

SOCIO-ECONOMIC STATUS AND WOMEN'S HEALTHCARE UTILIZATION: A STUDY OF SELECTED AREAS INNIGERIA

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ABSTRACT

Literature bordering on women's health care utilization in relation to their socio-economic status (SES) and other socio-cultural factors abound. However, while these studies have been carried out in different places across the globe under varying social conditions, and particularly on maternal mortality and morbidity issues, little is still known about the effects of SES on women's health care utilization in Nigeria. Consequently, this study described women's beliefs about the effects of socio-economic status in their utilization of health care services in Lokoja and Dekina Local Government Areas of Kogi State, Nigeria. By means of a probability multistage cluster sampling procedure and a purposive sampling method, we selected five hundred and ninety two respondents for the survey and sixteen respondents for the Focus Group Discussions. Following analyses of data, it was revealed that education, occupation and income impact on women's decision, quality of treatment, frequency of visits to the hospital, length and duration of hospital stay, time of visits to the hospital, and the type of health facilities visited. Also, the women in the study sample reported that they utilize health care services most frequently during the incidences of chronic disease like hypertension, diabetes, etc in the past six months compared with other incidences of illnesses and diseases. The study therefore recommends that women's socio-economic standing must be improved by workable policies that are aimed at improving their chances in the socio-economic ladder in order for them to fully maximize the opportunities inherent in the utilization of health care services.

Keywords: health care, women's health, utilization, Nigeria, socio-economic status.

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INTRODUCTION

This study attempted to describe women's beliefs about the effects of socio-economic status in their utilization of health care services in Lokoja and Dekina Local Government Areas of Kogi State, Nigeria. Literature bordering on women's health care utilization in relation to their socio-economic status (SES) and other socio-cultural factors abound, however, while these studies have been carried out in different places across the globe under varying social conditions, and particularly on maternal mortality and morbidity issues, little is still known about the effects of SES on women's health care utilization in all illness episodes in Nigeria. Although, some scholars (e.g., Currie, 2005; Hulka and Wheat, 1985; Owens, 2008; Redondo-Sendino, Guallar-Castillon, Banegas, and Rodriguez-Artalejo, 2006) have argued that women utilize health care services more than men, the question of whether the level of service is adequate to women's need is less clear, yet others (e.g., Coimbra et al., 2007; Owens, 2008; Pillai et al., 2003) have maintained that the quality and the levels of women's health care utilization is largely dependent on their SES and other socio-cultural factors, which influences them.

The relationship as well as the effects of SES on women's health care utilization has been investigated in a number of studies. For example, studies (e.g., Azuh, Fayomi and Ajayi 2015; Bredensen, 2013; Chakraborty, Islam, Chowdury, Bari, and Akhter, 2003; Halle-Ekane, et al., 2014) have found that women's level of education has a significant effect on their health care utilization. As opposed to the foregoing, Ochako, Fotso, Ikamari, and Khasakhala's (2011) in a cross-sectional study conducted in Kenya, found a seemingly counter-intuitive effect of education on early antenatal utilization. However, fewer sub-Saharan African studies examining the effect of education on utilization exist; those that do, find that the relationship between educational status and health care utilization is not simple; (Swedo, 2012) thereby making the understanding of the effects of education on health care utilization a complex one.

Regarding women's level of occupation and its effects on health care utilization, Shah and Belanga (2011) found out in their study that women who work are less likely to utilize health care services during illness episode—a contrasting discovery to evidences from other studies (Bredensen, 2013; Redondo-Sendino et al., 2006)—showing that the level of healthcare utilization increases as women advance in their line of work (career). Yet studies like that of Mamurnur and Antai (2014) have found the effect of occupation on health care utilization to be inconclusive. As for income, studies (e.g., Buor, 2003; Mackenbach and Howden-Chapman, 2003; Månsdotter, 2006; Taffa and Chepngeno, 2005) have revealed that women's level of income positively influence their level of health care utilization, while other studies from the developing countries have found negative effects of income on women's health care utilization (Geda and Shimeles, 2009; Mwabu, 2009). To this end, several studies have attempted to examine the

effects of education, occupation and income on women's health care utilization. In finding out these effects however, there exist contrasting evidences as to the impacts of these variables on health care utilization. As a result, the effects of education, occupation and income on women's health care utilization are poorly understood and thus may have a serious implication for intervention programme and policy recommendation.

As for the study areas of this research endeavour, Lokoja and Dekina LGAs of Kogi State, there is a dearth of literature on the levels of health care utilization by women. Even though very few studies (e.g., Akande and Owoyemi, 2009; Eze and Adhure, 2014) have identified the importance of education, income and other socio-cultural factors (that are peculiar to women in these areas) influencing health care services such as family planning and other health challenges, none of these studies have measured health care utilization by women and none has also examined the effects of SES on health care utilization. This situation reflects a huge epistemological and methodological gap and therefore deserves a pressing investigation.

Nevertheless, although literature that are foreign to the social cultural experiences of Lokoja and Dekina women abounds on SES, local research examining its effects on health care utilisation in Lokoja and Dekina is almost non-existent. This present study is therefore designed to achieve the following: (1) determine the level of health care utilization by women in Lokoja and Dekina Local Government Areas of Kogi State; (2) examine women's beliefs about the effects of their educational, occupational and income levels in the utilization of health care services in Lokoja and Dekina Local Government Areas of Kogi State. It is also imperative to note that knowledge of the effects of SES on the utilization of healthcare by women in Lokoja and Dekina LGAs is valuable for improving intervention programmes aimed at enhancing the quality of healthcare use, and can help to inform the decision-making of policy-makers on women's health. In all, the statement of the problem of this study put in form of a question is: "What are the perceived effects of SES on health care utilization by women in Lokoja and Dekina LGAs of Kogi State?"

THEORETICAL BACKGROUND

The behavioral model of health (BM) as propounded by Andersen M. R. in 1968 is most valuable in the understanding of the perceived effects of socio-economic status in the utilization of health care services by women (see for discussion Majaj, Nassar and Allegri, 2011), and because it is widely documented and used to determine predictors of access to health care (Hogan et al., 2012), it was applied to the study. The BM is hinged on the following assumptions:

- **Predisposing factors:** these includes demographic characteristics of gender, marital status, age and sex as biological necessities; 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 health services and health).
- **Enabling Factors:** these include financing factors such as income and wealth at individuals' disposal, which enables them to pay for health services and the effective price of health care or the quality of health care; which is determined by individuals' health insurance status. Financing here covers per capital income, affluence, the rate of health insurance coverage among others.
- **Need factors:** at the individual level Andersen and Newman (1973) differentiate between perceived need and evaluated need. The perceived need include how people view and experience their own general health, functional state and illness symptoms. And evaluated need refers to professional assessment and objective measurement of patients' health status and need for medical care.

This model identifies education and occupation as one of the factors under the predisposing characteristics that determine the use of health care access and utilization. These demographic positions according to Andersen equip individuals' belief and consequent utilization of health services (Rebhan, 2008) – this part carefully delineates the vantage point that education and occupation occupy in the life of women as they utilize health care services. Also, income as part of the key variables in the study, falls in the second category (enabling characteristics) upon which health care utilization is premised as it includes resources found within the community and the family (Rebhan, 2008) – here income has the capability of directing not only where health care is available but the quality of health care services utilized by women. The need based characteristics also includes the perception of needs for health services which leads to the actual utilization of health care services.

METHODOLOGY

Research Design

A cross-sectional, descriptive survey and exploratory qualitative methods were employed in eliciting data for this study. Survey is often a suited method for descriptive, explanatory and exploratory purpose (Babbie, 2013; Bhattacharjee, 2012; Haralambos and Holborn, 2013) and hence this study described women's beliefs about the effects of socio-economic status in their utilization of health care services in Lokoja and Dekina Local Government Areas of Kogi State.

Additionally, qualitative exploratory method was considered appropriate for the study (see Babbie, 2013; Shank, 2002 for discussion).

The study areas for this research are Lokoja and Dekina Local Government Areas of Kogi State. Lokoja with an estimated land mass of 3243.323 sq. km (National Population Census, 2010) is located between latitudes $7^{\circ}46' N - 7^{\circ}52'$ and longitudes $6^{\circ}38' E - 6^{\circ}46'$ and shares boundaries with Kabba-Bunnu, Okehi, Adavi, Kogi, Ajaokuta and Bassa LGAs of Kogi State (NPC, 2010). Lokoja has one federal public tertiary health facility, seven public state secondary health facilities, 26 Primary Health Centre (PHC) and 25 private health facilities making a total of 59 health facilities. The choice for this area was influenced by the fact that majority of the women play significant role in the economic activities of the area as traders, civil servants, teachers, health workers and so forth.

The second area of this study, Dekina LGA, falls between latitude $6^{\circ}.33'$ and $8^{\circ}.44'$, and longitude $5^{\circ}.22'$ and $7^{\circ}.49'$ (Adejo, Idoka and Adejo, 2013). Dekina shares boundaries with Ofu, Olamaboro, Anpka and Omala LGAs of Kogi State (NPC, 2010). Also Dekina has seven public state secondary health facilities, 100 PHCs and 15 private health facilities, totaling 122. The choice for this area was influenced by the fact that a preponderance of women play essential and dynamic roles in the rural economies of the area, being actively involved as small scale farmers who engage in crop (such as yam, maize, cocoa yam, cashew and palm oil production) and animal production for domestic and commercial purposes, traders, teachers and so on. The population of this study is given as the 225, 072 working women, aged 18 years and above in the study areas.

Sample Size and Sampling Procedure

The sample size for this study was 601. With 95 percent level of confidence (confidence interval $\pm 10\%$), an estimated level of health utilization by women at 50% (.5) and a permitted margin of error at .04 (4 percentage points), we determined the 601 sample size with the Cochran (1963, 75) formula:

$$n = \frac{[Z/2]^2 (p q)}{e^2} \quad n = \frac{[Z/2]^2 (P) (1-P)}{e^2}$$

Where: n = sample size, Z^2 = confidence level, p = rate of occurrence or prevalence (the estimated proportion of an attribute that is present in a population), q = complement of p and e = margin of error. Therefore;

$$n = \frac{[1.96]^2 0.5 (1-0.5)}{0.04^2} \quad n = \frac{3.8416 (0.25)}{0.0016n = 600.25. = 601.}$$

Furthermore, a proportional stratified sampling method of each population was employed for a possible modification of the 601 sample size above. The stratification variable here was geographical location.

Table 1

A proportionate stratified sampling for Lokoja and Dekina LGAs

Geographical Location	Population	Proportionate Stratified		
Lokoja	95498	42.4	255	42.4
Dekina	129574	57.6	346	57.6
Total	225072	100	601	100

Source: Survey (2016)

It should be noted that of the entire 601 questionnaires that were administered to respondents in both Lokoja and Dekina Local Governments areas of Kogi State, 592 (98.50%) were returned. The 592 respondents and the 16 other FGD participants served as the final source of data for the study. At this point, we adopted a probability multistage cluster sampling procedure. The reason for this was because of the unavailability of a sampling frame that contains the lists of women in the areas of study hence the technique is best suited for this circumstance as Babbie (2013, 153) succinctly averred that multi-stage cluster sampling “may be used when it’s either impossible or impractical to compile an exhaustive list of elements composing the target population.” This was a three stage sampling approach. We began the first stage by stratifying Lokoja and Dekina LGAs on the basis of residential differences, dividing the two areas into 31 and 24 residential zones respectively.

At the second stage, we employed a systematic sample with a random start to select a sub sample of 5 residential zones in Lokoja and 7 residential zones in Dekina (making 12 zones in all). The justification for the chosen numbers was to encourage adequate representation in the two areas. In doing this, we selected randomly one zone from each frame after which every K th (i.e., every 6th and 3rd respectively) (where sampling interval, $K = N/n$) elements (zones) were systematically selected. From the 12 zones that were systematically selected, the third stage began. This kick-started with a design of a workable list of households out of the 12 zones that were selected and subsequently, 50 households each were selected by a means of simple random sampling, from each of the 12 zones. This amounted to 600 households in all (one household was also purposively added from Ajara residential zone in Lokoja). In the end, each of the households that were selected produced women sampled respondents for the study in the two areas.

As for the other sample size (16 women) who served as participants in the FGDs, the selection technique adopted was a non-probability purposive sampling. Eight participants (4 with a skilled occupation and the other 4 with unskilled occupation) were selected in both areas of study based on the following inclusion criteria: (1) ownership of at least some primary school education or skilled in trading (2) have a job or profession (3) earn some form of income (4) willingness to participate and (5) an indigene of Kogi State.

Instrument for Data Collection

A semi-structured questionnaire instrument of two sections was employed for the present study. We also employed scales and measurement tests as a supplementary tool for this study. In this case, we adapted a self-reported Stanford Patient Education Research Center Health Utilization Scale ("SPERCHUS") developed by Lorig et al. (1996) which was modified into a 13 item scale and was included in the second section of the questionnaire instrument. The internal consistency of the "SPERCHUS" was conducted in order to ascertain the reliability of the scale. Cronbach's alpha (α) for the "SPERCHUS" items was .96 (96 percent) and was found to be highly reliable. As for the qualitative aspect, the focus group discussion (FGD) guide was employed to elicit data from participants. The guide contained the purpose for the study, ground rules for participants and open ended questions that guided the discussions in both areas of study.

Administration of Instruments

In the administration of the questionnaire instrument, we specifically trained six volunteers (on data administration process), while three of them (residents of Dekina LGA) helped in the distribution of questionnaire to respondents in Dekina, the remaining three (residents of Lokoja LGA) helped in the distribution of questionnaire to respondents in Lokoja area. Under our supervision, this stage of the research endeavor lasted for a period of 2 weeks and the first three days were slated for distribution and retrieval of questionnaire in Dekina from Monday to Wednesday (from 10am to 5pm). Meanwhile questionnaires that could not be retrieved within this three day period later retrieved within the following days (Thursday to Saturday) within the same time frame. Next, within the same 6 day period and time frame of the second week, volunteers in Lokoja under the supervision of the researchers undertook the exact process that was carried out in Dekina LGA in the previous week.

Also, a combination of two FGDs was conducted in the areas of study. The FGD sessions took place in both areas of study and thus comprised of eight women (4 with a skilled occupation and the other 4 with unskilled occupation) each in both areas of study. The discussions were held in public places that were approved by selected participants in both areas of the study.

Method of Data Analysis

A combination of quantitative and qualitative methods of data analysis was used for this study. We utilized an interpretative phenomenological analysis (IPA). The aim of this tool according to Smith and Osborne (2007) is to "explore in detail how participants are making sense of their personal and social world" (53). This design was employed due to its capacity of eliciting in-depth understanding of the research topic. In order to identify themes from the data that were collected, key words and phrases, repetition of concepts and ideas (recurring ideas), indigenous

categories, and metaphors and analogies (Ryan and Bernard, 2003) were employed. Furthermore, descriptive statistics was used to describe women's beliefs about the effects of socio-economic status in their utilization of health care services in the study areas. Specifically, simple percentages and central tendency measures were employed. Graphs and charts were also used to describe some aspects as they are best suited for visual representation. These two methods of data analysis complemented each other at this stage of the research work.

RESULTS

Health Care Utilization by Sample of Women in the Study Areas

Table 2

Health Care Utilization by Sample of Women in Lokoja and Dekina Local Government Areas of Kogi State

S/N	Level of Health care Utilization (n/%)	N	M(SD)	95%CI
1	Minor illnesses like headache or cold 0=never 139 (23.5%) 1=once 204 (34.5%) 2=twice 111(18.8 %) 3=three times 73(12.3%) 4=four times 45(7.6%) 5=five times and more 20(3.4%)	592	1.56(1.35)	[1.45, 1.67]
2	Injury 0=never 152 (25.7%) 1=once 171 (28.9%) 2=twice 99 (16.7%) 3=three times 105 (17.7%) 4=four times 43 (7.3/%) 5=five times and more 22 (3.7%)	592	1.63(1.41)	[1.52, 1.75]
3	Menstrual related problems like stomach ache, etc 0=never 239 (40.4%) 1=once 193 (32.6%) 2=twice 72 (12.2%) 3=three times 53 (9.0%) 4=four times 17 (2.9%) 5=five times and more 18 (3.0%)	592	1.10(1.27)	[1.00, 1.21]
4	Chronic disease like hypertension, diabetes, etc 0=never 13 (2.2%) 1=once 81(13.7%) 2=twice 102 (17.2%) 3=three times 108 (18.2%) 4=four times 110 (18.6%) 5=five times and more 178 (30.1%)	592	3.28(1.49)	[3.15, 3.39]

5	Clinical tests for breast lumps or ovarian, cancer, etc. 0=never 341 (57.6%) 1=once 127 (21.5%) 2=twice 61 (10.3%) 3=three times 48 (8.1%) 4=four times 12 (2.0%) 5=five times and more 3 (.5%)	592	.77(1.10)	[.68, .86]
6	Check ups 0=never 162 (27.4%) 1=once 229 (38.7%) 2=twice 67 (11.3%) 3=three times 108 (18.2%) 4=four times 8 (1.4%) 5=five times and more 18 (3.0%)	592	1.37(1.26)	[1.26, 1.47]
7	Depression 0=never 187 (31.6%) 1=once 202 (34.1%) 2=twice 96 (16.2%) 3=three times 53 (9.0%) 4=four times 18 (3.0%) 5=five times and more 36 (6.1%)	592	1.36(1.39)	[1.25, 1.47]
8	Family planning 0=never 159 (26.9%) 1=once 207 (35.0%) 2=twice 108 (18.2%) 3=three times 56 (9.5%) 4=four times 37 (6.2%) 5=five times and more 25 (4.2%)	592	1.46(1.36)	[1.35, 1.57]
9	Pregnancy related visits (e.g., antenatal visits or complication, etc) 0=never 203 (34.3%) 1=once 156 (26.4%) 2=twice 90 (15.2%) 3=three times 85 (14.4%) 4=four times 26 (4.4%) 5=five times and more 32 (5.4%)	592	1.44(1.46)	[1.33, 1.56]
10	Medication visits and hospital admission 0=never 136 (23.0%) 1=once 146 (24.7%) 2=twice 93 (15.7%) 3=three times 94 (15.9%) 4=four times 80 (13.5%) 5=five times and more 43 (7.3%)	592	1.94(1.59)	[1.81, 2.07]
11	Surgery related visits 0=never 158 (26.7%) 1=once 158 (26.7%) 2=twice 130 (22.0%) 3=three times 45 (7.6%) 4=four times 77 (13.0) 5=five times and more 24 (4.1)	592	1.66(1.48)	[1.54, 1.78]

12	Visits for eye problems 0=never 310 (52.4%) 1=once 166 (28.0%) 2=twice 65 (11.0%) 3=three times 30 (5.1%) 4=four times 9 (1.5%) 5=five times and more 12 (2.0%)	592	.81(1.12)	[.72, .91]
13	Visits for oral health problems 0=never 253 (42.7%) 1=once 156 (26.4%) 2=twice 85 (14.4%) 3=three times 57 (9.6%) 4=four times 22 (3.7%) 5=five times and more 19 (3.2%)	592	1.15(1.34)	[1.04, 1.26]

Source: Survey (2016)

Note. CI= confidence interval, M=mean, SD=standard deviation, N=Total number of sample, n (%) =sub-sample of items and percentages.

Percentages and Measures of central tendency were computed to summarize the data for the self-reported health care utilization by a sample of women in the areas of study. Result from Table 2 revealed that majority of the women in the study sample reported that they utilize health care services most frequently during incidences of chronic disease like hypertension, diabetes, etc. in the past six month. On the other hand, regarding health issues such as illnesses and cold, injury, menstrual related problems like stomach ache, etc., check-ups, depression, family planning, pregnancy related visits (e.g., antenatal visits or complication, etc.), medication visits and hospital admission, surgery related visits, and visits for oral health problems, the self-reported health care utilization scores showed that women visit less frequently for the aforementioned reasons. Additionally, health behaviors like clinical tests for breast lumps or ovarian, cancer, etc., and visits for eye problems had the lowest score on the health care utilization scale by women. This result indicates that in the past six month, women in the study areas mostly do not utilize health care services during experiences of most health issues except during incidences of chronic disease like hypertension, diabetes, etc. This may partly be due to the fact that such health conditions as diabetes and hypertension are perceived as life threatening and can also serve as risk factors for more severe chronic and acute disorders, hence the women's high score on the health care utilization scale.

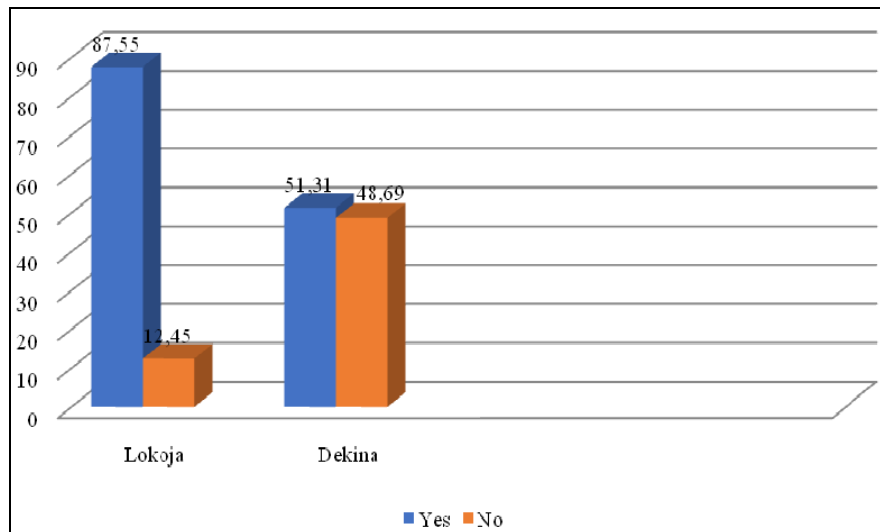


Figure 1. Women's Belief on the Influence of Educational Levels on Their Use of Health-Care.
Source: Survey (2016)

As shown in Figure 1, respondents were asked whether they believe that their level of education can influence the way they use health care services, 87.55% of women in Lokoja and 51.31% of women in Dekina affirmed that they believe that their level of education can influence the way they use health care services. On the contrary however, 12.45% in Lokoja and 48.69% in Dekina believe otherwise. This result suggests that more women in Lokoja than Dekina believe that education could impact on health care utilization of women. On the whole, this result (Figure 1) is indicative of the fact that a preponderance of women in the study area sees a linkage between their educational levels and health care utilization.

In order to further test the ways in which education can influence women's use of health care services during sickness in the study areas, a multiple response question was attempted by the sample of women who believe that the level of education can affect health care utilization. Table 3 shows the distribution of respondents via ways in which education can influence health care utilization by women in the study areas.

A thorough look at this list of multiple items (see Table 3) reveals that the quality of treatment appeared in almost all the categories of items that were provided. Therefore, this suggests that the quality of health care use is closely understood, by the respondents, as a product of women's level of education. As for respondents who gave other ways in which educational levels influence health care utilization, a further assessment of their choices reveals that cost, insurance, demand for certain kind of treatment at the hospital, the course of redress when and after women's right have been abused in the hospital and perception of women (patients) who utilize health care services are important.

Table 3

Distribution of Respondents by the Ways in which Women's Level of Education Can Influence Their Use of Health Care Services.

	Multiple Items Chosen by Respondents	Lokoja(%)	Dekina(%)	Total(%)
1	Decision to go or not to go, Frequency of Visits, Time of Visits, quality of treatment and "others"	32(14.68)	40(22.73)	72(18.3)
2	Frequency of visits, decision to go or not to go, time of visits, and quality of treatment	53(24.31)	30(17.05)	83(21.1)
3	Time of visits, quality of treatment, and "others"	44(20.18)	25(14.20)	69(17.5)
4	Quality of treatment, and frequency of visits	48(22.02)	27(15.34)	75(19.0)
5	"Others" and quality of treatment	27(12.39)	35(19.89)	62(15.7)
6	I can't really say	14(6.42)	19(10.79)	33(8.4)
	Total	218(100)	176(100)	394(100)

Source: Survey (2016)

In reaffirming these findings, a FGD participant in Dekina LGA noted that:

Education is very crucial to how women view their bodies, illnesses and disease which in turn determines how well women visit the hospital and most importantly, the quality of hospital visits. By quality, I mean having the ability to always ask questions for clarification and avoiding complications that may be caused by ignorance (female, 27 years, Nurse in Dekina Local Government Area).

This position as given by this participant suggests the vital role education can play in informing the perception women have about their body as well as frequency and quality of health care services. This quality as defined by the participants is what Andersen, Rice, and Kominski (2007) refer to as the *effective price of health care*. In other words, quality refers to the process of getting in return more or the exact amount of health care that is being paid for. This according to the data from this participant can be influenced by women's level of education. Although, Andersen's work linked income with quality of health care, the present study also finds a perceived link between education and quality of health care.

However, there was a counter-intuitive opinion from a FGD participant in Lokoja LGA who expressed her personal view that education means nothing to a woman. By means of interpretative phenomenological analysis (IPA), a theme of surrounding "gender and education in health" emerged. Specifically, she shares a perspective that:

Whether women are educated or not, there are strong socio-cultural factors which make the purpose of education in this direction useless, most especially for married women. It is as if we hang our thinking caps to our husbands only as decisions regarding hospital visits for any reason must be

sanctioned or approved by the men. For me personally, I can only visit the hospital whenever my husband is around; if he travels or anything, I stay at home no matter how serious it is (female, 41 legal practitioner, Lokoja LGA).

Another participant then corroborated this perspective by narrating a personal experience:

I sustained a skin burn by boiling water recently and as a result I did not allow anyone to take me to the hospital until my husband came. So, it is not about how educated I am; I have been trained from time not to take such decisions without my husband's approval or presence (female, 22 years, senior secondary school certificate, and trader in Lokoja LGA).

The opposing responses given above are indicative of the fact that the level of a woman's education does not lead to corresponding health care utilization. In other words, beyond whatever level of education one must have acquired, gender (i.e., being a woman) is a primary, superior and most importantly, a determinant of health care utilization. This perhaps explains why some social, biological and psychological experiences that come with womanhood are seen as conditions, in which women themselves are incapable of treating or taking care of, hence the emotional dependence on their husbands or any male figure in the household for health care utilization. It could therefore be argued that education within this context does little in empowering women to seek health care. This in the participants' view is caused by socio-cultural factors out of which marriage is key to the understanding of women's health care utilization and therefore not only makes the link between a woman's education and health care utilization unobservable, but also redundant. The position for instance confirms Swedo's (2012) assertion that the relationship between educational status and health care utilization is not simple within the sub-Saharan African context.

Just as in the previous Figure (1), Figure 2 shows whether women believe that the type of job or occupation by women can influence the use of health care services. Following analysis of the obtained data, it was revealed that a sheer majority of the entire respondents (89.56% of sampled women in Lokoja and 92.42% of sampled women in Dekina) are of the opinion that the type of job they do can influence their health care use. On the other hand however, the remaining respondents (10.44% of the sampled women in Lokoja as against 7.58% of the sampled women in Dekina) have a contrary view. The choice of the overwhelming majority leaning towards the affirmation that occupation type can influence health care utilization by women is suggestive of the fact that it (type of job) is particularly important in their daily lives and may therefore impact positively or negatively on the use of health care by women.

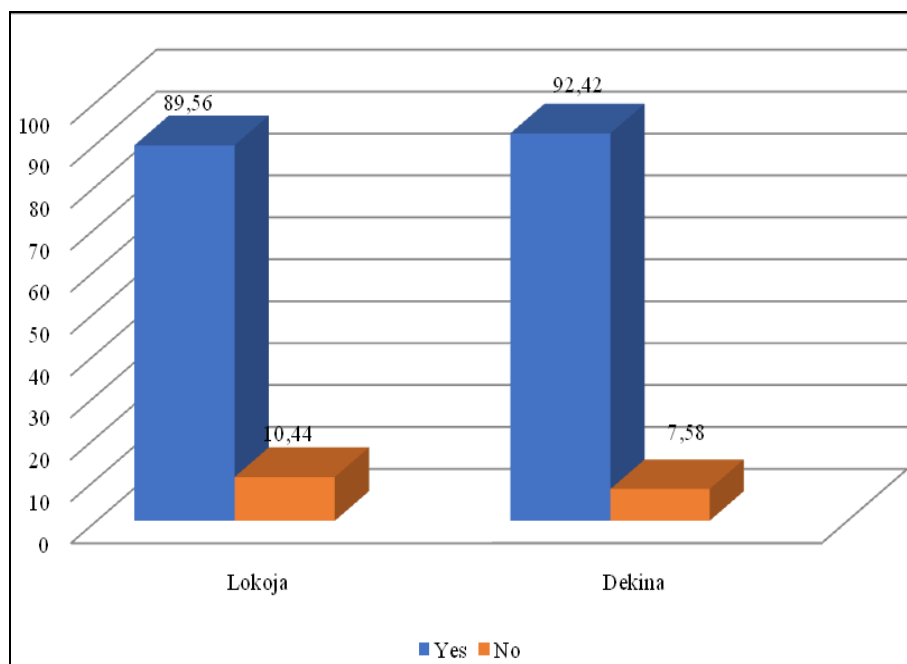


Figure 2. Distribution of Respondents By Belief That Women's Type of Job (Occupation) Can Influence the Way They Use Health Care Services.

Source: Survey (2016)

Table 4

Distribution of Respondents by the Ways in which Women's Type of Occupation Can Influence Their Use of Health Care Services.

Multiple Items Chosen by Respondents	Lokoja(%)	Dekina(%)	Total(%)
1 Time of visit and treatment, Frequency of visits, Quality of treatment, and Length and duration of visits	43(19.28)	46(14.51)	89(16.5)
2 Length and duration of visits, Frequency of visits, quality of treatment	27(12.11)	88(27.76)	115(21.3)
3 Frequency of visits and "others"	92(41.26)	98(30.91)	190(35.2)
4 Quality of treatment and length and duration of visits	28(12.56)	52(16.40)	80(14.8)
5 "Others" and time of visit and treatment, and frequency of visits	32(14.35)	12(3.79)	44(8.1)
6 I can't really say	1(0.44)	21(6.62)	22(4.1)
Total	223(100)	317(100)	540(100)

Source: Survey (2016)

In order to further test the ways in which types of job or category of occupation can influence women's use of health care services during sickness in the study areas, a multiple response question was attempted by the sample of women who believe that the type of occupation can affect health care utilization. Table 4 shows the distribution of respondents via ways in which occupation can influence health care utilization by women in the study areas.

From Table 4 above, it can be observed that respondents' most frequent view suggested a link between the types of occupation a woman engages in and the frequency of her hospital visits during illness episode. In other words, majority of the respondents attributed the number of times they visit the hospital to the nature of their jobs. Furthermore, we took a qualitative approach to understanding the perceived link between and effects of occupation on health care utilization. Consequently, the FGD participants in the study were divided in their views. While some believed that the type of occupation women engage in could influence their healthcare utilization, others had a contrary opinion. To this end, a FGD participant is quoted as saying:

Today, women work outside the home. However, this new development does not take away the fact that women still work to keep the home either as a daughter, daughter in-law or as a wife and mother. These many responsibilities take a huge toll on women's health and personal time to seek healthcare. I know this because, as a mother, there are instances where you work round the clock and even when you are feeling sick, you still manage or hide the feelings so as to be able to take care of your kids and get back to work the next day (female, 48 years, primary school teacher in Dekina LGA).

Another FGD participant from Lokoja expressed her view thus:

For certain kinds of very demanding job such as banking, or some other time taking jobs, women may not have time to go for checkups or even cater for their health. They only get a break once in a year. Except for conditions that are life threatening, women doing such jobs may not be able to use healthcare services well (female, 26 years, civil servant with the federal government in Lokoja).

The response from this participant and others who share similar view describes how despite the transition between the times past where women had little or no opportunity to work outside the home to the present times where women have proven their capacity to handle responsibilities outside the home, the reality of being a girl-child or woman within the home increases the responsibilities of work place and therefore serves as a risk factor for illness episodes. However, this position (contrived life style) tends to push some women into a corner where they "fake" sound health or pretend that they are healthy all for the sake of their children. On the whole, this type of experience impacts significantly on the extent

or level of their healthcare utilization. For the majority of women who have this experience, they are most likely not to utilize health care services even if it is readily available.

Similarly, in the view of other participants, women who work outside their homes as professionals or who engage in time consuming jobs rarely have time to assess their bodies or health status subjectively; leading to little or no time to visit the hospital. In other words, this type or quality of job impacts negatively on women's health care utilization.

Taken from another perspective, participants believe that high paying jobs lead to a corresponding health care utilization. This can take place in two different dimensions. First, high paying jobs leads to high pay or salary, which eventually helps women (or anyone) to maintain good health or lead a disease preventive life style (e.g., good diet, exercise, regular medical checkup, etc.). Second, it leads to proper health care utilization during illness episode. Here, there is a perceived relationship between occupation (especially, professional or skilled types), income and health care utilization as Stevenson (cited in the American Psychological Association, 2007) posits that higher income provides access to goods and services such as health care, including mental health services. The expression of this FGD participant summarizes it all:

Well I see it this way, if you have a good job and earn good money, you will live well and take good care of your body and there will be no need visiting the hospital and when in fact there is any need, you can afford it because you have a good job. In this manner, your type of occupation may have a lot to do with how well you visit the hospital and how well you are treated (female, 30 years, business woman and student in Lokoja LGA).

The sampled respondents were further asked to confirm whether income could influence women's healthcare utilization. Figure 3 therefore shows the distribution of respondents on this. While the majority (84.97%) of the entire respondents affirmed that indeed income could influence the ways in which women use health care services, the remaining (15.03%) respondents confirmed otherwise. Specifically, 93.98% of sampled women in Lokoja and 78.43% of the sampled women in Dekina affirmed that income has an impact on health care utilization by women.

A look into the separate areas of study showed that more women in Lokoja than in Dekina believe that income level can impact on health care utilization by women. On the whole, this result is indicative of the fact that in providing health care services in most part of the world, Nigeria inclusive, out-of-pocket service is the basis upon which healthcare services is utilized and this has enormous implication on women's health bearing in mind the general low socio-economic status of women especially in a less developed country like Nigeria.

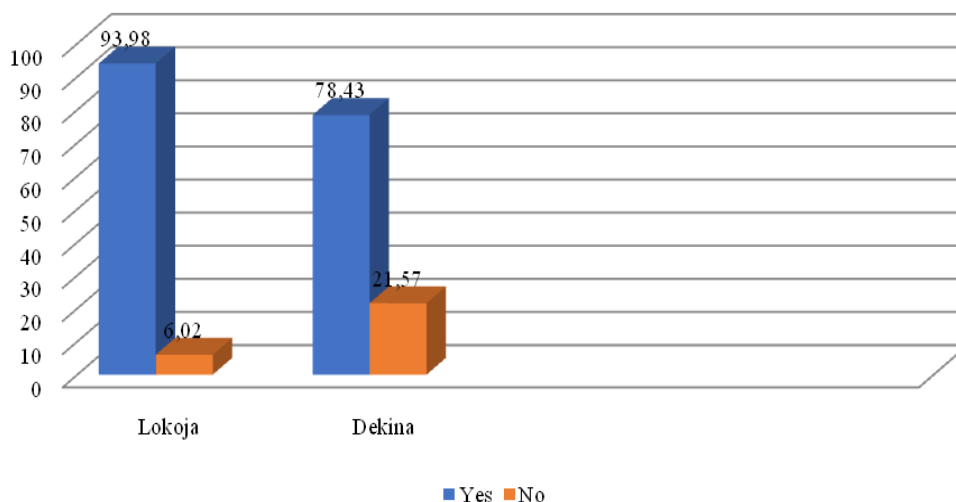


Figure 4. Distribution of Respondents by Belief That Women's Income Can Influence the Way They Use Health Care Services.

Source: Survey (2016)

The above table (5) shows the distribution of respondents as to how income can influence women's use of health care services in the areas of study. More respondents have emphasized on the quality and timing of hospital visits as ways by which the impact of income can be felt in utilizing health care services when the need arises.

This result is indicative of the fact that the quality and timing of consulting health care practitioners during illness episode, will in the view of the respondents measure the effectiveness of the associated link between income and health care utilization.

Table 5

Distribution of Respondents by the Ways in which Income Can Influence Their Use of Health Care Services

Multiple Items Chosen by Respondents	Lokoja(%)	Dekina(%)	Total(%)
1 Quality of healthcare services, and the time to visit the hospital	44(18.80)	68(25.28)	112(22.3)
2 The time to visit the hospital, quality of healthcare services and 'others'	55(23.50)	68(25.28)	123(24.5)
3 The Place to visit for healthcare service	28(11.97)	100(37.17)	128(25.4)
4 'Others'	87(37.18)	21(7.8)	108(21.5)
5 I can't really say	20(8.55)	12(4.46)	32(6.4)
Total	234(100)	269(100)	503(100)

Source: Survey (2016)

Additionally, data gathered from the FGD participants suggests that women who earn better income choose where they intend to receive health care. In support of the above position, a FGD participant opined that:

To get treated, one needs money so I am of the opinion that if women earn more money, or have more education to be qualified to be put in a position where they earn well, it will determine which health facility to go to whenever they have some kind of health challenges. In my own case if I have a bigger salary I would be going to Federal Medical Centre here in Lokoja and not patronizing the patent medicine stores. It is all about money (female, 43 years, Accountant in Lokoja LGA).

On the other hand, the amount of income or money a woman has in her possession may not matter when the kind or severity of disease conditions is considered. This view is strongly shared by a number of women who opined that in severe cases of disease like a metastasized cancer of the breast for instance, a woman is most likely to express fear over the incurable nature of the disease as it is generally believed that preventing it at this level (metastatic stage) is too late and no amount of money can cure it. Put another way, respondents whose awareness' level of incurable conditions is average, women's level of income can go a very long way in employing measures (e.g., medical checkups, etc.) in preventing and lessen the likelihood of occurrence of such incurable diseases. A FGD participant also summarized the perception of the majority thus:

Depending on the nature and severity of the diseases or ill health, the amount of money women earn monthly or yearly may be inconsequential. For instance, for a condition like cancer, no amount of money or income is sufficient to treat this. The only way to by pass this is through awareness, exposure and early detection. Therefore, money can do very little because of the high cost of treatment (female, 51 years health worker in Dekina LGA).

DISCUSSION

This study attempted to describe women's beliefs about the effects of socio-economic status in their utilization of health care services in Lokoja and Dekina Local Government Areas of Kogi State, Nigeria. In doing this, data were obtained from the study's respondents, analyzed and interpreted accordingly. First, regarding the level of health care utilization as reported by the women in the study, result revealed that majority of the women in the study sample reported that they have most frequently utilized health care services during incidences of chronic disease like hypertension, diabetes, etc in the past six months. This result is not surprising because chronic diseases that are associated with life-style and other

risks factors have become increasingly prevalent in Nigeria and therefore compels both men and women to seek healthcare. This thus explains why the majority of women in this study have visited the hospital more for incidences of chronic diseases than any other type of diseases. On the other hand, regarding health issues such as illnesses and cold, injury, menstrual related problems like stomach ache, etc., check-ups, depression, family planning, pregnancy related visits (e.g., antenatal visits or complication, etc), medication visits and hospital admission, surgery related visits, and visits for oral health problems, the self-reported health care utilization scores showed that women visit less frequently. This result is consistent with that of Rendendo-Sendino, Guallar-Castillon, Banegas, and Rodriguez-Artalejo (2006) which found out that women visit the hospital more during chronic health conditions than any other health conditions.

The reason for this outcome is perhaps due to the fact that some conditions or illnesses are considered minor with little or no harm to the body of a woman especially when she is not pregnant. As a result, when a woman feels headache or pains associated with her menstrual period for instance, she finds a way of treating it without going to the hospital, although she may visit the hospital when experiencing excruciating pains associated with such conditions. However, for health behaviours such as check-ups, the women in the study may have never visited or visited less frequently because of the financial implication associated with such health behaviour. In the final analysis, the cost associated with, and the severity of any health issues may serve as impediments to the utilization of healthcare services by women in the study areas. Thus, this result implies that women in this area would only attempt to utilize more of healthcare services when they are faced with life threatening situation than at other times.

As to whether there is a perceived effects of women's educational levels on health care utilization, result revealed that most of the respondents through multiple item responses believed that educational levels of women can impact on the following: frequency of visits, decision to go or not to go, time of visits, and quality of treatment. This result is consistent with findings of Coimbra et al. (2007), Owens, (2008), and Pillai et al. (2003) who maintained that the quality and the levels of women's health care utilization is largely dependent on their SES and other socio-cultural factors in which women find themselves; but contrary to the findings of Ochako et al. (2011) who found a seemingly counter-intuitive effect of education on early antenatal utilization. This goes to show the importance of education on healthcare use as it has been observed to be the foundation upon which other SES (e.g., occupation and income) is premised (Michaelowa, 2000) and ultimately the needed impetus that transforms healthcare information to health care utilization (Aue and Roosen, 2010; Geyer, Hemstro, Peter, and Vagero, 2006; Ivancic, Mirceva and Vreecer, 2008; Lahelma, Martikainen, Laaksonen and Aittomaki, 2004; Lynch and Kaplan, 2000; Mackenbach, Meerding and Kunst, 2007). On the other hand, data from the qualitative analysis suggested that

education may have little to do with women's health care utilization as some women (FGD participants) in the study disregard the importance of education in health care utilization but expressed biological, social, and emotional dependency on their husbands for their health care utilization.

Additionally, analyses of data revealed that the type of jobs women engage in may produce significant impact on the following: length and duration of visits, frequency of visits, and quality of treatment. This result corroborates that of Pebley, Goldman, and Rodriguez (1996) and Stekelenburg et al., (2004) that women with formal jobs were more likely to use healthcare services while other studies found no effect of women's working status or occupation on health care utilization (e.g., Elo, 1992; Toan et al., 1996; Mekonnen and Mekonnen, 2003; Duong, Binns, and Lee, 2004; Chowdhury et al., 2007). One explanation for this outcome still lies in the general belief that women who work outside of home are saddled with dual responsibilities of keeping the family together and staying relevant at work which in the long run impact on the way women respond to their own health. This situation may largely affect women's length and duration of hospital visits, frequency of hospital visits, and quality of treatment received at the hospital during illness episode. Also, result from the FGD showed that for women who do demanding jobs and still manage to attend to compulsory home affairs, healthcare utilization may be challenging. This finding is congruent with the study of Novak (2010) who opined that individuals who are engaged in demanding jobs may have difficulties in maximizing the potentials of healthcare facilities and personnel have to provide.

Lastly, result revealed that the amount of income women earn can influence; quality of healthcare services, the time to visit the hospital and the place to visit for healthcare services. The result from the FGDs also indicated that out-of-pocket health care expenses can only be possible when women earn better income. While contrary to the findings of Larson and Correa-de-Araujo (2005), the present study agrees with studies elsewhere (Buor, 2003; Mackenbach and Howden-Chapman, 2003; Månsdotter, 2006; Taffa and Chepngeno, 2005), which established that women with high income are more likely to use health care more than women with low income in under virtually all circumstances. One explanation for this outcome may not be far from the logical notion that earning enough income translates to better health care utilization and subsequently better health status. Whether this is true or not for women, the reality of the low status of women coupled with the rising cost of healthcare may complicate healthcare utilization for women. Be that as it may, the relevance of regular and substantial income for women cannot be overemphasized in their healthcare utilization experience. Also, the severity of a disease or health conditions can mean a lot for a woman beyond her earnings.

While the perceived effects of SES (education, occupation and income) have been examined in different dimensions, the behavioural model of Andersen has helped in explaining how these measures of SES impact on the health attitudes

beliefs and behaviors of women in the study. For instance, variables or factors (under predisposing factors) such as gender (being a woman), marital status, age, education, occupation, etc have been found to impact on the health belief and attitude as well as the manner of health care utilization in the study. Similarly, Andersen's enabling factors (e.g., income and individual's wealth) have been confirmed by the findings of this study to enable women in utilizing health care. Finally, Andersen's need factors (especially the perceived needs of the women in the area of study) have provided newer insights into how these women view their body, health status and approaches to seeking health care services. However, some aspects of this study's findings contradicts Andersen's behavioral model, suggesting that a woman's education, occupation and or income do not necessarily determine health care utilization.

LIMITATIONS AND CONCLUSION

This study has attempted to describe women's beliefs about the effects of socio-economic status in their utilization of health care services in Lokoja and Dekina Local Government Areas of Kogi State. It is believed that this study is a stepping stone to advancing further research endeavours in the area of women's SES and health care utilization in Nigeria and other places around the world. However, the current study is limited in the following areas, which we hope further research endeavours can help improve upon in future:

1. The validated health care utilization instrument (SPERCHUS) cannot be generalized to ranges of populations except the specific population of the present study. It will therefore be necessary to carry out more validation research on the health care utilization scale (SPERCHUS) or its equivalent, which was adopted in this study in order to understand how women use healthcare services in other areas in this country.
2. Relying on self-report may be misleading in a research of this nature. Reasons being that individuals may experience memory loss, inaccurate references and so forth in reporting their frequency of health care utilization. In order to avoid this type of limitation in future research related to the current subject, More qualitative (such as participant observation of clinical and household experience) studies are encouraged so as to get more insights into the dynamics and factors involved with women's health care utilization as quantitative studies can get little information as to the true nature of SES and other factors that may influence health care utilization by women.
3. In this study, we did not inquire into the perspective of men on the effects of their SES on their wives or women's health care utilization. Although, the women tend to give convincing insights into the subject matter for the

study, getting additional insights from men may have provided further insights into the study. To this end, research could be carried out to compare the nature of health care utilization between men and women as well as how their SES influences their health care utilization or that of the women's.

Based on the results of this study, the following conclusions were reached:

1. Women in the study sample have most frequently utilized health care services during incidences of chronic disease like hypertension, diabetes, etc in the past six months and less frequently visited the hospital for other health issues or needs such as illnesses and cold, injury, menstrual related problems like stomach ache, etc., check-ups, depression, family planning, pregnancy related visits (e.g., antenatal visits or complication, etc), medication visits and hospital admission, surgery related visits, and visits for oral health problems in the past six months. This may be reflective of the reality of the pattern of health care utilization in the parent population, Kogi State.
2. Education, occupation and income impact women's decision, quality of treatment, frequency of visits to the hospital, length and duration of hospital stay, time of visits to the hospital, and the type of health facility to visit. The study therefore recommends that women's socio-economic standing must be improved by workable policies that are aimed at improving their chances in the socio-economic ladder in order for them to fully maximize the opportunities inherent in the utilization of health care services.

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