APPLICATION OF LOCUS OF CONTROL TO MATERNAL AND CHILD HEALTH (MCH) CHALLENGES TOWARDS ACHIEVING THE MILLENNIUM DEVELOPMENT GOALS 4 AND 5 IN NIGERIA

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Application of locus of control to maternal and child health (MCH) challenges towards achieving the millennium development goals 4 and 5 in Nigeria

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The poor state of maternal and child health (MCH) is one of the greatest challenges menacing social stability in Nigeria as the problem continues unabated in spite of global and local efforts to address the trend. Available literature indicates that Nigeria has the worst health indicators in the Sub-Saharan African region. This study is a qualitative descriptive effort which attempts to apply the Locus of Control Model of health to Maternal and Child Health challenges in Nigeria. This paper has shown that the determinants of maternal and child health such as family planning, maternity care, immunization coverage, nutrition, prevention and treatment of diseases among nursing mothers lies along bipolar lines of external and internal controls. Findings reveal that majority of women as well as children are characterized by external loci owing socio economic and cultural factors. Hence, utilization family planning, maternity care and immunization services; as well as effective nutrition, prevention and treatment of diseases are given poor attention with implications for poor maternal health and child survival outcomes. However, women with formal education tend to have internal loci with favorable implications for their reproductive lives and the society at large.

Key words: Locus of control, maternal health, child health, millennium development goals.

INTRODUCTION

Every single day, Nigeria loses about 2,300 under-five year olds and 145 women of childbearing age. This makes the country the second largest contributor to the under-five and maternal mortality rate in the world. According to UNICEF publication (2010), a woman's chance of dying from pregnancy and childbirth in Nigeria is 1 in 13 and survivors suffer several ailments and disabilities. Although many of these conditions are preventable, the coverage and quality of health care services in Nigeria continue to fail women and children. Presently, less than 20 per cent of health facilities offer emergency obstetric care and only 35 per cent of deliveries are attended by skilled birth attendants. Underneath the statistics lies the pain of human tragedy, for thousands of families who have lost their children. Even more devastating is the knowledge that, according to recent research, essential interventions reaching women and babies on time would have averted most of these deaths. It is on the basis of these dichotomies and its levers that the United Nations Millennium Declaration was adopted in September 2000 at the largest ever gathering of heads of States committing countries both rich and poor to do all they can to eradicate poverty, promote human dignity and equality and achieve peace, democracy and environmental stability. In specific terms, the goals include those dedicated to eradicating poverty, achieving universal primary education, promoting gender equality and empowering women, reducing child mortality, improving maternal health, combating HIV/AIDS, malaria and other diseases, ensuring environmental sustainability and developing a global partnership for development. These goals are corollary to promotion of health and the survival of mothers and their children.

In corroboration, Article 5 of the African and people’s rights expressly acknowledges the right to reproductive self determination in women which includes integrity and privacy in the context of fertility and utilization of obstetric care. Unfortunately, Nigerian women are said to be voiceless and powerless in matters affecting their own reproduction (Makinwa 2001). In corroboration, Metiboba (2008) noted that some women in Nigeria may not seek
medical care unless their spouses permit them. This situation constitutes flagrant abuse of the rights of women with negative implication for reproductive health and child survival.

According to UNICEF (2010), preventable or treatable infectious diseases such as malaria, pneumonia, diarrhea, measles and HIV/AIDS account for more than 70 per cent of the estimated one million under-five deaths in Nigeria. The contribution of malnutrition is also significant as it is implicated for more than 50 per cent of deaths of children in this age bracket. The deaths of newborn babies in Nigeria represent a quarter of the total number of deaths of children under-five. The majority of these occur within the first week of life, mainly due to complications during pregnancy and delivery reflecting the intimate link between newborn survival and the quality of maternal care. Main causes of neonatal deaths are birth asphyxia, severe infection including tetanus and premature birth (Park 2007). It is in the wake of these calamities that the United Nations Organization (UNO) Countries seeks achieve maternal and child death reduction by two thirds before the year 2015 under the auspices of the Millennium Development Goals using the instrumentalities of:
- Ensuring safe pregnancy, child birth and new born care.
- Expanded routine immunization coverage.
- Promotion of proper child feeding and the delivery of micronutrients.
- Prevention, diagnosis and treatment of acute respiratory infections, diarrhea and malaria.
(United States Agency for international development USAID 2009)

The onus of these intervention strategies lies with mother who is biologically and culturally implicated for child birth and nurture. Ochiawunma (2002) documented that an element in determining the survival of the mother and the birth outcome is likely to be the extent to which the mother receives prenatal care tetanus toxoid vaccination and the quality of assistance at delivery. In a similar trend WHO (2005) attributes child and maternal mortality to lack of antenatal care, low proportion of women attended to by skilled birth attendants, delay in the treatment of complications, poverty, harmful traditional practices and low status of women.

Regrettably, women make up half of the world’s population and yet, represent a staggering 70% of the world’s poor. For the millions of women living in poverty, their lives are a litany of injustice, discrimination and obstacles in the way of achieving the basic needs of education, good employment, good health and safe childbirth. We live in the world in which women face gross inequalities and injustice from birth to death From poor education to poor nutrition, to vulnerable and low paid employment: The sequence of discrimination that a woman may suffer during her entire life is unacceptable but all too common (Global poverty project 2010). These ugly situations generate a cause for concern if juxtaposed with the irreducible roles of women in child birth and nurturing.

**Locus of control model**

Locus of control orientation is a belief about whether the outcome of our actions is contingent on what we do or on events outside our personal control (Zimbardo, 1985). Locus of Control Model is a concept from the social learning theory which health care providers use to determine whether clients are likely to take actions regarding their health on their own or are being controlled by forces external to them. Locus of Control was formulated within the frame work of Rotters in the 1950s (Rotters 1966)

The disposition of an individual at the time a health related behavior is expected from him/her determines who takes the decision under the circumstance. This suggest that one could be disposed to take a health behavior and consequently, be responsible for the outcome as well as indisposed owing to social circumstances; consequently, depending on powerful others or chance for health or illness behavior. Metiboba (2008) argued that service factors, client factors, institutional factors and access factors influences appropriate utilization of health care. Julian Rotters provided a detailed approach of locus of control by classifying generalized beliefs concerning who or what influences things along bipolar lines from internal to external controls.

**Internal locus of control**

This is the belief that outcomes are directly the consequences of one’s behavior. It was Young (1976) who also used the terminology of internalizing to further buttress the concept of internal locus of control. According to Young, internalizing systems emphasizes physiological functions. People that have internal locus of control believe that they control their own destiny. They also believe that they are controlled by their own skill or efforts.

Stone and Jackson (1965) argued that a person with internal locus of control believes she has control over reinforcing events in her life; attributes change to herself and to her actions, believes and act as though she controls her own future and sees herself as an effective agent in determining the occurrence of reinforcing events.

Lending credence, Koziier and Erb (2005) reported that people who exercises internal locus of control are more likely to take initiative on their own health and are more knowledgeable about their health and adhere to prescribed healthcare regimens such as taking medications, keeping appointments with the physicians, diets and giving up of health habits that are detrimental to their health. The argument of Koziier and Erb is corollary of educated people. According to Cieland (1990), education empowers the woman in the contexts of
instrumentality, social identification and confidence. In his analysis, instrumentality is the ability to manipulate and feel control over the outside world; social identification is concerned with the engagement with modern institutions and bureaucracies while confidence permits interaction with such officials and bureaucracies.

This is further captured by Joseph Adiscon cited in Iluebe (2006) who averred that education is a companion which no misfortune can depress, no crime can destroy, no enemy can alienate, no disposition can enslave. At home a friend, in society an ornament. Without it what is man? A splendid slave: a seasoning savage.

The social gains of women education is further captured by UNICEF in a statement which argues that education for girls is the key to the health and nutrition of populations; to overall improvements in the standard of living; to better agricultural and environmental practices; to higher Gross National Product; and to greater involvement and gender balance in decision-making at all levels of society. Wikipedia, Locus of Control documented that males tend to be more internal than females, and as people gets older, they tend to become more internal.

In another dimension, internal orientations need to be matched up with self efficacy and opportunity so that the person is able to successfully experience a sense of personal control and responsibility (Mamlin, Haris and Case 2001). Environmental conveniences therefore play enormous roles in achieving internal loci.

External locus of control
This is the belief that outcomes and consequences of actions are determined by powerful others, fate, luck or chance.

Young (1976) while attempting a criticism of health belief model coined the concept of externalizing to explain the roles of external factors as determinant of reproductive health behaviors. Consequently, Rotters (1966) argued that a person with external locus of control believes that reinforcement is the result of luck, chance, fate as under the control of powerful others or is unpredictable because of the great complexity of the forces.

Tinuola (2009), in his contribution to the understanding of the concept of Locus of Control, posited that external factors believed to have influence on health related behavior are: Social, cultural, and economic. He added that specifically, cultural norms, environmental factors, legal position, finance, education level, influence of relations, spouse decision; religious factors are all external factors influencing health related behavior. These externalities are obvious challenges militating against the success of maternal and child survival and development programs in Nigeria.

Application of locus of control
Locus of control is relevant to this study because of its emphasis on motivations for health and illness behavior in the contexts of psychological, socio-cultural, economic, religious, political and environmental factors which are very relevant to reproduction, child nurture and development.

Through time and space Women are biologically and culturally implicated for child birth and nurture. Tiger and Robin fox (1972) documented that the emotional bond between the mother and child is a genetically based predisposition which is particularly important for the welfare of the child. In a related development, Bicego and Boerma (1990) posited that children are dependent on their mother's skills and socio-economic conditions for all aspects of their survival.

From this standpoint, the health and illness behavior of children is externally determined as a result of their age indisposition. In another dimension, mothers are influenced by both internal and external loci in their health and illness behaviors for themselves and their children. These premises shall form the compass for this discussion.

Family planning
WHO (2010) documented that family planning allows individuals and couples to anticipate and attain the desired number of children; spacing, and the timing of their births through the use of contraceptives and the treatment of infertility. The report added that a woman's ability to space and limit her pregnancies has direct impact on her health and wellbeing as well as the outcome of each pregnancy. Unfortunately, the NDHS (2008) documented that only 10% of Nigerian women of reproductive age utilized the modern family planning services while unmet need is 20 percent.

There are many externalities to family planning decisions. According to Adebuseoye-Makinwa (2001) lineage consciousness, patrilocal residence, male dominance and low status of women induces women to high fertility. It is generally believed that lineage doesn't die, members die and are replaced through birth, so, preventing birth is tantamount to consigning an ancestor to Oblivion (Bleeck1987; Makinwa-Adebusoye and Egbisola, 1992; National Research Council 1993; Caldwell and Caldwell 1988). Arguing further, women are powerless and voiceless in matters affecting their own reproduction owing to their subordinate position in the family cycle. The social status of women is contingent on either her wealth or the number of children. In similar perspective, Ochiawunna (2002) argued that family planning in Nigeria is limited by socio-cultural and economic factors particularly, religious beliefs, low educational levels, poverty, misinformation and poor spousal communication.

In contrast, The Nigerian Health Review (2006) reported that educated mothers are associated with greater emphasis on child quality; perhaps ensuring that fever children are more likely to survive, have greater
food and human capital investment and thus end up as higher quality citizens being healthier; better educated, more affluent and emotionally better developed. This has implications for maternal and child health in Nigeria.

**Medical maternity care**

Maternity care is encapsulated in three related concepts of ante-natal care, intra-natal care and post partum care. According to Park (2007), maternity care provides education, information and curative services. Regrettably, Metiboba (2008) reported that Nigerian women in some sub-cultures may not seek medical help from experts during child labor unless their spouses permit them. Others even prefer to be examined only by female physicians when they are sick. The social and cultural constraints on women mobility and their income and wealth, women time burden, and limited information about their health, needs and rights; men's control over all decision making as well as health budget and local perceptions of illness and local treatment norms inevitably renders pre-natal and postnatal care for mothers and children externally controlled. However, Ochiawunma (2002) documented that educated women are more likely to identify a problem; report a problem and seek medical care. Corroborating, educated women are better able to break away from tradition to utilize modern means of safeguarding their own health and that of their children than those with little or no formal education (Caldwell and Caldwell, 1988; Cleland, 1990; Jegede, 1998; Metiboba, 2004).

**Immunization**

Immunization is corner stone and the most cost effective strategy for childhood disease prevention. However, it is widely believed that that Nigeria’s immunization programme is the most costly with the worst coverage in the African Sub region. Caldwell and Caldwell, 1988; Bicego and Boema, 1999; Govindasamy and Ramesh, 1990 agree that children are dependent on their mother for all aspects of survival. Mother’s skills; beliefs and social conditions plays important roles in child survival as local perceptions, service factors, structural barriers and low level of community participation are partly responsible for low immunization coverage in Nigeria. The NDHS (2008) report indicating that mothers of unimmunized children complained of fear of side effects, health post too far away and ignorance of immunization days are vocal testimonies of the socio cultural externalities bedeviling immunization coverage in Nigeria.

Providing a lease, the Nigerian Health Review (2006) reported that the proportion of children not immunized at all decreases from 41% among illiterate mothers to 18% in mothers with primary education to a low level of 8% in mothers with secondary education. In a similar trend, Author’s finding (2011), in Kogi East Senatorial District of Kogi State, Nigeria, indicates that immunization coverage decreases from 95% points among mothers with tertiary education, through 83% and 37% points in mothers with secondary and primary education respectively; to a low level of 23% points in mothers with no formal education.

**Nutrition**

Nutrition is the relationship between food and the delivery of micro-nutrients required for normal functioning of the body. The physical and chemical composition of the soil as well as weather and climatic conditions determines the quality and quantity of food available to the population with which the staple food is determined. Similarly, culture which is intricately linked with the environment determines food preferences and preparation practices (Huff and Klinne 1999). Lending credence, Ochiawunma (2002) noted that in some tribes, colostrums is not fed to new born babies because it is believed to be dirty, the tendency to with hold protein rich foods such as eggs, and chicken from infants and pregnant mothers because of the misconception that it will encourage children to steal latter in life. Child and mother’s nutrition is bound by these socio cultural externalities resulting in malnutrition with implication for poor maternal and child survival outcomes.

Unveiling a point of advantage; UNICEF (2010) argues that education of girls is the key to health and nutrition of populations; to overall improvements in the standard of living, to better agricultural and environmental practices; to higher Gross National product and to greater involvement and gender balance in decision-making at all levels of the society. Lending credence, Kannani (2010) unveils that educated women are quick to adopt proper feeding practices and rise above obnoxious cultural believes for them selves with implications for their children.

**Disease prevention and treatment**

Park (2007) documented that environmental factors play important roles in determining morbidity and mortality in children. He noted that tetanus infection, diarrhea, pneumonia and other bacterial, viral and parasitic infection are common with children exposed to unsanitary and hostile environments. The report added that these conditions depend on ecological conditions, home, and family hygiene, the extent to which they come in contact with earth, water and above all adults and other children. Insufficient supply of safe water, inadequate disposal of human excreta and other waste, an abundance of insects and other disease vectors are among the environmental factor continuously menacing family health in Nigeria.

In another dimension, The Nigerian Health Review (2006) documented that there are deeply rooted belief systems that attribute disease and illness to supernatural forces (spiritual forces). These results in seeking help from spiritualists, which lead to delays in seeking appropriate care a situation Metiboba (2008) describes as shopping for treatment with the implication for worsening the condition of ailments. In some
communities, cow dung is used to dress the umbilical cord stump in neophytes resulting in high risk for neonatal tetanus, children have had part of their bodies roasted in fire as remedy for febrile convulsion; and native concoctions are administered in some circumstances resulting in liver failure and death in children. The report also added that Nigerian health systems are characterized by dearth of adequate and accessible health services, decaying infrastructure, chronic drug shortage, poor quality service, poor staff attitude, and official bureaucracy with negative implication for medical service utilization crucial to maternal and child health.

However, Education helps to form the attitude to practice manners of hygiene; educated women tend to marry educated men, live in cities and have access to piped water, sanitation and decent housing. They have access to the Mass- media: television, radio, newspapers, magazine and the internet (Kannani, 2010). These services are potent tools for unraveling the etiology of diseases as well providing useful information about the changing trends of diseases towards effective health and illness behavior. A research by the author in 2011 on the utilization of Oral Rehydration Salt by nursing mothers indicates that utilization decreased from 91% points among mothers with tertiary education through 70% and 22% of mothers with secondary education and primary education respectively, to an abysmal level of 7.5 % in mothers with no formal education.

**Criticisms of locus of control**

Locus of control is encapsulated in the belief that people should accept responsibility for their actions. This model is founded on the belief that people should be lauded or blamed for their actions. These beliefs negate belief in the influence of favorable environment for effective social actions actions.

Taking responsibility for actions often encourage people to blame victims. It is on the basis of this attitude that a social critic Wendy Kaminer derides the anti social strain of the positive thinking/ mind-cue tradition which holds that compassion is a waste of psychic energy. In the light of this assumption, high risk pregnancies, infertility, abortion etc are blamed on victims without recourse to socio- environmental factors that are external to the victim.

Another critic of locus of control model demonstrates that they perceive personal development as selfish. According to Barbara Erenreich, why spend so much time working on one’s self when there is so much real work to be done? They argued that time spent meditating; saying affirmations taking workshops could be better spent helping others. Conversely, psychologists agree that those who engage in personal development are more compassionate with the poor (Edgar, 2010). In another dimension, internals can be unhealthy and unstable in an unstable environment like Nigeria. If they lack competence, efficacy and opportunity, they can become neurotic, anxious and depressed. Hence favorable environment is indispensable for efficiency of those with internal locus of control. Locus of Control is amenable to the inevitabilities of changing social circumstances across different social strata.

In spite of these criticisms, locus of control model provides ample opportunities for investigating who assumes responsibility for decisions on preventing diseases and promoting the health of mothers and their children towards achieving the Millennium Development Goals (MDGs) on Maternal and Child Health before 2015.

**SUMMARY AND CONCLUSION**

This paper is an attempt to apply the locus of control model of health to maternal and child health (MCH) challenges in Nigeria. Locus of control is a health model used by health practitioners to measure whether clients are likely to take actions on their own or influenced by chance or powerful others. The paper has shown that utilization of maternal and child health (MCH) services are largely externally controlled in Nigeria. Consequently, there exist avalanche of problems manifesting in high risk pregnancies and low utilization of maternity services with implications for maternal and child morbidity and mortality; poor immunization coverage resulting in wide spread existence of vaccine preventable diseases with mortality implications; and poor cognitive, affective and effective development of survivors; ineffective child feeding practices resulting in malnutrition which is implicated for 50% of all child deaths; and poor attitude towards prevention and effective treatment of diseases.

The reviews above indicates that the locus of health behavior of women and their children is to a large extent influenced by inherent Social values, cultural norms and economic factors. In Specific terms, education level, cultural values, environmental factors, influence of relations, spouse decision and religious factors are external loci menacing reproductive health in Nigeria.

However, available findings affirm the postulation of Clelland (1990), who avers that education empowers a woman in the contexts of instrumentality, social identification and confidence. Therefore, it is justified that education provides women with the levers to rise above the negative socio cultural, environmental and economic externalities; and to take appropriate steps towards preventing diseases but enhancing their health and that of their children.

**RECOMMENDATIONS:**

In consonance with the findings of this study, the following short and long term recommendations as well as implementation strategies are germane for the achievement of the Millennium Development Goals 4, and 5in Nigeria.

First, there is a need for increased access to education
among women through: The incorporation of adult education as an appendage of the universal basic education programme (UBE) with emphasis on family life education and certification at the end of the course; provision of gainful employment for successful candidates as a means of women empowerment and motivation; and providing education that is free, compulsory and attractive for women at primary and secondary levels of education. Second, this study also calls for improvement in access to maternity care through: Provision of free obstetric and pediatric care at all levels of health care in all areas of the country, provision of free nursing education in all parts of the country for interested candidates for at least a period of six years; and consequent posting of the certified nurses to all Primary Health Care centers in the country.

REFERENCES