

Socio-Demographic Correlates of Illness Behaviour Among Pregnant Women in Gboko Local Government Area of Benue State, Nigeria

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Abstract

Illness behaviour has multiple effects on pregnancy outcome of pregnant women particularly in the middle belt areas of Nigeria. This study determined the socio-demographic correlates of illness behaviour of pregnant women in Gboko LGA of Benue state, Nigeria. Using correlational design, a total of 480 pregnant women were sampled and studied. A researcher structured questionnaire with a reliability coefficient of .84 was used for data collection. The illness behaviour of the pregnant women was determined through a correlation coefficient index < 0 = negative relationship; 0 -.009 = No relationship (NR); .01 – .19 = very low relationship (VLR); .20 -.39 = low relationship (LR); .40-.69 = moderate relationship (MR); .70 –.89 = high relationship (HR); .90 -.99 = very high relationship (VHR). All the research questions were answered using Pearson product moment correlation while linear regression analysis was adopted in verifying the null hypotheses of no significant difference at 0.05. The following results were found: there was no significant relationship between level of education ($r = -.009$; $p = .848$), very low mean correlation between occupation ($r = -.042$; $p = .369$); and very low relationship between income ($r = -.087$; $p = .063$) of pregnant women and their illness behaviours. There was very low correlation between socio-demographics and illness behaviours of pregnant women in Gboko LGA. Therefore, health professionals should educate pregnant women and equip them with the necessary skills to face pregnancy-related illnesses with ease.

Keywords: Illness behaviour, Socio-demographic, Correlates, Pregnant Women, Gboko LGA

Introduction

Illness behaviour in pregnancy is a matter of great concern, as it affects pregnancy outcome and has adverse effect on pregnant women. In Nigeria, nearly 20 per cent of all global maternal deaths occur due to pregnancy-related illnesses (World Health Organization-WHO, 2019). The report also posited that a Nigerian woman has a 1 in 22 lifetime risk of dying during pregnancy, childbirth or postpartum/post abortion; whereas in the most developed countries, the lifetime risk is 1 in 4900. WHO (2019) estimated a worldwide number of 295,000 maternal deaths in 2017 from pregnancy related causes and 94 per cent of these deaths occur in the developing countries. Hemabh-Hilekaan, Eka, Maanongun and Unazi (2019) affirmed that Makurdi which shares same state with Gboko LGA is among the places with highest magnitude of maternal deaths in Nigeria. This calls for investigation into the illness behaviours of pregnant women in the area.

The term illness behaviour was first introduced by Mechanic and Volkart, to describe the individuals' ways of responding to their own health (Sirri & Grandi, 2012). Illness behaviour is the term used to describe the way individuals or social groups respond to abnormal body signs and symptoms (Nwankwo & Emerho, 2017). Obviously, this involves issues such as how a pregnant woman monitors her symptoms, takes action and uses the health care system. It includes any behaviour undertaken by an individual who feels ill, to relieve that experience, or to better define the meaning of the illness experience. It equally encompasses both macro and micro social aspects of health-seeking behaviour. In this study, illness behaviour refers to the ways pregnant women respond to illnesses as well as actions taken in order to be relieved from the illnesses and regain health.

Nonetheless, previous research classified illness behaviour into five stages (Suchman, 2005). These include: symptom experience stage, assumption of sick role stage, medical care contact stage, stage of dependent patient role, and stage of recovery and rehabilitation. Illness behaviour in pregnancy is often associated with psychological feeling and attention seeking from husbands and

relatives by the pregnant women. Interestingly, illness behaviour begins prior to the use of services and shapes decisions about whether to seek care and what pathways to follow. With respect to types of illness behavior, some individuals on slight experience of minor physical or mental symptoms turn to the medical care system for help; while others may turn to self-help strategies, faith-based clinics, traditional healers, quacks, among other options. Some others may also decide to dismiss the symptoms or are reluctant to bother themselves with even quite severe problems. It is also possible that the same person over quite a short time-span can react and behave in very different ways. Some people are stoical in the face of illness, and yet others react hypochondriacally. Individuals who when they evaluate their state of health as abnormal or unusual but remain reluctant to seek prompt medical action, are described as having negative illness behavior. Such individuals are often undecided about what to do, or where to go when they experience illness. This is unlike those with positive forms of illness behaviour who promptly attend to illness situations by adopting any of the pathways to health. This suggests that the way individuals, especially pregnant women react to illness varies considerably with time, space, personality type and from culture to culture.

Pregnancy is a normal process, but it may be associated with complications, which may occur as result of hormonal and physiological changes in the body. These changes are not confined on the reproductive organs only but extend to every tissue and organ which responds to the stimulus of the pregnancy metabolic processes. Also, the emotional, chemical and hormonal balances are affected and thus the need for antenatal care services (Hemabh-Hilekaan et al. 2019). Antenatal care provides the enablement of absolute care and supervision of the pregnant woman from the early stage of pregnancy till day of delivery. From the foregoing, it is obvious that pregnancy is associated with illnesses arising from the physiological and hormonal changes which are referred to as pregnancy related illness in this paper.

Pregnancy related illnesses are complaints that are associated with pregnancy. Centre for Disease Control and Prevention (CDC, 2015) defined pregnancy related illnesses as any physical, psychological condition resulting from pregnancy that has an adverse effect on the woman's health. The CDC further identified two types of pregnancy related illnesses to include problems that are caused by pregnancy such as constipation, heart burn, early morning vomiting or morning sickness, hyperemesis gravidarum, among others and existing illnesses which anybody can suffer but they are made worse in pregnancy. These include varicose veins, backache, and waist pain. This study focused on minor pregnancy related illnesses such as nausea and vomiting, hyperemesis gravidarum, varicose veins, backache, excessive salivation, heartburn, waist pain, and constipation. Nausea and vomiting in pregnancy commonly known as morning sickness are self-limiting conditions that may be controlled with conservative measures. Nausea and vomiting of pregnancy often develop by five or six weeks of pregnancy, but the symptoms continue until third trimester in 15 to 20 per cent of women and until delivery in five per cent of women (Committee on Practice Bulletins-Obstetrics, 2018). A profound form of nausea and vomiting may lead to hyperemesis gravidarum (Hinkle, 2016). Hyperemesis gravidarum is the most severe form of nausea and vomiting in pregnancy, characterized by persistent nausea and vomiting associated with ketosis and weight loss (>5% of pre-pregnancy weight) (Ogunyemi, 2017). Malnutrition and other serious complication such as volume depletion, electrolyte and acid-base imbalances, nutritional deficiencies, and even death can result from this condition.

Pregnancy itself is one of the major risk factors of varicose vein. Varicose veins during pregnancy event limited to the woman's legs can also occur at the vulva. They can be small and barely noticeable or they can be quite large and somewhat disfiguring. The vulva can feel sore and swollen, and it can be uncomfortable to sit (National Institute for Health and Care Excellence, 2013). Pregnancy is a time of many physical changes. These changes also impact the spine, joints and muscles and can result in mild to severe back and low back pain in pregnancy. Usman, Abubakar, Muhammad, Rabi and Garba (2017) pointed out that as the baby grows heavier and a woman's balance changes, her low back is put under increasing strain. The authors explained that during pregnancy, the pregnancy hormones especially progesterone softens the ligament and fibrous tissue that normally hold the spine and pelvic joints firmly together. Excessive sitting and bad postures increase the strain and makes the pain worse. Excessive salivation (ptyalism) is another symptom of pregnancy. It occurs frequently in women who are suffering from nausea or morning sickness and seems to occur most often during the first 12 weeks of pregnancy. Heartburn and constipation are also common problems during pregnancy. Heartburn (acid indigestion) is an irritation or burning sensation

of the oesophagus caused by stomach contents that reflux from the stomach. Heartburn is common in pregnancy and tends to become more so as pregnancy progresses. The best way to abate heartburn is by prevention such as avoiding carbonated drinks, alcohol, caffeine, eating small meals, drinking plenty water, chewing gum after eating and avoiding smoking and environmental tobacco smoke (Baby Centre Staff, 2017). Constipation on the other hand is generally described as infrequent bowel movements or difficult evacuation. Pregnancy predisposes women to developing constipation owing to physiologic and anatomic changes in the gastrointestinal tract (Brown, 2013). Brown added that there is increased water absorption from intestine which causes stool to dry out, decreased maternal activity and increased vitamin supplementation of iron and calcium can further contribute to constipation.

All things being equal, the desire of every ill person is to get well. Pregnant women who experience the above illnesses may turn to medical care services for help, others may go for traditional healing, and others may turn to self-help strategies; while others may decide to dismiss the symptoms. These illness decisions may be a mixture of behavioural decisions. Earlier studies indicate that a range of other factors- such as relatively low socio-demographic status of women, cultural beliefs and practices, and perception of the cause of the illness may contribute to abnormal illness behavior (Abubakar, Van Baar, Fischer, Bomu, Gona, & Newton, 2013; Nwankwo & Emerho, 2017). Gboko LGA is not an exception to maternal deaths since culture encourages them to patronize traditional healing and visit hospital only when the situation has become worse (Hemabh-Hilekaan et al. 2019). The normal health seeking behaviour by pregnant women is to turn to medical care system for help. It may be in realization of this that Usman et al. (2017) reported that a good antenatal care is necessary during pregnancy to ensure that both the mother and the foetus are safe and healthy. Pregnant women are therefore advised to seek adequate antenatal care in antenatal clinic during pregnancy irrespective of their socio-demographic status.

Socio demographic factors are characteristics of a population that are usually expressed statistically, such as age, educational level, income level, birth rate, death rate, average size family, average age of marriage. Socio demographic correlates of illness behaviour in this study are delimited to factors such as maternal age, parity and location. Age of mothers during pregnancy is one of the factors that are associated with pregnancy related illnesses. United Nations Children's Fund (2015) approved 19-35 years as acceptable childbearing age, and discourages child marriage. UNICEF (2015) also reported that Nigeria's 40 million women between 15 and 49 years of age suffer a disproportionately high level of health issues surrounding birth. Parity is correlated with illness behaviour in pregnancy. It is concerned with the number of deliveries a woman has. However, grand multigravidae are exposed to high pregnancy risk and illnesses than primigravida (first pregnancy). Parity in this context refers to the number of times a woman has given birth to a child (whether live birth or still birth) in the study location. Location is an environmental factor, which may influence pregnancy related illnesses. In areas where access to hospitals or health centers are difficult, pregnancy related illnesses are on the increase.

Correlate means something that leads to another thing or something that influences each other or has a mutual relationship or connection in which one-thing affects or depends on another. According to Harper Collins (2012), correlates refer to when one thing is associated with another or the two things are closely connected. However, in this study correlates are used as factors that influence or have relationship with illness behaviour of pregnant women in Gboko Local Government Area of Benue State.

Gboko Local Government Area is one of the 23 local government areas in Benue state. It is bounded with Tarka LGA in the North, Buruku LGA in the East, Gwer East and Konshisha LGA in the West, and Ushongo LGA in the South. The major ethnic group in the LGA is the Tiv. However, smaller tribes such as Etulo, Hausa, Ibo, Yoruba and Igalas are found in Gboko town. It is mostly characterized by rural dwellers with majority of them being farmers and traders with few civil servants. The area is characterized by polygamous marriage, male dominance among couples and early marriage. They are multiparous in nature with the view of giving birth to many children who would help them in their farms. They also have high value on traditional medicine that could be dangerous and may have adverse effect on the growing foetus.

Pregnant women in Gboko LGA who suffer from pregnancy related illnesses seem not to exhibit normal illness behaviours. For example, a pregnant woman in Gboko LGA who is ill instead

of going to health care professionals for help may go for traditional healing which is abnormal. Gboko LGA is characterized by some socio-cultural practices with poor socio-economic background, high illiteracy level which affect the pregnant women. Traditionally early marriages, lack of basic and qualitative education of women, male preference, love of children, male dominance among couples are the order of the day. These practices have severe effect on pregnant mothers. Some health facilities in the LGA are not evenly distributed and close to people's houses. Pregnant women do not seek medical advice from the appropriate source because of their belief that traditional healing is the most effective and cheaper. The health of pregnant women is at risk because of these beliefs. These are the main problems of the present study and they underscore the need for the choice of the area of the present study.

This study determined socio-demographic correlates of illness behaviour among pregnant women in Gboko Local Government Area of Benue State, Nigeria. Specifically, the study seeks to determine the relationship between: maternal age; parity; location, and illness behaviours of pregnant women in Gboko LGA.

Research Questions

The following research questions were posed to guide the study:

1. What is the relationship between age and illness behaviours of pregnant women?
2. What is the relationship between parity and illness behaviours of pregnant women?
3. What is the relationship between location and illness behaviours of pregnant women?

Hypotheses

The following null hypotheses were postulated and tested at .05 level of significance.

1. There is no significant relationship between age and illness behaviours of pregnant women in Gboko LGA.
2. There is no significant relationship between parity and illness behaviours of pregnant women in Gboko LGA.
3. There is no significant relationship between location and illness behaviour of pregnant women accessing antenatal in Gboko LGA.

Method

The study adopted correlational research design. The population for the study consisted of all the pregnant women attending antenatal clinic in the 42 health facilities in Gboko LGA of Benue State, estimated at 5608 pregnant women registered for antenatal clinic between April 2017 to May 2019. The sample size of the study consisted of 480 pregnant mothers accessing antenatal care in Gboko LGA based on the suggestion of Cohen, Manion, and Morrison (2011).

The sample was drawn using multistage sampling procedure. The first stage involved stratification of Gboko LGA into urban and rural areas. Gboko LGA has seventeen council wards (four council wards in the urban and thirteen council wards in rural communities). The second stage involved proportionate sampling of the urban and rural wards (eight rural wards and the four urban wards). Stage three involved selecting two health facilities each from the twelve sampled wards (4 Urban and 8 Rural) using purposive sampling. This yielded a total of 24 health facilities. Stage four involved the systematic sampling technique to select twenty pregnant women from each of the sampled health facilities.

The instrument for data collection was a researcher structured questionnaire titled 'Socio-demographic Correlates of Illness Behaviour of Pregnant Women Questionnaire (SCIBOPWQ)'. A four-point likert-type rating scale (Always, Sometimes, Occasionally and Never) was used. The instrument was face validated by five experts. Cronbach alpha statistics was used to test the reliability and a reliability coefficient of .84 was established and was considered high enough for use. This is in line with the guidelines of Crouch, Mack, Wilson and Kwan (2017) that if the reliability coefficient obtained is 0.72 and above, the instrument should be considered reliable for the study. A total of 480 copies of the questionnaire were administered by hand and collected back on the spot by the researchers. The respondents were reached at health facilities where they attend antenatal care services. This approach yielded a high return rate of 100 per cent of the instrument. However, out of the 480 copies, only 460 (95.8%) were duly completed and were used for the data analysis, while those that were not well completed were discarded.

Data was coded and analyzed using Internal Business Machine, Statistical Package for Social Sciences (IBM-SPSS) version 23. Data were analyzed using Pearson Product Moment Correlation (PPMC) in order to answer the research questions. Wilson (1989) criteria for interpreting correlation coefficient index were used to determine the extent of relationships. Correlation coefficient index < 0 = negative relationship $0 - .009$ = No relationship (NR); $.01 - .19$ = very low relationship (VLR); $.20 - .39$ = low relationship (LR); $.40 - .69$ = moderate relationship (MR); $.70 - .89$ = high relationship (HR); $.90 - .99$ = very high relationship (VHR). The null hypotheses were tested using linear regression at .05 level of significance.

Results

Table 1
Pearson Product Moment Correlation between Age and Illness Behaviours of Pregnant Women in Gboko LGA (n=460)

S/n	Item	Pearson value	Std Error	p. value
Symptom Experience Stage				
1	Feeling like vomiting (nausea)	-.074	.046	.111
2	Feeling waist pains	.006	.046	.900
3	Feeling sleepy during pregnancy especially in the morning	-.103	.044	.027*
4	Vomiting frequently during pregnancy	-.151	.041	.001*
5	Experiencing leg pains in pregnancy (varicose veins)	.093	.047	.047*
	Cluster average	-.108	.045	.021*
Assumption of Sick Role Stage: As a pregnant woman:				
6	I consult friends, neighbours, associates and family members for advice when ill	.114	.045	.015*
7	I go to work when am ill	.066	.045	.156
8	I cope with illness by lying down	.117	.047	.012*
9	I still perform my household chores when am ill	.023	.44	.630
	Cluster average	.150	.047	.001*
Medical Care Contact Stage: As a pregnant woman:				
10	I seek medical help when am ill	.068	.045	.144
11	I avoid seeking medical help when am ill	.006	.045	.891
12	I go to hospital/health centre for help when am ill	-.062	.045	.148
13	I go to spiritualist for help when am ill	-.53	.044	.261
14	I take herbs when am ill	.026	.049	.583
15	I seek medical help when am ill	.042	.047	.365
	Cluster average	-.044	.048	.342
Dependent Patients Role Stage: As a pregnant woman:				
16	I comply with the prescribed dosage of drugs given to me when am ill	-.021	.047	.653
17	I reject the choice of treatment given to me by the doctor when am ill	.039	.047	.409
18	I complete the dosage of drugs therapy given by the doctor when am ill	.006	.045	.903
19	I persuade the health professionals to follow the choice of treatment	.117	.041	.012*
20	I find it difficult to complete my prescribed dosage of drugs	-.087	.045	.063
	Cluster average	-.090	.048	.053
Recovery and Rehabilitation Stage				
21	I refuse to agree that I am healed even when am told by a doctor	-.022	.047	.645
22	I refuse to resume normal role obligations and task when am healed	.000	.047	.997
23	I follow the instructions given to me by health professionals when am ill	-.014	.044	.765
24	I comply with follow up visit as advised by health professionals during pregnancy	-.032	.048	.488
	Cluster average	-.029	.047	.533
	Grand Average	-.034	.048	.473

Key: *Significant

Correlation coefficient index < 0 = negative relationship 0 -.009 = No relationship (NR); .01 – .19 = very low relationship (VLR); .20 – .39 = low relationship (LR); .40-.69 = moderate relationship (MR); .70 –.89 =high relationship (HR);.90 –.99 = very high relationship (VHR).

Results of the Pearson correlation in Table 1 indicate that there was very low negative relationship between age and mean responses of pregnant women regarding their illness behaviours ($r=.034$, $p=.473$). The Table also shows that the mean illness behaviours at symptom experience stage ($r= -.108$; $p=.021$), and assumption of sick role stage ($r= -.150$; $p=.001$) were low and significant at .05 level of significance.

Table 2
Pearson Product Moment Correlation between Parity and Illness Behaviours of Pregnant Women in Gboko LGA (n=460)

s/n	Item	Pearson value	Std Error	p-value
Symptom Experience Stage				
1	Feeling like vomiting (nausea)	-.080	.046	.087
2	Feeling waist pains	.065	.048	.165
3	Feeling sleepy during pregnancy especially in the morning	-.161	.048	.001*
4	Vomiting frequently during pregnancy	-.134	.045	.004*
5	Experiencing leg pains in pregnancy (varicose veins)	.036	.050	.436
	<i>Cluster average</i>	-.127	.047	.006*
Assumption of Sick Role Stage: As a pregnant woman:				
6	I consult friends, neighbours, associates and family members for advice when ill	.096	.049	.041*
7	I go to work when am ill	.133	.047	.004*
8	I cope with illness by lying down	.056	.048	.232
9	I still perform my household chores when am ill	.113	.044	.015*
	<i>Cluster average</i>	.172	.043	.000*
Medical Care Contact Stage: As a pregnant woman:				
10	I seek medical help when am ill	.031	.050	.501
11	I avoid seeking medical help when am ill	-.093	.048	.047*
12	I go to hospital/health centre for help when am ill	.023	.050	.630
13	I go to spiritualist for help when am ill	-.042	.045	.364
14	I take herbs when am ill	-.016	.046	.727
15	I go to patent medicine dealers for help when am ill	-.036	.047	.439
	<i>Cluster average</i>	-.065	.047	.163
Dependent Patients Role Stage: As a pregnant woman:				
16	I comply with the prescribed dosage of drugs given to me when am ill	.057	.047	.224
17	I reject the choice of treatment given to me by the doctor when am ill	-.070	.046	.136
18	I complete the dosage of drugs therapy given by the doctor when am ill	.053	.048	.260
19	I persuade the health professionals to follow the choice of treatment during pregnancy	-.040	.046	.389
20	I find it difficult to complete my prescribed dosage of drugs	-.076	.046	.389
	<i>Cluster average</i>	-.049	.046	.295
Recovery and Rehabilitation Stage				
21	I refuse to agree that I am healed even when am told by a doctor	-.006	.046	.295
22	I refuse to resume normal role obligations and task when am healed	-.006	.037	.890
23	I follow the instructions given to me by health professionals when am ill	-.045	.047	.338

24	I comply with follow up visit as advised by health professionals during pregnancy	-.099	.039	.034*
	Cluster average	-.105	.043	.025*
	Grand Average	-.063	.043	.180

Key*Significant

Results of the Pearson correlation in Table 2 indicate that there was very low relationship between parity and mean responses of pregnant women regarding their illness behaviours ($r=.063$; $p=.180$). The Table also shows that the mean illness behaviours at symptom experience stage ($r= -.127$; $p=.006$), assumption sick role ($r= -.172$; $p=.000$) and recovery and rehabilitation stage ($r= -.105$; $p=.025$) were very low and significant at .05 level of significance.

Table 3

Pearson Product Moment Correlation between Location and Illness Behaviours of Pregnant Women in Gboko LGA (n=460)

s/n	Item	Pearson value	Std Error	p-value
	Symptom Experience Stage			
1	Feeling like vomiting (nausea)	.020	047	.674
2	Feeling waist pains	-.109	046	.020*
3	Feeling sleepy during pregnancy especially in the morning	-.156	046	.001*
4	Vomiting frequently during pregnancy	-.084	047	.072
5	Experiencing leg pains in pregnancy (varicose veins)	.113	044	.015*
	Cluster average	-.100	046	.032*
	Assumption of Sick Role Stage: As a pregnant woman:			
6	I consult friends, neighbours, associates and family members for advice when ill	-.019	047	.688
7	I go to work when am ill	.036	047	.436
8	I cope with illness by lying down	.068	046	.146
9	I still perform my household chores when am ill	.067	047	.151
	Cluster average	.065	046	.165
	Medical Care Contact Stage: As a pregnant woman:			
10	I seek medical help when am ill	-.034	047	.472
11	I avoid seeking medical help when am ill	.121	047	.009*
12	I go to hospital/health centre for help when am ill	-.133	047	.004*
13	I go to spiritualist for help when am ill	.157	043	.001*
14	I take herbs when am ill	.224	044	.000*
15	I go to patent medicine dealers for help when am ill	-.019	047	.681
	Cluster average	.130	043	.005*
	Dependent Patients Role Stage: As a pregnant woman:			
16	I comply with the prescribed dosage of drugs given to me when am ill	-.128	045	.006*
17	I reject the choice of treatment given to me by the doctor when am ill	.161	045	.001*
18	I complete the dosage of drug therapy given by the doctor when am ill	-.119	046	.011*
19	I persuade the health professionals to follow the choice of treatment during pregnancy	-.117	044	.000*
20	I find it difficult to complete my prescribed dosage of drugs	-.041	047	.382
	Cluster average	-.133	044	.004*
	Recovery and Rehabilitation Stage			
21	I refuse to agree that I am healed even when am told by a doctor	.102	047	.028*
22	I refuse to resume normal role obligations and task when am healed	-.056	047	.234

23	I follow the instructions given to me by health professionals when am ill	-.223	042	.000*
24	I comply with follow up visit as advised by health professionals during pregnancy	-.285	041	.000*
	Cluster average	-.222	042	.000*
	Grand Average	-.088	046	.060

Results of the Pearson correlation in Table 3 indicate that there was very low relationship between location and mean responses of pregnant women regarding their illness behaviours ($r = -.088$, $p = .060$). The Table also shows that the mean illness behaviours at symptom experience stage ($r = -.100$; $p = .032$), medical care contact stage ($r = -.130$; $p = .005$), dependent patients role stage ($r = -.117$; $p = .000$), and recovery and rehabilitation stage ($r = -.222$; $p = .000$) were significant at .05 level of significance.

Table 4

Summary of Linear Regression Table for Relationship between Age and Illness Behaviours of Pregnant Women Accessing Antenatal Care in Gboko LGA (n= 460)

Computed R	R Square	Adjusted R Square	Standard Error	Beta	F. Val	P. Val
.028	.001	-.001	.251	-.028	.367	.545

Table 4 shows that the relationship between age and illness behaviours of pregnant women accessing antenatal care in Gboko LGA. The calculated F-value with the corresponding P-value on illness behaviours of pregnant women accessing antenatal care services ($F = .367$, $P = .545 > .05$) indicated acceptance. This implies that there is no significant relationship between age and illness behaviours of pregnant women accessing antenatal care in Gboko LGA.

Table 5

Summary of Linear Regression Table for Relationship between Parity and Illness Behaviours of Pregnant Women Accessing Antenatal Care in Gboko LGA (n= 460)

Computed R	R Square	Adjusted R Square	Standard Error	Beta	F. Val	P. Val
.047	.002	.000	.250	-.047	1.008	.316

Table 5 shows that the relationship between parity and illness behaviours of pregnant women accessing antenatal care in Gboko LGA. The calculated F-value with the corresponding P-value on illness behaviours of pregnant women accessing antenatal care services ($F = 1.008$, $P = .316 > .05$) indicated acceptance. This implies that there is no significant relationship between parity and illness behaviours of pregnant women accessing antenatal care in Gboko LGA.

Table 6

Summary of Linear Regression Table for Relationship between Location and Illness Behaviours of Pregnant Women Accessing Antenatal Care in Gboko LGA (n= 460)

Computed R	R Square	Adjusted R Square	Standard Error	Beta	F. Val	P. Val
.103	.011	.008	.249	-.103	4.872	.028

Table 6 shows that the relationship between location and illness behaviours of pregnant women accessing antenatal care in Gboko LGA. The calculated F-value with the corresponding P-value on illness behaviours of pregnant women accessing antenatal care services ($F = 4.872$, $P = .028 <$

.05) indicated rejection. This implies that there is significant relationship between location and illness behaviours of pregnant women accessing antenatal care in Gboko LGA.

Discussion

Based on the analysis done on the responses to the questionnaire schedule, socio-demographic correlates of illness behaviour among pregnant women in Gboko LGA of Benue State was evaluated. The findings in table 1 revealed that there is low correlation between age of pregnant women and their illness behaviours in Gboko LGA of Benue State, at symptom experience stage, assumption of sick role stage, medical care contact stage, dependent patients' role stage and recovery and rehabilitation stage. Findings in Table 4 indicated no significant relationship between age and illness behaviours of pregnant women accessing antenatal care in Gboko LGA, implying that age cannot be used to predict illness behaviours of pregnant women. These findings were expected because hormonal changes in pregnant women affects all ages, though differently irrespective of age. These findings were at variance with Nwankwo and Emerho (2017) who found out that there was a significant relationship between age and illness behaviour among rural dwellers in Ethiopia East Local Government Area. Howbeit, the discrepancies in the finding could be as a result of the respondents' composition and other cultural and ecological conditions. The present study considered pregnant women in both urban and rural locations of Gboko LGA while Nwankwo and Emerho (2017) studied both men and women in rural settings.

Most studies of illness show that women go to doctors more readily and more frequently than do men. Perhaps there are real sex differences with respect to many diseases (i.e. some are common in women than men) (Freedman, 2016). Also, women have lower threshold of tolerance to symptoms and may be more concerned that they keep sound health because of considerable pressure on them to maintain family and home life. They are also culturally conditioned within the patriarchal structure of Nigeria's socio-cultural setting to obligatorily clear with an authority figure in the home before proceeding to the health system. Such clearance which serves as morale booster and the fact that they do not bear the cost of services constitute limited hindrances or considerations they must be disposed on their way to access health services.

The findings on table 2 revealed moderate correlation between parity and illness behaviours of pregnant women in the LGA, while table 5 revealed no significant relationship between parity and illness behaviours of pregnant women, implying that parity cannot be used to predict illness behaviours of pregnant women. These findings were surprising and quite shocking because women tend to get used to the illnesses and processes that are associated with pregnancy after one or more deliveries. Latunji and Akinyemi (2018) asseverated an indication that could lead to the finding as pregnant women being aware of the importance of appropriate treatment service and its sources. One possible explanation for this could be that they have enough access to information due to their constant exposure to sources of information during antenatal services. Furthermore, Adanikin, Padmadas, and McGrath (2019) submitted that Nigeria remains one of the countries with high total fertility rates. Also, having a large family which is culturally symbolic as a proof of social standing especially in Gboko LGA is a patriarchal tradition and may not be accepted by the women. But to keep farm work, boost of good social standings and attain recognition of father of multitude, parity is higher in northern Nigeria. These attributes are deeply entrenched within the existing cultural norm and have been resistant to change. The implication of this finding is that health educators should educate pregnant women especially multiparous client on need to always seek medical help during pregnancy.

The findings on table 3 revealed high correlation between location and illness behaviours of pregnant women in the LGA while table 6 revealed a significant relationship between location and illness behaviours of pregnant women accessing antenatal care services implying that location can be used to predict illness behaviours of pregnant women. This finding was expected because great disparities exist between health facilities in rural areas against those in urban areas. Nevertheless, the findings were in dissonance with Onyeonoro et al. (2016) who conducted a study on urban-rural differences in health-care-seeking pattern of residents of Abia State, Nigeria. In their analysis, the urban-rural differences in formal care seeking were not statistically significant. However, illness and health seeking behaviours was almost the same in both urban (21.1%) and rural areas (20.1%). More

respondents in urban areas (17.2%) visited a hospital/clinic following the onset of illness compared to 11.1% in rural areas, while more respondents in rural areas (9.0%) were more likely to visit primary health centers than urban residents (3.9%). The implication of this finding is that there should be equitable distribution of health services both in urban and rural areas to ensure accessibility of health services. Removing barriers to accessing health-care services and improving the quality of health-care services will help improve the illness behaviours of some pregnant women.

Conclusions and Recommendations

The study concludes that there was no significant relationship between the socio-demographic correlates (level of education, occupation and income) of pregnant women in Gboko LGA and their illness behaviours. Based on the findings, discussions and conclusions of the study, the following recommendations were made;

1. Health professionals (health educators, doctors, nurses, community health workers, midwives) should health educate pregnant women on the importance of preconception care, antenatal care, and post-natal care to improve the health of child bearing mothers. To promote the health of women of reproductive age before conception and there by improve pregnancy related outcomes.
2. Government agencies in collaboration with nongovernmental organizations should strengthen their outreach and community-based programmes to sensitize the women of all ages on the necessity of attending antenatal care services during pregnancy.

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