Role of Education on Maternal Mortality: A Study of South Senatorial District of Edo State, Nigeria

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Abstract

The study examines the role of education on maternal mortality in Edo South senatorial district of Edo state, Nigeria. The study adopted the survey research design. The population of the study included all females within the reproductive age of 15-49years. This age bracket was adopted because it is in line with the World Health Organisation (WHO) standard definition of reproductive age of women. Cluster sampling was adopted in this study. The local government areas (LGAs) in the district constituted the cluster. From the list of LGAs, simple random sampling was used to select three LGAs. The wards in each LGA selected were further listed. The findings revealed that education is a key determinant of maternal healthcare and invariably maternal mortality in South Senatorial District of Edo State. It was discovered that women who are not knowledgeable in the act of seeking healthcare are less likely to utilise healthcare service when pregnant especially in the rural area and urban slums. This is because access is a matter of the knowledge of the functionality of the service of the healthcare providers.

Keywords: Education, Healthcare, Maternal Mortality, Reproductive Age and Role.

Introduction

Maternal mortality is a major global health concern. It is an indicator of both access to quality healthcare and healthcare utilisation by women of reproductive age (Akpenpuun, 2013). The state of healthcare services of a country, and by extension, her maternal health is essential for the continued existence of the human race in both developed and developing nations (Nnamani, 2015).

Globally, the reproductive health status of women in recent times is quite disturbing. Part of the explanation for this phenomenon is the fact that women in general and pregnant women in particular operate within a cultural milieu which exacerbates the inability to access healthcare coupled with other factors such as geographical location, residence and the availability of specialists (The United Nations Population Fund, 2012). According to Franny (2013), the kind of reproductive health care a woman receives before, during pregnancy and after delivery plays significant role in her wellbeing as well as that of the child. Such reproductive healthcare services include family planning, prenatal, natal, and postnatal care aimed at reducing maternal morbidity and mortality (Nigeria Demographic & Health Survey, 2013).

Globally, the joy of childbirth is often a positive and fulfilling experience, however, for a major proportion of women in Sub-Saharan Africa; including Nigeria, the phenomenon of childbirth has assumed a different dimension because it is associated with avoidable outcomes, such as ill-health and even maternal/infant death (Kayode, Fayemi & Ike, 2015; Olatoye, 2009). The death of a woman during pregnancy or child birth is a tragedy that carries a huge burden of grief and pain, affecting both the family and the society at large because of the vacuum their demise creates

(Mojekwu & Ibekwe, 2012). This is often the case in developing nations where a significant percentage of child birth results in maternal mortality. For instance, global statistics on maternal mortality revealed that about 99 per cent of all maternal deaths worldwide occur in developing countries, while less than one per cent of maternal deaths occur in developed countries combined (Bayer, 2001; Nnena, 2015). This scenario is serious because of the gloom and uncertainty associated with childbirth in developing nations including Nigeria.

Women mostly affected by the problem associated with maternal health are those with poor socio-economic status like education and others who live in remote rural areas and could hardly access healthcare services. This is so because, all things considered, they are unable to take advantage of modern healthcare services which are generally now available. This, forces such women to seek alternative qualitative healthcare options with their attendant hazards. Studies have shown that improving women's access to schooling decreases their desired for high fertility, delays their sexual debut and improves their ability to negotiate sex (Baird et al. 2010). They have also shown that increasing women's education protects against sexually transmitted infections and reduces the risk of infant and maternal mortality (Grépin & Bharadwaj, 2015). This is because as education expands and fertility falls, women's exposure to maternal health complications, diminish alongside their number of pregnancies and births (Behrman, 2015).

According to Lindros and Lukkainen (2004), only 31% pregnant women deliver in health facilities in Nigeria, while others give birth at home or at Traditional Birth Attendance (TBA) centres. This situation, not only heightens the anxieties associated with poor health care utilisation, but results in exclusion of huge information on health and health statistics.

Over the years, there has been some improvement in health care services with a number of health services available for women to meet their medical needs during pregnancy and child birth. Despite this, poor maternal health outcomes remained a great concern to health authorities in Nigeria, including Edo State. The endemic maternal mortality in Nigeria have defied several measures and intervention programmes conferences of various bodies, both local and international, aimed at addressing the problem of maternal health (Ugal, Ushie & Ushie, 2017). The United Nations (UN) decades for Women Population Conference held in Mexico City in 1984, the Safe Motherhood Initiative (SMI) in 1987 of international concern, the United Nations Conference on Population and Development, and the United Nations Millennium Development Goals (MDG'S) 5 targeted to reduce maternal mortality by 75% in 2015 as well as the sustainable development programmes were all held in an attempt to tackle maternal mortality issues, draw attention to the reproductive health issues, gender equity, and equality (Yar'Zever, 2014). This is because, every pregnant woman is at risk of pregnancy complications which are unpredictable and can lead to morbidity or mortality of both the baby and the mother if adequate attention and care is not put into consideration (JHPIEGO, 2004). Although a lot of studies have been carried out on this issue in Nigeria and other Third World Nations, none of these studies have been conducted on Edo South Senatorial District. This has created a gap in the discourse of the endemic maternal and infant mortality in Nigeria. The rationale for this study therefore is to fill this gap by reporting the situation in South Senatorial District of Edo State.

The study therefore examines the nature, structure, dimension and the impact of education on maternal mortality in South Senatorial District of Edo state as well as make some recommendations that would help in dealing with the problem and in the process contribute to meeting the goal 5 of the MDG now SDG targeted at reducing maternal death by 75% by 2030.

Objectives of the Study

The aim of the study is to examine the impact of education on maternal mortality in South Senatorial district, Edo State of Nigeria using access to maternal healthcare as an intervening variable.

The specific objectives of the study are;

a. To examine the causes of maternal mortality in South Senatorial district, Edo State.
b. To identify the role of education and proximity to healthcare facilities and maternal mortality South Senatorial district, Edo State.

Research Questions

The following research questions will be answered in the study.

a. What are the causes of maternal mortality in South Senatorial district, Edo State?
b. What is the role of education and proximity to healthcare facilities on maternal healthcare utilisation and maternal mortality in South Senatorial district, Edo State?

Hypotheses

The below hypothesis is formulated to guide this study.

$H_0$1: There is no relationship between level of education and access to maternal healthcare in South Senatorial district, Edo State.

Theoretical Framework

Although there are a number of theories that can be used to explain the relationship between health condition and socio-economic status, we however find the Health Belief Model the most appropriate for explaining the nexus between social economic status and maternal mortality. The health belief model was one of the first models of health-promoting behaviours and it remains one of the most widely recognised conceptual frameworks of health behaviours. The model explains health behaviours from a social psychology perspective using theories of value-expectancy and decision making. The HBM was developed in 1950s to explain why people do not engage in health related programmes to detect and prevent diseases even when those services were free and within their reach. Specifically, the model was developed by a group of psychologists in the United State in response to the failure of a free Tuberculosis (TB) health screening programme, that is, to understand and explain why medical screening programmes offered by the United State Public Health Service were not very successful (Hoch-Baum, 1958). This theory has gained much relevance and has become a theory of human behaviour adopted to explain two major construct of individuals, that is, their perception and utilisation of health behaviour. The theory provides an opportunity to explore how health-care provider's behaviour can influence patient perceptions of safety and the likelihood of patient involvement in the safety behaviour (Andrea, Baker, Boyle & MacKinnon, 2014). Individual perception and action as it relates to health behaviour is divided into six constructs to determine how patients perceive the health provider's behaviour in relation to their (patients) health safety. The constructs as identified are: perceived risk susceptibility, perceived risk severity, perceived benefits to action, and perceived barriers to action, self-efficacy, and cues to action (Becker, 1974; Champion & Skinner, 2008).

The HBM is relevant to this work in a number of ways. First, it draws attention to the relationship between the belief system of a people and their perception of health facilities. Secondly, it points

to the fact that it is not only environment or psychological variables that influences health or wellness level of a people but their cultural environment. Indeed, this component is very significant in the determination of how people respond to health institutions in their environment.

Material and Methods

The study adopts the survey research design because it is interested in the attribute of a population through the study of sample considered a representative of the population. The study was conducted in South Senatorial District of Edo State. The population of the study included all females within the reproductive age of 15-49years without prejudice to ethnic nationality and socio-economic status. This age bracket was adopted because it is in line with the World Health Organisation standard definition of reproductive age of women (World Health Organisation, 2006). There are 586,478 women aged 15-49 years residents in Edo South Senatorial District as at 2018. This figure constituted the target population on which the research instruments were administered although a sample was drawn for actual investigation.

Table 1: Population Projection (2018) in the Study Area

S/N	Local Government Area	Total Projected Population of Females 15-49years as at 2006	Total Population of Females 15-49years as at 2018	Percentage (%) of females 15years and 49years in the LGAs
1.	Egor	94,623	130,830	22.3%
2.	Ikpoba-Okha	80,132	101,874	17.37%
3.	Oredo	104,954	145,114	24.7%
4.	Orhionmwon	46,532	64,337	10.97%
5.	Ovia Northeast	41,461	57,327	9.77%
6.	Ovia South West	34,129	47,188	8.05%
7.	Uhunmwode	28,791	39,808	6.79%
	TOTAL	**430,622**	**586,478**	**100%**

Source: National Population Commission, 2010

Cluster sampling was adopted in this study. The local governments in the district constituted the cluster. From the list of LGAs (7), simple random sampling was used to select three LGAs. From each list, three wards were elected using the simple random sampling technique. On the basis of the wards selected, eight (8) communities/localities were further selected. Thereafter, households were numbered and systematic random sampling technique was adopted to select the respondents.

Table 2: Sampling Technique

S/N	Total LGA in Edo South Senatorial District	LGA Selected	No of Political Wards Selected	No of Communities Selected	No of individual selected	No of In-depth Interview
1.	Egor	Egor	3	8	158	3
2.	Ikpoba-Okha					
3.	Oredo	Oredo	3	8	186	3
4.	Orhionmwon					
5.	Ovia Northeast					
6.	Ovia Southwest					
7.	Uhunmwode	Uhunmwode	3	8	131	3
	TOTAL		9	24	475	9

Source: Field Research, 2019

The sample size for this study was 484. Out of this number, 189 were picked from Oredo LGA, 161 from Egor and 134 from Uhunmwode local government area. The variations (differences) in

size selected are a reflected the strength of the population of the LGAs in question while 9 interviewees were purposively selected. Three each from the LGAs selected. The study adopted both primary and secondary methods of data collection. Structured questionnaire and In-depth Interview constituted the primary sources of research instruments for data collection in this study. Data were also sourced through secondary sources such as publications, books, journals, periodicals, reports, conference proceedings and the internet (World Wide Web). The rationale for the different instruments was to enable the researcher obtain comprehensive data from the various segments of the population.

Data generated in this study were analysed both quantitatively and qualitatively. Data obtained were analysed using adequate statistical methods and presented in simple and understandable forms. Data on social demographic variables of respondents were analysed with the aid of descriptive statistics and results presented in tables, graphs and simple percentage. The hypotheses were tested using chi-square statistical method at alpha level of 0.5. The result was to test if there was significant relationship between socio economy status like education and maternal mortality. Quantitative data were analysed and presented using descriptive and inferential statistics while qualitative data were content analysed. Specifically, verbatim reporting and thematic analysis formed the core of the major activities in this session.

Result of the Findings

Table 3: Frequency distribution of respondent's view on (or perception of) the causes of maternal mortality in South Senatorial district, Edo State

	Variable	Frequency	Percentage
Does inadequate medical care during antenatal causes maternal death?	Yes	330	70.5
	No	64	13.7
	Cannot Tell	74	15.8
	TOTAL	**468**	**100.0**
Complications from delayed medical care causes mortality among pregnant women	Yes	448	95.7
	No	14	3.0
	Cannot Tell	6	1.3
	TOTAL	**468**	**100.0**
Does lack of access to good healthcare facilities causes maternal death	Yes	417	89.1
	No	30	6.4
	Cannot Tell	21	4.5
	TOTAL	**468**	**100.0**
Does poverty and lack of awareness of the need for medical care causes maternal death	Yes	358	76.5
	No	13	2.8
	Cannot Tell	97	20.7
	TOTAL	**468**	**100.0**
Pregnancy related infection may cause ill health and death	Yes	402	85.9
	No	25	5.3
	Cannot Tell	41	8.8
	TOTAL	**468**	**100.0**

Source: field work, 2019

Data in Table 3 showed respondents response on the causes of maternal mortality in South Senatorial district, Edo State. With regards to respondents' responses to the question of inadequate medical care during antenatal period and complications from delivering medical care, the data showed that more than half of the respondents agreed that inadequate/poor medical treatment during antenatal care and complications from delivery is one of the predisposing factor to maternal mortality while 64 representing 13.7% of the respondents do not agree. Some of the respondents that do not believe poor antenatal care are one of the causes of complication or mortality among women further opined that antenatal care is good but not a necessity because of their previous experiences of giving birth without complications though they did not go for any antenatal care during conception. While those that agreed that lack of antenatal care could be a predisposing factor for maternal mortality further opined that antenatal care is the partway to every successful delivery and reduced post natal issues. This group noted that women that utilises the services of Traditional Birth Attendance usually go for routine herbs to soften the delivery process but may not be as regimented as those of the orthodox hospital. Hence, the relevance of antenatal care delivered by professionals. This implies that the quality and quantity of antenatal service/care matters a lot in controlling and reducing maternal mortality. This is in corroboration with the findings of Nafiu, Kabir, Adiukwu (2016) that opined that there is a positive relationship between the number of visit to healthcare institution for check-up and the pregnancy outcome of women. The higher the number of antenatal and postnatal call of women to healthcare centres, the lower the likelihood of maternal deaths. Maternal mortality decreases when there is an increase in the number of antenatal visits. This implies that the likelihood of expectant mothers experiencing maternal mortality reduces with number of visits to healthcare institution.

Antenatal care is generally acknowledged as an effective method of preventing adverse outcomes among pregnant women and their babies. Phoya and Kamg"oma (2005), however noted that the benefit of antenatal care in influencing outcomes of pregnancy depend to a large extent on the timing of the antenatal care as well as the content and quality of service provided. Therefore, women are expected to have a minimum of four antenatal visits spread throughout the pregnancy period, with the first visit in the first trimester. According to Idowu (2013), the first trimester and early second trimester are very crucial in the antenatal care. It is at this stage that many antenatal screening tests, including ultrasonography for the detection of foetal anomalies and biochemical screening for neural tube defects and Down's syndrome are conducted. Women who initiate antenatal care after these stages will be denied the benefits from these screening tests. Some expectant mothers miss out in this stage because they delayed antenatal care which in turn might have adverse effect like complications at the later time of child delivery. Findings from previous study further revealed that some expectant mother regardless of their age delayed antenatal visit till fifth month into pregnancy even when some of them are well informed about the relevance of antenatal visit. That is, many expectant mothers attend antenatal but not early into their pregnancy, hence they are hedged out of the intended benefits of early antenatal care. This was more rampant among the older women possibly because they believe they are experienced in the process and will prefer to go when there is issue or when the pregnancy becomes noticeable.

Data in Table 3 also revealed respondent's perception on the impact of delay in seeking medical health on maternal mortality. The data revealed that among the total respondents, 448 representing 95.7% of the respondents believed that complications from delayed medical care causes mortality among pregnant women, 14 representing 3% of the respondents disagreed while 6 representing 1.3% are undecided as to whether complication from delayed medical care causes death among

pregnant women. This suggests that majority of the respondents agreed that complications that results because of delayed medical care is one of the causes of mortality among women. Some pregnant women delay utilisation of healthcare services until situation arises that will cause panic and before they are taken to the hospital, the issue becomes severe and worsen.

Data in Table 3 further revealed that lack of awareness is also another reasons expectant mother do not seek healthcare. Some of the expectant mothers do not know what to do because of where they live. Some of the expectant women though are aware of the health benefits but still prefer the local methods because it is cheaper and less stressful to access compared to the orthodox health care. The table also revealed that ignorance and lack of awareness of danger signs of complication may cause death during pregnancy. In the study conducted by Oye-Adeniran, Odeyemi, Akin-Adenekan, Akinsola, Ekanem and Osilaja (2014), bleeding was mentioned by respondents as a cause of death during pregnancy, during labour and also postpartum. Knowledge was reported as lacking about the warning signs for haemorrhage and the potential danger for bleeding after delivery. Some of the women that do not seek medical health care during complication like bleeding believed that supernatural forces are the cause of haemorrhage during pregnancy and delivery.

Data in Table 3 further revealed that among the total respondents, 402 representing 85.9% of the respondents linked pregnancy related infection to ill health and death among women. 25 representing 5.3% of the participant disagreed while 41 representing 8.8% of the respondents are undecided as to whether pregnancy related infections could be linked to the maternal mortality in the study area. This suggests that majority of the respondents believed that pregnancy related infections are the cause of maternal death among pregnant women.

Research Question Two: What is the role of education on maternal healthcare utilisation in the study area? The research questions raised under this section covers questions regarding role of education in women access to healthcare institutions and mortality level. Four questions were raised under this objective.

Table 4: Frequency distribution of respondents view on role of education on maternal mortality

	Variable	**Frequency**	**Percentage**
Is there a relationship between level of education and maternal mortality level	Yes	350	74.8
	No	90	19.2
	Cannot Tell	28	6.0
	TOTAL	**468**	**100.0**
Does education influences access to health care?	Yes	328	70.1
	No	112	23.9
	Cannot Tell	28	6
	TOTAL	**468**	**100.0**
Is it the more educated you are the better you are willing to access health care during pregnancy?	Yes	369	78.8
	No	73	15.6
	Cannot Tell	26	5.6
	TOTAL	**468**	**100.0**
Are educated people more willing to access healthcare than those who are less educated?	Yes	356	76.1
	No	86	18.4
	Cannot Tell	26	5.6
	TOTAL	**468**	**100.0**

Source: field work, 2019

Data in Table 4 showed respondents responses to question generated on the level of education and maternal health in the study area. Among the total respondents, 350 representing 74.7% of the respondents agreed that there is a relationship between level of education and health care utilisation. 90 respondents representing 19.2% disagreed that there is a relationship while 28 representing 6% of the total respondents were undecided as to whether education has any role to play in the utilisation of healthcare among women in the study area. This suggests that among the total respondents, majority agreed that education plays significant role in the utilisation of maternal health in the study area.

Furthermore, with regards to the opinion that the level of education influences maternal health, majority of the respondents agreed that education plays a key role in healthcare utilisation by pregnant women. For instance, the data revealed that 328 respondents representing 70.1% agreed that education influences access to healthcare utilisation in the study area, 107 representing 22.9% of the respondents disagreed that education has influence on the maternal mortality rate while 33 respondents representing 7.1% were undecided. This is implying that majority of the respondents agreed that education plays a role or influences access to maternal health.

Table 4 also revealed that the more educated a woman, the better they are willing to access healthcare. 356 representing 76.1% of the respondents agreed that the more educated a person, the better they are willing to access health care especially before, during and after pregnancy, 73respondents representing 15.6% do not believe that the more educated you are, the better you are willing to access health care during pregnancy while 26 representing 5.6% of the respondents were undecided as to whether the more educated you are the better you are willing to access health care during pregnancy. The table further revealed those who are educated are more willing to access healthcare than those who are less educated. For instance, 356 representing 76.1% of the respondents are agreed, 86 representing 18.4% of the respondents disagreed while 26 representing 5.6% of the respondents are undecided as to whether educated people are more willing to access healthcare than those who are less educated.

Table 5: Cross tabulation of respondent's view on role of education on maternal healthcare by educational qualification

			Do you think your level of education influences your access to healthcare?			Total
			YES	NO	CANNOT TELL	
	Never Went To School	Count % Within Respondent's Education Completed	11 47.8%	12 52.2%	0 0.0%	23 100.0%
	Primary School	Count % Within Education Completed	93 85.3%	12 11.0%	4 3.7%	109 100.0%
	Secondary School	Count % within Education Completed	65 127.0%	16 17.6%	18 65.4%	99 100.0%

Respondent's Education Completed	Diploma and equivalent	Count % Within Education Completed	85 58.2%	55 37.7%	6 4.1%	146 100.0%
	B.Sc. and equivalent	Count % Within Respondent's Education Completed	74 81.3%	17 18.7%	0 0.0%	91 100.0%
	Total	Count % Within Respondent's Education Completed	328 70.1%	112 23.9%	28 6.0%	468 100.0%

Data in Table 5 show cross tabulation of respondents view on role of education on maternal healthcare by educational qualification. Among the total respondents who have no former education, 11 (47.8%) believed that level of education influences access to healthcare, while 12(52.2%) of the respondents who never went to school do not believe that level of education influences access to healthcare. Among those with primary school as the highest educational qualification level, 93(85.3%) believe that level of education influences access to healthcare, 12(11%) do not agreed that level of education influences access to healthcare while 4(3.7%) were undecided. Among the total respondents with senior secondary school as the highest educational qualification who had their highest educational qualification, 61(67%) agreed that level of education influences access to healthcare, 16(17.6%) not agreed while 14(15.4%) were undecided. respondents with Diploma, 85(58.2%) agreed that level of education influences access to healthcare, 55 (37.7%) do not agree while 6(4.1%) were undecided. the table further revealed that among those with B.Sc. and equivalent 74(81.3%) agreed ones' level of education influences access to healthcare while 17(18.7%) do not agreed level of education influences access to healthcare.

Test of Hypotheses

Hypothesis that bothers on education as correlates was tested from questions generated from the questionnaire. The results are represented with cross tabulation of variable like educational qualification of the respondents.

Hypothesis One-

H_0: There is no relationship between level of education and access to maternal healthcare in the study area

H_1: There is relationship between level of education and access to maternal healthcare in the study area.

Table 6 Chi-Square Tests

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	115.117[a]	15	.000
N of Valid Cases	468		

a. 9 cells (37.5%) have expected count less than 5. The minimum expected count is .09.

At 0.05 level of significance, the chi-square tabulated as shown in table 4 above is 24.996 under the degree of freedom 15, while the chi-square calculated is 115.117 (Table 6). For this reason, the null hypothesis is rejected while the alternate hypothesis is accepted thus; there is a relationship between education and access to maternal health and by implication maternal mortality.

Discussion of Findings

The study examines the role of education on maternal mortality in Edo South senatorial district. The findings identified education as key determinant of maternal healthcare and invariably maternal mortality in South Senatorial District of Edo state. It was discovered that women who are not knowledgeable in the act of seeking healthcare are less likely to utilise healthcare service when pregnant especially in the rural area and urban slums. This is because access is a matter of the knowledge of the functionality of the service of the healthcare providers. This implies that most of the women who do not utilise healthcare do so because they are ignorant of the benefits accrue to seeking healthcare services and lack of information on the usefulness of healthcare facilities. This was in corroboration with the findings of Olalekan (2019) that opined that the odds of non-use of health service during delivery increased for women who had no education, from poor households, aged 25–34 years, unmarried, never attended antenatal clinic, experienced difficulty getting to health facility and lived in the most socioeconomically disadvantaged communities and states. This was used to provide a more direct measure of the woman's relative socio-economic status. Numerous studies in developing countries have shown that more educated women have lower perinatal mortality rates. Higher education does not only presume higher economic standing but suggests a more informed approach to both self-care and the use of the health care system. Better knowledge of health-related behaviours is also likely to be reflected by the woman's education level. Although some study avail that knowledge of the functionality of healthcare alone does not propel people to access healthcare rather, their choice and the relevance that is placed on it. The outcome of this study is in conformity with findings of Umurung (2010 in Dawud, 2016) that averred education as one of the key determinant of health facility utilization for delivery, because education increases women's autonomy, understanding and decision making power within the house hold. In addition, educated women tend to seek out higher quality health care services and likely to deliver at a health facility compared to the uneducated one.

The influence of education on maternal mortality is assumed to derive from various dimensions of the educational experience; schooling imparts literacy skills, which enables pupils to process a wide range of information and stimulate cognitive development (Idowu, Osinaike & Ajayi, 2011). More so, educated women may have more understanding of the physiology of reproduction and be less disposed to accept the complications and risks of pregnancy as inevitable, than illiterate or uneducated women (Oxaal & Baden, 1996). More so, Chakraborty *et al* (2006) and Navaneethem and Dharmalingamb (2002) also found that female education is a strong determinant of maternal health services utilization, while uneducated women are less likely to use maternal health care services for delivery. This is also in tandem with an in-depth interview with in the study. The interviewees had divergent opinions as regards education and maternal mortality in Edo south. One of the interviewee, Mrs S while responding to the question on the causes of maternal mortality opined that:

> "Antenatal care is a key determinant of the aftermath of successful outcome of child delivery. This is because it is at this stage that every other thing follows. It is during antenatal care expectant mothers are guided on what to do or not to

> do at the early stage of pregnancy. If the early stage is right, every other stage will fall in place.' (IDI-2019).

In a separate interview with Mrs N, it was also noted that some women do not go for antenatal care when pregnant because of possible fear that they will be asked to pay money or will be diagnosed of ailment that they cannot afford (IDI-2019).

According to Mrs R,

> "there are a lot of expectant women that do not come for check-up/antenatal care to know the state of their foetus. They alone choose to come when there are complications that cannot be handled by the Traditional Birth Attendance. They prefer to go to the TBA than to go to the hospital. Part of the reasons is that they are scared to be diagnosed of complication during the conception. They go with the belief that all will be well and most time, it does not come out well for some of them. Mrs R further noted that women in rural area prefer Traditional Birth Attendant to attend to them during delivery. These kinds of help are not scientific but try by error. Some of the expectant women that utilise the orthodox medical care do it wrongly to the point that they mix herbs and 'English drug'. This tends to have side effect on them and the unborn babies because of the chemical reaction that could occur from such combination." (IDI-2019).

This is also in tandem with Dr Y (a female research discussant). According to her,

> "Pregnancy has three stages, the trimesters which comprise the first three months of conception, second stage, comprise the second three stage of conception and the third stage. This comprise the third three months of conception. Each of these stages is important and expectant mother are responded to according to the stage, when an expectant mother skip any of the stage, it will portend danger especially during delivery because they are vaccines and injections that is given out at each stage to avoid infection. The best person to recommend the required vaccinations at each of the stages is medical personnel. When women decline going for antenatal care, this vaccine/injections will not be given hence complication/infection could result that could possibly cause death of the expected mother" (IDI-2019).

Conclusion

The study examines the role of education on maternal mortality in Edo South senatorial district, Edo state, Nigeria. The study revealed that different factors account for maternal mortality among expectant mothers but education stood out as a major factor. Some women who are well informed about the important of health care during pregnancy still delay access. This has serious implication because complication that arises from delivery does not happen at a time but a compilation of ignored health issues. Knowledge or information as well as early access has significant impact in mitigating the menace of maternal mortality.

Recommendations

The study examines education as correlate to maternal mortality in South senatorial district of Edo state. Based on the findings outlined from the study, the following recommendations are presented:

i. Healthcare facilities should be beefed up and running so as to address challenges of maternal health especially during emergence.
ii. Measures that enhance safe delivering among expectant mothers in Edo south should be given good consideration.
iii. Girl child education should be enshrined. In extreme case, women's education should be made at a very low cost or free so as to encourage them to seek education
iv. The empowerment of women should of top priority of government so as to strengthen the decision making power in time of health emergency.

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