	100	VH
11	Do you observe regular checkup and routine immunization for you and your baby respectively?	33	83.0	VH	74	98.7	VH	25	86.2	VH
12	Do you practice exclusive breastfeeding?	29	73.0	H	55	73.3	H	22	76.0	H
	Cluster 2	27	67.5	H	65	86.7	VH	25	86.2	VH
	Overall 2	27	60.5	H	57	76.0	H	25	86.2	VH

Table 8 shows an overall mean percentages of high (60.0%) and (76.0%) and very high practice (86.2%) s reported for WCBA that earns N20000 or less, N21000-N60000 N61000 and above respectively. All cluster means of WCBA that earns N20000 or less shows high extent of practice to SMI except the cluster mean of prenatal care which shows low extent (32.5%). Table 8 also shows that WCBA that earns between N21000-N60000 has very high practice for antenatal care (81.3%) and postpartum care (86.7%) while prenatal care (64%) and delivery care (69.3%) are high. Table 8 further shows that WCBA that earns above N60000 has very high practice for all SMIs except for delivery care where they have high practice (79.3%).

Hypothesis one.

There is no significant difference on the attitude of WCBA to SMI based on age. Data testing this hypothesis are contained in Tables 9 and 10.

Table 9

Summary of Analysis of Variance in Attitude of WCBA to SMI based on Age (n=144)

		Sum of Squares	Df	Mean Squares	F-Value	P-Value	Decision
Prenatal care	Between groups	43.22	2	21.61	3.81	.047	Reject
	Within groups	799.27	141	5.67			
	Total	821.67	143				
Antenatal care	Between groups	49.69	2	24.84	5.41	.001	Reject
	Within groups	647.87	141	4.60			
	Total	684.13	143				
Delivery care	Between groups	7.09	2	3.55	.67	.520	Accept
	Within groups	749.46	141	5.32			
	Total	766.12	143				
Postpartum care	Between groups	10.57	2	1.05	.109	.741	Accept
	Within groups	683.42	141	.957			
	Total	683.57	143				

Table 9 shows that there is a significant difference on the attitude of WCBA to parental care (F-Val= 3.81, P=.047< .05) and antenatal care (F-Val= 5.41, P=.001< .05). Their mean P-values are lesser than .05 level of significance at 2 and 141 degrees of freedom. Therefore, the null hypothesis which started that there is no significant difference in the attitude of WCBA towards these dimensions of SMI is rejected. This implies that the attitude of WCBA towards prenatal and antenatal care are different for the various age ranges.

Table 10

**Scheffe Post Hoc Analysis of Group Mean Difference based on SMI Attitude and Age
(n=144)**

Dependent Variables	(I) Age	(J) Age	Mean difference (I-J)	Std. Error	Sig	Decision
Attitude to prenatal care	15-25 years	26-39 years	-.1571	.4743	.947	Accept
		40/Above years	-1.720	.6785	.043	Reject
	26-39 years	15-25 years	.1571	.4743	.947	Accept
		40/Above years	-1.563	.6011	.037	Reject
Attitude to antenatal care	15-25 years	26-39 years	-.9302	.427	.097	Accept
		40/Above years	-1.9699	.611	.007	Reject
	26-39 years	15-25 years	.9302	.427	.097	Accept
		40/Above years	-1.0398	.541	.162	Accept
40/Above years	15-25 years	1.9699	.611	.007	Reject	
	26-39 years	1.0398	.541	.162	Accept	

Hypothesis two.

There is no significant difference on the practice of WCBA to SMI based on age. Data testing this hypothesis are contained in Tables 11 and 12.

Table 11

Summary of Analysis of Variance in Practices of WCBA to SMI based on Age (n=144)

		Sum of Squares	df	Mean Squares	F-Value	P-Value	Decision
Prenatal care	Between groups	9.05	2	4.53	10.94	.001	Reject
	Within groups	58.38	141	.41			
	Total	59.31	143				
Antenatal care	Between groups	13.15	2	6.57	18.97	.007	Reject
	Within groups	48.85	141	.35			
	Total	50.33	143				
Delivery care	Between groups	1.32	2	.66	1.39	.250	Accept
	Within groups	66.66	141	.47			
	Total	68.83	143				
Postpartum care	Between groups	5.54	2	2.77	5.56	.009	Reject
	Within groups	70.21	141	.50			
	Total	74.98	143				

Table 11 shows that there is a significant difference on the practices of WCBA to parental care (F-Val= 10.94, P=.001 < .05), antenatal care (F-Val= 18.97, P=.007 < .05) and postpartum care (F-Val= 5.56, P=.009 < .05). Their mean P-values are lesser than .05 level of significance at 2 and 141 degrees of freedom. Therefore, the null hypothesis which started that there is no significant difference in the practices of WCBA towards these dimensions of SMI is rejected. This implies that the practices of WCBA towards prenatal, antenatal and postpartum care are different for the various age ranges.

Table 12

Scheffe Post Hoc Analysis of Group Mean Difference based on SMI Practices and Age (n=144)

Dependent Variables	(I) Age	(J) Age	Mean difference (I-J)	Std. Error	Sig	Decision
Attitude to prenatal care	15-25 years	26-39 years	-.1190	.1282	.651	Accept
		40/Above years	-.8120	.1834*	.000	Reject
	26-39 years	15-25 years	.1190	.1282	.651	Accept
		40/Above years	-.6930	.1625*	.000	Reject
Attitude to antenatal care	40/Above years	15-25 years	.8120	.1834*	.000	Reject
		26-39 years	.8930	.1625*	.000	Reject
	15-25 years	26-39 years	-.3143	.1173	.030	Reject
		40/Above years	-1.030	.1677	.000	Reject
Attitude to postpartum care	26-39 years	15-25 years	.3143	.1173	.030	Reject
		40/Above years	-.7158	.1486	.000	Reject
	40/Above years	15-25 years	1.030	.1677	.000	Reject
		26-39 years	.7158	.1486	.000	Reject
Attitude to postpartum care	15-25 years	26-39 years	-.4508	.1406	.007	Reject
		40/Above years	-.1654	.2011	.714	Accept
	26-39 years	15-25 years	.4508	.1406*	.007	Reject
		40/Above years	.2854	.1782	.280	Accept
40/Above years	15-25 years	.1654	.2011	.714	Accept	
	26-39 years	-.2854	.1782	.280	Accept	

*. The mean difference is significant at the P-value < .05 level.

Hypothesis three.

There is no significant difference on the attitude of WCBA to SMI based on level of education. Data testing this hypothesis are contained in Table 13.

Table 13

Summary of t-test Analysis of No Significant Differences in the Attitude of WCBA with OND and Lesser Qualifications and those with NCE and Higher Qualifications about SMI (n=144)

	Level of Education		t-cal	df	P-Val	Decision
	OND/Below (n=60)	NCE/Above (n=84)				
	X ₁	X ₂				
Prenatal care	2.15	3.20	-2.35	142	.045	Reject
Antenatal care	1.37	2.66	-.98	142	.331	Accept
Delivery care	1.28	2.48	-.81	142	.420	Accept
Postpartum care	1.61	3.41	-.75	142	.782	Accept

Table 13 shows calculated t-value with the corresponding P-values for the attitude of WCBA about prenatal care (t-cal= -2.35, P=.045 < .05). Since the P-value is lesser than .05 level of significance, the null hypothesis of no significant difference in the attitude of WCBA about prenatal care is rejected. This implies that the attitude of WCBA with OND/Below and those with NCE/Above towards prenatal care is different.

The Table further shows that calculated t-value with the corresponding P-values for the attitude of WCBA about antenatal care (t-cal= -.98, P=.331 > .05), delivery care (t-cal= -.81, P=.420 > .05) and postpartum care (t-cal= -.75, P=.782 > .05). Since the P-values are greater than .05 level of significance, the null hypothesis of no significant difference in the attitude of WCBA with OND/Below and those with NCE/Above about these dimensions of SMI is accepted. This implies that the attitude of WCBA based on level of education towards antenatal care, delivery care and postpartum care are the same.

Hypothesis four.

There is no significant difference on the practice of WCBA to SMI based on level of education. Data testing this hypothesis are contained in Table 14.

Table 14

Summary of t-test Analysis of No Significant Differences in the Practices of WCBA with OND and Lesser Qualifications and those with NCE and Higher Qualifications about SMI (n=144)

	Level of Education				t-cal	df	P-Val	Decision
	OND/Below (n=60)		NCE/Above (n=84)					
	f	%	f	%				
Prenatal care	26	43.3	76	90.5	-2.90	142	.047	Reject
Antenatal care	46	76.7	80	95.2	-1.77	142	.082	Accept
Delivery care	34	56.7	64	79.2	-1.30	142	.201	Accept
Postpartum care	43	71.7	81	96.4	-3.96	142	.007	Reject

Table 14 shows calculated t-value with the corresponding P-values for the practices of WCBA about prenatal care (t-cal= -2.90, P=.047 < .05) and postpartum care (t-cal= -3.96, P=.007 < .05). Since the P-values are lesser than .05 level of significance, the null hypothesis of no significant difference in the practices of WCBA about prenatal care and postpartum care are rejected. This implies that the practices of WCBA with OND/Below and those with NCE/Above towards prenatal care and postpartum care are different.

The Table further shows that calculated t-value with the corresponding P-values for the practices of WCBA about antenatal care (t-cal= -1.77, P=.082 > .05) and delivery care (t-cal= -1.30, P=.201 > .05). Since the P-values are greater than .05 level of significance, the null hypothesis of no significant difference in the practices of WCBA with OND/Below and those with NCE/Above about these dimensions of SMI is accepted. This implies that the practices of WCBA based on level of education towards antenatal care and delivery care are the same.

Hypothesis five.

There is no significant difference on the attitude of WCBA to SMI based on level of monthly income. Data testing this hypothesis are contained in Tables 15 to 16.

Table 15

Summary of Analysis of Variance in Practices of WCBA to SMI based on Level of Monthly Income (n=144)

		Sum of Squares	df	Mean Squares	F- Value	P- Value	Decision
Prenatal care	Between groups	21.26	2	10.63	3.99	.046	Reject
	Within groups	375.63	141	2.66			
	Total	379.21	143				
Antenatal care	Between groups	12.95	2	6.48	2.49	.092	Accept
	Within groups	366.27	141	2.60			
	Total	382.51	143				
Delivery care	Between groups	42.82	2	21.61	3.81	.041	Reject
	Within groups	589.34	141	4.18			
	Total	599.65	143				
Postpartum care	Between groups	10.80	2	9.48	1.72	.190	Accept
	Within groups	421.25	141	.627			
	Total	422.32	143				

Table 15 shows the F- cal with the corresponding P-values for the attitude of WCBA about prenatal care (F-cal= 3.99, P=.046 < .05) and delivery care (F-cal= 3.81, P=.041 < .05). Since the P-values of the WCBA's attitude about prenatal care and delivery care are lesser than .05 level of significance at 2 and 141 degrees of freedom, the null hypothesis that level of income is not a significant factor in these dimensions of SMI is therefore rejected. This implies that the attitude of WCBA based towards prenatal care and delivery care are not the same based on level of monthly income.

The Table further shows the F- cal with the corresponding P-values for the attitude of WCBA about antenatal care (F-cal= 2.49, P=.092 > .05), and postpartum care (F-cal= 1.723, P=.190 > .05). Since the P-values are greater than .05 level of significance, the null hypothesis that level of income is not a significant factor in these dimensions of SMI is therefore accepted. This implies that the attitude of WCBA based on level of monthly income towards antenatal care and postpartum care are the same.

Table 16

Scheffe Post Hoc Analysis of Group Mean Difference based on Attitudes of WCBA about SMI and Level of Monthly Income (n=144)

Dependent Variables	(I) Level of Monthly Income	(J) Level of Monthly Income	Mean difference (I-J)	Std. Error	Sig	Decision
Attitude to prenatal care	₦20000/Below	₦21000-60000	-1.255	.4003*	.009	Reject
		₦61000/Above	-1.092	.4986	.094	Accept
	₦21000-60000	₦20000/Below	1.255	.4003*	.009	Reject
		₦61000/Above	.1628	.4471	.936	Accept
Attitude to Delivery care	₦61000/Above	₦20000/Below	1.092	.4986	.094	Accept
		₦21000-60000	-.1628	.4471	.936	Accept
	₦20000/Below	₦21000-60000	-.1333	.3196	.917	Accept
		₦61000/Above	-1.035	.3981*	.037	Reject
₦21000-60000	₦20000/Below	.1333	.3196	.917	Accept	
	₦61000/Above	.9011	.3569*	.044	Reject	
₦61000/Above	₦20000/Below	1.035	.3981*	.037	Reject	
	₦21000-60000	-.9011	.3569*	.044	Reject	

*. The mean difference is significant at the P-value < .05 level.

Hypothesis six.

There is no significant difference on the practices of WCBA to SMI based on level of monthly income. Data testing this hypothesis are contained in Tables 17 and 18.

Table 17

Summary of Analysis of Variance in Practices of WCBA to SMI based on Level of Monthly Income (n=144)

		Sum of Squares	df	Mean Squares	F-Value	P-Value	Decision
Prenatal care	Between groups	9.63	2	4.82	7.42	.044	Reject
	Within groups	91.53	141	.65			
	Total	97.34	143				
Antenatal care	Between groups	2.46	2	1.23	1.67	.187	Accept
	Within groups	104.09	141	.74			
	Total	109.93	143				
Delivery care	Between groups	2.46	2	1.23	2.25	.113	Accept
	Within groups	77.20	141	.55			
	Total	81.54	143				
Postpartum care	Between groups	15.14	2	7.57	9.99	.001	Reject
	Within groups	106.80	141	.76			
	Total	112.35	143				

Table 17 shows the F-cal with the corresponding P-values for the practices of WCBA about prenatal care (F-cal= 7.42, P=.044 < .05) and postpartum care (F-cal= 9.99, P=.001 < .05). Since the P-values of the WCBA's practices about prenatal care and postpartum care are lesser than .05 level of significance at 2 and 141 degrees of freedom, the null hypothesis that level of income is not a significant factor in these dimensions of SMI is therefore rejected. This implies that the practices of WCBA based towards prenatal care and postpartum care are not the same based on level of monthly income.

The Table further shows the F-cal with the corresponding P-values for the practices of WCBA about antenatal care (F-cal= 1.67, P=.187 > .05), and delivery care (F-cal= 2.25, P=.113 > .05). Since the P-values are greater than .05 level of significance, the null hypothesis that level of income is not a significant factor in these dimensions of SMI is therefore accepted. This implies that the practices of WCBA based on level of monthly income towards antenatal care and delivery care are the same.

Table 18

Scheffe Post Hoc Analysis of Group Mean Difference based on SMI Practices and Age (n=144)

Dependent Variables	(I) Age	(J) Age	Mean difference (I-J)	Std. Error	Sig	Decision
Attitude to prenatal care	₦20000/Below	₦21000-60000	-.0683	.1578	.910	Accept
		₦61000/Above	-.6853	.1965*	.003	Reject
	₦21000-60000	₦20000/Below	.0683	.1578	.910	Accept
		₦61000/Above	-.6170	.1762*	.003	Reject
Attitude to postpartum care	₦61000/Above	₦20000/Below	.6853	.1965*	.003	Reject
		₦21000-60000	.6170	.1762*	.003	Reject
	₦20000/Below	₦21000-60000	-.7583	.1704*	.000	Reject
		₦61000/Above	-.4181	.2123	.148	Accept
₦21000-60000	₦20000/Below	.7583	.1704*	.000	Reject	
	₦61000/Above	.3402	.1903	.206	Accept	
	₦20000/Below	.4181	.2123	.148	Accept	
		₦21000-60000	-.3402	.1903	.206	Accept

*. The mean difference is significant at the P-value < .05 level.

Summary of Major Findings

Based on the analysis of the data, the major findings of the study are hereby summarized below.

1. WCBA's attitude to SMI was positive ($\bar{x} = 2.84$). this is contained in Table I
2. WCBA's practice towards SMI was high (75%). This is contained in table 2.
3. WCBA's attitude to SMI was directly proportional to age. WCBA aged 40 years and above and 26 ó 39 had positive attitude (40 years/Above = $\bar{x} = 3.9$; 26 ó 39 years = $\bar{x} = 2.76$) while those aged 12 ó 15 years had negative attitude to SMI ($\bar{x} = 1.79$). These are contained in table 3.
4. WCBA's practice to SMI was directly proportional to age. WCBAs within the age ranges of 40 years/Above was very high (88.16%), while those within 26 ó 39 years (73.89%) and 15 ó 25 years (70.71%) were high. These are contained in Table 4.
5. WCBAs with OND/below certificates had negative attitude to SMI ($\bar{x} = 1.6$) while those with NCE and higher qualifications had positive attitude ($\bar{x} = 2.97$). This is contained in Table 5.
6. WCBAs practice to SMI was high (62.1%) for OND/Below and övery highö for NCE/Above. This is contained in Table 6.
7. The higher the income, the higher the attitude of WCBA towards SMI. WCBA that earns ₦20,000 or less had negative ($\bar{x} = 1.86$) attitude to SMI; those that earn ₦21,000 ó ₦60,000 ($\bar{x} = 2.7$) and those that earn from ₦61,000 upwards ($\bar{x} = 3.71$) had positive attitude to SMI. These are contained in Table 7.
8. WCBAs practice to SMI was high for those that earn ₦20,000 and below (60%), and those that earns ₦21,000 to ₦60,000 (76%) while those that earn more than ₦60,000 earn very high (86.2%).
9. There was significant difference in the attitude of WCBA toward prenatal care ($F=3.81$, $P = .047$), and antenatal care ($F = 5.41$, $P = 0.01$) based on age. This is contained in table 9.
10. There was significant difference in the practice of WCBA toward prenatal care ($F_{cal} \acute{o} cal = 10.94$, $P = .001$), antenatal care ($F \acute{o} cal = 18.97$, $P = .007$), and postpartum care ($F_{cal} = 5.56$, $P = .009$) based on age. This is contained in Table 11.
11. There was significant difference in the attitude of WCBA towards prenatal care ($t = -2.35$, $P = .045$) based on level of education. This is contained in table 13.

12. There was significant difference in the practice of WCBA towards prenatal care ($t = -2.90$, $P = .047$) and post partum care ($t = -3.96$, $P = .007$) based on level of education. This is contained in Table 14.
13. There was significant difference in the attitude of WCBA on prenatal care ($F\text{-cal} = 3.99$, $P = .046$) and delivery care ($F\text{-cal} = 3.81$, $P = .041$) based on level of monthly income. This is contained in Table 15.
14. There was no significant difference in the practice of WCBA towards prenatal care ($F\text{-cal} = 7.42$, $P = .044$) and postpartum care ($F\text{-cal} = 9.99$, $P = .001$) based on level of monthly income. This is contained in Table 17.

Discussion

The findings of the study are discussed under the following headings:

- Attitude and practice of WCBA towards SMI based on Age
- Educational level of WCBA and attitude to and practice of SMI
- Level of income of WCBA and attitude to and practice of SMI

Attitude and practice of WCBA towards SMI based on age.

In this study, a significant difference in attitude to SMI of WCBA based on age was found. Data in Table 3 showed that the higher the age of mothers, the higher their attitude to SMI. This finding was expected because as WCBA progresses in life, they tend to understand some of the SMIs and therefore accept it wholeheartedly. This finding collaborates with the findings of Nwaniki, Kabiru and Mbugua (2002) who found out that 97.5 percent of mothers utilized health facilities for antenatal services. Data in Table 3 further showed that WCBA within the age ranges of 15 ó 25 had negative attitude to SMI. This finding was not surprising because most of them still perceive SMI as a package/services for pregnant and nursing mothers.

Efforts should be made to correct this negative perception and attitude of younger women, because the earlier they start to benefit from SMI, the better their health. In line with the above, Igbokw and Adama (2011) advocated that health education programmes should be intensified at the grass-root level to increase and promote the knowledge and use of MCH services among WCBA.

Data in Table 4 revealed that SMI was directly proportional to age. This implies that the higher the age, the more the practice of SMI. This was expected because

experience they say is the best teacher. This finding is in consonance with the findings of Nitai, Islam, Chowdhury, Bari and Akter (1993) who found out that older women are more likely to seek and utilize SMI in Bangladesh than younger women. As a mother gets older, there is the likelihood that she will have more children and have increased experiences relating to childbirth and the level of peripheral experiences. An older or more experienced mother may have a better attitude to and practice of safe motherhood. For example, Fosu (1994) noted that mother's age may sometimes serve as a proxy for the women's accumulated knowledge of health care services, which may have a positive influence on the use of health services. Also, studies like Elo (1992) and Normon, hopez, Carcamo and Galindo (1993) have all recognized that as a woman gets older, the age plays an important role in the utilization of medical services. This is not always so for younger mothers especially adolescent mothers (Daly, Azefer & Wasah, 1993) who seldom seek reproductive health services from older mothers.

Findings in Tables 9 and 11 showed that significant difference exists between the attitude to and practice of prenatal care among WCBA of various age ranges. This finding was surprising. The finding is at variance with the assertions of Normon et al (1993) who argued that with the development of modern medicine and improvement in educational opportunities for women in recent years, younger woman might have an enhanced knowledge of modern health care services and place more value upon modern medicine and so may practice safe motherhood more than the older ones. But according to SIHFW (2008) report has it that adolescent mothers were less likely than adult mothers to practice safe motherhood initiatives. In our various homes, older women can be seen acting as teachers to young mothers on issues pertaining to safe motherhood. Even though they may not have gotten formal education, their experiences on childbirth over the years serve as a veritable tool that gives them an edge on attitude to and practice of SMI:

Educational level of WCBA and attitude to and practice of SMI.

The findings in Tables 13 and 14 showed that there was significant difference on SMI (Prenatal care) and attitude of WCBA, while practice of prenatal and postpartum care were also significant based on the level education. From findings in Tables 5 and 6, WCBA with NCE/Above had positive attitude with corresponding very high practice of SMI, while those with OND/Below had negative attitude with high practice to SMI. This finding was expected. Education plays an important role in the knowledge one possesses on a subject matter. In this

case, the knowledge WCBA posses about SMI is dependent on their level of education. The findings are in line with WHO (1996) who stated that many of the ailments people suffer from are to a large extent self inflicted by anti-health practices due to lack of knowledge (education). Okereke, Aradeon, Akerele, Tanko, Yisa and Obonyo (2013) reported that acquiring some level of education is strongly associated with the attitude and practice of safe pregnancy practices among some women in rural communities. The authors further reported that knowledge of safe motherhood and utilization of available health services/facilities are closely associated with level of education of the women. These results and findings are not surprising because education enlightens one and creates the understanding and awareness of services, which health services and facilities are inclusive.

Having higher-education exposes one to more global information regarding the danger and benefits of SMI as well as reduces negative cultural preconceptions about SMI and increases positive attitude to and practice of SMI. This view are tangential to some studies (Alhilfy & Esaa, 2007; and Nitai et al, 1993). In India, Govindasamy and Ramesh (1997) found that the practices of educated women are quite different from those of uneducated women with regard to pregnancy, childbirth, immunization and management of childhood diseases. Also, higher level of maternal education results in improved child survival because health services that effectively prevent fatal childhood diseases were used to a greater extent by mothers with higher education than by those with little or no education. Even among some women in rural communities, acquiring some level of education is strongly associated with the knowledge of safe pregnancy practices (Okereke et al, 2013). Other areas that maternal education can significantly influence include higher exclusive breastfeeding practices (Tiwari, Mahajar & Lahariya, 2009).

Level of Income of WCBA towards attitude and practices of SMI.

Data obtained show that level of income of WCBA influence their attitude and practice of safe motherhood initiatives. Findings in Tables 15 and 17 showed that there was significant differences in the attitude to prenatal and delivery care and practice of prenatal and postpartum care of WCBA towards SMI. This finding was expected because income determines one's way of life. Low income earners would be more concerned about survival as compared to high income earners that would be more mindful of quality of lifestyle. Therefore, wealthy WCBA are more likely to posses positive attitude to and consistent practice for safe motherhood. In support, Nanda (2002) asserted that the introduction of user

fees resulted to rise in maternal deaths by 56 percent in Zaria along with decline of 46 percent in the number of deliveries in the main hospitals.

Many studies lends credence to this findings of this study. It has been reported that wealth index is closely associated with health practices (Ale mayehu, Haldar & Haste, 2009).; unemployment is associated with deliveries outside the hospital (Vanden, Demey, Buddingh & Bots, 1999); women who worked for cash went to some qualified medical personnel for treatment, compared to those who did not, work (Nital, et al, 1993), and that unaffordable medical bills is a major barrier to practice of SMI vis a vis utilization of maternal and child healthcare services (Okafor, Obi & Ugwu, 2011). In all these reports, mothers with high level of income are seen to be highly likely to have a better attitude to and consistent practice for SMI because they can afford the medical bills and associated hospital expenses compared to poorer ones.

CHAPTER FIVE

Summary, Conclusions And Recommendations

Summary

The study investigated the attitude to and practices of SMI among WCBA attending health facilities in Igbo-Eze South LGA of Enugu State. Eight specific objectives were formulated with eight corresponding research questions and six null hypotheses were postulated to guide the study. Literatures relevant to the study were reviewed. Population for the study was 7210 registered WCBA who attended health facilities in Igbo-Eze South LGA of Enugu State. The study adopted a cross sectional survey research design, Multistage sampling procedure was used to select the sample which was 144. A three section (27 item) researchers designed questionnaire was the instrument used for data collection. Face validity of the questionnaire was established by five experts and split half method of spearman's Rank difference correlation method was employed to test the reliability of the study. The instrument was administered to respondents by the researcher by hand. Mean scores, frequencies and percentages were used to answer the research questions while t-test and ANOVA were used to test the hypotheses at .05 level of significance. Below is the summary of the findings from the study:

1. Attitude of WCBA to SMI was positive.
2. Practices of WCBA to SMI were high.
3. Attitude of WCBA between 15 to 25 years was negative while those of WCBA between 26 years/Above was positive.
4. Practices of WCBA to SMI was high for ages between 15 to 25 and 26 to 39, while those from 40 years/Above was very high.
5. Attitude of WCBA to SMI was negative for those with OND/Below and positive for those NCE/Above.
6. Practice of WCBA towards SMI was high for those with OND/below and very high for those with NCE/Above.
7. Attitude of WCBA to SMI increased with increase in level of income.
8. Practice of WCBA to SMI progressed with higher level of income.
9. There was significant difference in attitude of WCBA to prenatal and antenatal care based on age.
10. There was significant difference in practices of WCBA towards prenatal, antenatal and postpartum care based on age.

11. There was no significant difference in the attitude of WCBA towards prenatal and postpartum care based on level of education.
12. There was significant difference in the practice of WCBA towards prenatal and postpartum care based on level of education.
13. There was significant difference in the attitude of WCBA towards prenatal and delivery care based on level of income.
14. There was no significant difference in the practice of WCBA towards antenatal and delivery care based on level of income.

Conclusion

Based on the result of the findings, the following conclusions were drawn:

1. WCBA had positive attitude to SMI. This answers research question one.
2. Practices of WCBA to SMI were high. This answers research question two.
3. Attitude of WCBA between 15 ó 25 years was negative while those of WCBA between 26 years/Above was positive. This answers research question three.
4. Practices of WCBA to SMI was high for ages between 15 ó 25 and 26 ó 39, while those from 40 years/Above was very high. This answers research question four.
5. Attitude of WCBA to SMI was negative for those with OND/Below and positive for those NCE/Above. This answers research question five.
6. Practice of WCBA towards SMI was high for those with OND/below and very high for those with NCE/Above. This answers research question six.
7. Attitude of WCBA to SMI increased with increase in level of income. This answers research question seven.
8. Practice of WCBA to SMI progressed with higher level of income. This answers research question eight.
9. There was significant difference in attitude of WCBA to prenatal and antenatal care based on age. This is the result of testing hypothesis one..
10. There was significant difference in practices of WCBA towards prenatal, antenatal and postpartum care based on age. This is the result of testing hypothesis two.
11. There was no significant difference in the attitude of WCBA towards prenatal and postpartum care based on level of education. This is the result of testing hypothesis three.

12. There was significant difference in the practice of WCBA towards prenatal and postpartum care based on level of education. This is the result of testing hypothesis four.
13. There was significant difference in the attitude of WCBAs towards prenatal and delivery care based on level of income. This is the result of testing hypothesis five.
14. There was no significant difference in the practice of WCBA towards antenatal and delivery care based on level of income. This is the result of testing hypothesis six.

Recommendations

From the findings of this study therefore, the following recommendations were propounded to checkmate the growing trend of mortality and morbidity of child-bearing women especially as it relates to SMI:

1. Health Education programmes should be established and intensified at the grass-root level to increase and promote the utilization of SMI services among childbearing mothers. This is especially important for child-bearing mothers with minimal educational level.
2. The Ministry of Education should include a curriculum tagged maternal studies in secondary schools. This is important because in this study, it was found that child-bearing mothers of 12-25 year olds have more negative attitude to and lower practice of SMI. Mothers at that age could be victims of unwanted pregnancies (pregnancy resulting from friendship without parental consent) and may shy away from SMI because they want to hide the pregnancy from parents and friends. But with proper knowledge of the importance of SMI to maternal and child survival that attitude may change.
3. More research is needed to establish the demographic variables that predisposes child-bearing mothers from having a positive attitude to and high practice of SMI. It is therefore recommended that researchers should be encouraged to be highly interested in this all important field.
4. In Igbo-Eze South L.G.A. the traditional rulers (Igwes) are grass root movers and it is so in all communities in Enugu State. It is recommended that as part of their duties, the government should mandate them to intermittently organize a sensitization programme for awareness of SMI for child-bearing mothers.

Limitations of the Study

This study was not devoid of limitations. They include:

1. Although 20 per cent of the total population of registered child-bearing mothers who attend health facilities in Igbo-Eze South LGA of Enugu state was used as sample size and

backed by literature, for proper generalization the sample should have been larger. Also, the conceptualization of level of income that failed to take cognizance of other sources of income is a limitation. Further studies should take note of that.

Suggestions for Further Studies.

1. Further studies should look at locality of mothers. It is most likely that there will be a difference in attitude and practice of SMI between urban and rural women.
2. Cultural variables are also important in understanding the attitude and practice of SMI. Those cultural variables like the influence of withes, believe in concoctions, e.t.c. should be studied.
3. Researchers that may wish to study level of income should try to capture other sources of income so as to give a clearer picture of the difference in income level.

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Appendix 1

Department of Health and Physical Education,
University of Nigeria,
Nsukka.

Dear Respondent,

I am a postgraduate student of the above address conducting research on the attitude to and practice of safe motherhood among the women of child bearing age attending health facilities in Igbo-Eze South LGA of Enugu State. Please, the answers you provide are strictly for research purpose and will be kept confidential. Therefore, I guarantee your anonymity as I urge you not to write your name anywhere on this questionnaire. I request and wish that you may respond to the following questions sincerely. Thanks.

Yours sincerely,

Eze, Paulinus Onyebuchi

SECTION A

Bio-Demographic Information.

Please tick the option that applies to you in the following question

1. Which of the following age group do you belong (Please tick one option)?

- a) 12-25 years
- b) 26-39 years
- c) 40 years and above

What is your level of education?

- a) OND and below
- b) NCE and above

2. What is your average level of income per moth?

- a) ₦20,000 and below
- b) ₦21,000 to 60,00
- c) ₦61,000 and above

SECTION B: Attitude to safe motherhood initiative components

Please indicate whether you strongly agree (SA), agree (A), disagree (D), or strongly disagree (SD) in the following statements

S/N	Attitude to prenatal care	SA	A	D	SD
1	It is necessary to visit a doctor to ensure that you are fit for pregnancy before conception.				
2	There is need to ensure that you are medically certified infection-free before conception.				
3	There is need to seek medical advice on the type food and drug consumption prior to pregnancy.				
	Attitude to antenatal care				
4	Antenatal care is necessary for the health of the mother and the unborn child				
5	Antenatal care is for the weakling.				
6	It is a waste of time and resources to attend antenatal care				
	Attitude to delivery care				
7	Delivery in the care of traditional birth attendant (TBA) is better than hospital delivery.				
8	Home delivery is better because strong women do not need assistance during labour and delivery				
9	I do not have to wait until the labour is at the peak before seeking assistance				
	Attitude to postpartum care				
10	A mother and her newborn should not leave the hospital after delivery until the care provider certifies them fit to be discharged				
11	Mothers and newborns should regularly visit hospital for medical checkup and immunization respectively as and when due				
12	People who practice exclusive breastfeeding are those who cannot afford formula milk				

SECTION C: Practice of safe motherhood initiative components

Please indicate whether you practice (YES) or not (NO) in the following statements:

	Practice of safe motherhood components	Yes	No
	Practice of prenatal care		
13	Do you visit the hospital to find out if you are fit pregnancy before you conceive?		
14	Do you visit the hospital to find out if you are have any infection which can be transmitted to the unborn child with the intonation of preventing it?		
15	Are there some diets or practices you curtail because you are expecting a pregnancy?		
	Practice of antenatal care		
16	Do you observe the minimum of 4 antenatal visits as recommended by WHO?		
17	When pregnant, do you take your routine drugs and exercises as and when due?		
18	Do you take adequate and purposeful diets and rest during pregnancy?		
	Practices of delivery care		
19	Do you go to hospital for delivery?		
20	Do you make conscious efforts to ensure that you avoid unassisted delivery?		
21	Do you wait until the peak of labour before you seek assistance?		
	Practice of postpartum care		
22	Do you wait in the hospital after delivery until the medical personnel certifies you and your baby (ies) fit to be discharged?		
23	Do you observe regular checkup and routine immunization for you and your baby respectively?		
24	Do you practice exclusive breastfeeding?		