ROLE CONFLICTS, SOCIAL SUPPORTS, AND MATERNAL HEALTH CONDITION IN LAGOS

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Abstract

The study adopted the use of questionnaire, and in-depth interview research approaches to examine the maternal role conflicts and the access to social support that can cushion or prevent the incidence of ill-health during pregnancy among 1362 women that were in their reproductive age (15-49). Data analysis employed univariate and multivariate (binary logistic regression) and two models were formulated. The result shows where women were exclusively doing all the household chores were 0.803 times less likely to be in good health condition. It also indicated that lack of spouse or relatives' support were negatively related to maternal good health. These factors would 0.583 and 0.927 less likely to enhance good maternal health. The authors conclude that woman double roles have negative influence on maternal health. The author recommends better enlightenment and education of men on exigent maternal health complications issues, to secure their support for current mothers and potential mothers.

Key Words: Role conflict, social support, maternal health, women, and development.

Introduction

Many attempts to empower women and increasing their labour force participation have ignored the health implications of management of multiples roles of been a parent, spouse, caregiver, employee and in some cases, as family head, business owner or head of corporate body. Maternal health refers to the health of woman during pregnancy, childbirth, and the postpartum period. While motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill-health and even death WHO, 2016). Balancing home and

work responsibilities is an emerging issue of concern in the strife for good health for women, especially during pregnancy and postnatal period (Lee *et al*, 2006). In addition, the feeling of hardship and discontentment which results from overwhelming motherhood condition, child temperament, and mother's physical and mental tensions and a sense of restriction alike are influential in creating stress and conflict (Javadifar, *et al*, 2013). Studies have also indicated a feeling of extreme and overwhelming tiredness, and loss of physical and mental energy in women due to their double role (Raynor, 2006; George, 2005; Doyel, 2002).
Consequently, safe motherhood which eludes many women due to inadequate knowledge about reproductive health, complicated by unmitigated socio-cultural and economic backgrounds of women (Okemgbo, *et al*,2002; Omo-Aghoja, 2013) such as poverty, high risk social environment, inconsiderate working policies as well as role conflicts that lead to both emotional and physical stress which ultimately induce complications during pregnancy. This scenario seems to explain why several women lose their lives daily because of pregnancy-related complications (WHO, 2008). Therefore, maternal and child health approach need to focus on issues beyond medical and facility-based interventions, to examine social, cultural, economic, legal, and even religious factors, which equally need to be addressed for any meaningful improvement in maternal health (Health Reform Foundation of Nigeria (HERFON), 2006). Thus, this study aim to understand the influence of maternal multiple role conflicts on their health; and to identify those family support factors that might be associated with their functional status during pregnancy.

In literature, scholars have considerably associated adverse pregnancy outcomes with numerous factors. Among those factors are level of income, and education. The lower the number of years of formal education a mother has, the higher the maternal death (Jegede, 2010; Ufford and Menkiti, 2001; Graczyk, 2007; Abdul'Aziz, 2008; Idowu, *et al*, 2011). The likelihood of complications with mothers' age has also been established, which connotes the idea of superiority in terms of ability to think and make decisions, the readiness of the physiology of the mother (Naigaga, *et al*, 2015; Aviram *et al*, 2013). Also, cost of maternal health services, lack of vehicular transportation and accessibility of formal obstetrics care services were among the major causes of maternal health complications identified in literature (Essendi, 2010; Atuoya, 2015; Tawiah, 2011).

Recently, studies have looked at more contextual factors; in Idowu, *et al*, (2014), mothers poor working conditions such as low wages, long working hours, and lack of adequate weekly and annual rest in addition to unhealthy and hazardous workplaces and lack of social protection, can have negative effects on maternal health. The effect of neighbourhood socioeconomic poverty; living in environment with lower income and higher unemployment rate association with increased probability of adverse pregnancy outcome have been described (Garcia-Subirats *et al*, 2011). Also, consequences of armed conflict effects on maternal health outcome which includes: increased maternal and new born morbidity and mortality; high prevalence of HIV/AIDS and high levels of prostitution, teenage pregnancy, and clandestine abortion; and high levels of fertility (Chi *et al*, 2015).

Over the last decades, studies (Ahmadifaraz *et al*, 2013; Poduval and Poduval, 2009) have drawn attention to the intersection of work and family, arguing that there is a reciprocal relationship between the two spheres of social life that often results in conflict and tension (Runte and Mills, 2004). The health impact of stressful events not only depends on the nature of these events but also contingent upon the individuals' ability to cope with the ensuing crisis. However, the eventual stress can be cushion by the degree of social support received from relatives, friends, and other members of their social network (Poduval and Poduval, 2009; Stroebe, 2000), where these supports are absent, depression, and ill-health are inevitable (Lee *et al*, 2006).

The link between social networks/supports and maternal health has increasingly been recognized by public health as an important topic of interest in population study and development. Kodzi *et al* (2010) and Koenig *et al* (2001) studied and reviewed several studies examining the relationship between social support and health, found a predominantly positive association. Social support refers to the emotional, practical, or functional aspects of interpersonal relationships (Israel *et al*, 2002; Stansfeld, 2006). This is including advice, love, help, resources, information and empathy women give and receive among family and friends. This study therefore describes the role conflict and social support receives from family as important factors in maternal health. Therefore, we hypotheses that role conflict is likely to influence maternal health and secondly, there is a significant relationship between social support and maternal health.

Data and Methods

A mixed method cross sectional study was conducted to determine the adverse effect of role conflicts on maternal health and family social support variables. The data for this study came from a sample size of one thousand three hundred and sixty-two women of reproductive age range of 15- 49. This is also complimented with 20 key informant interviews. The study population comprises eligible participants which include all women that have given birth in the last one year and/or were pregnant and resident in Lagos State during the period of the survey. Every eligible woman in Lagos State had equal chance of being selected for the study. The respondents were married, single, divorced, separated or widowed. The general denominator of the population is that they were of reproductive age and have a child below one year and/or pregnant.

The study also adopted a multi-stage sampling technique, to select a representative sample from the study population. The sampled population was drawn from households and from each of the four Local Government Areas (LGA). As at the time of the field work, the national maternal mortality ratio was 650 per 100,000 lives birth. The first stage of the sampling process involved stratification of LGAs into maternal mortality rates. The LGAs in Lagos State were divided into two, those who had MMR of less than the national 650 per 100,000 births and those with above 650 per 100,000 live births. Ten LGAs were made up of each of the strata. Ratio 3:1 was adopted in selecting from high MMR and low MMR respectively. However, respondents for the key informant interviews were purposively selected from each of the LGAs.

Variables and Indicators

The interrelationship between some selected socio-demographic variables and maternal health complications were computed in this model to identify socio-demographic correlates of maternal health. In terms of measurement, the dependent variables in this model (maternal health challenges) were measured by means of a checklist containing maternal health complications, some of which include pre-eclamsia, excessive bleeding, convulsions/eclamsia, sepsis, prolonged labor, obstructed labor, unsafe abortion torn uterus, placenta previa, high fever, and fistula. Respondents were classified per whether (during the last pregnancy) they had ever experienced at least one of these. Variables were dichotomized into 0 and 1. Where 0 means the absence of complications and 1 denotes suffered/suffering from one or more of the complications. This makes the dependent variable to satisfy the condition for logistic regression.

Problems encountered carrying out house chores due to paid-work demand, performance of house chore either with or without other helping hands, time taken to rest, etc; were used to assessed role conflicts. While social support was measured by placing attention on the interpersonal support system; where husbands normally help

them with the house chore, whether there is someone to turn to when there is a need for practical help, or the relatives/in-laws are there to give support, whether there is someone to turn to for comfort or share concerns and if the colleagues do help to do their duties when necessary and, the influence of religion on maternal health.

Analysis

We present the demographic characteristics of the respondents and proportions. We used binomial logistic regression to conduct the multivariate analyses, accounting for the interrelationship between women role conflicts and social support and probability of maternal health to log-odds of maternal health complications. Two models were fitted to analyze the effects of role conflicts and social supports factors for the outcome variables. The first model estimated the effect of role conflicts; the second model estimated effect of social support on maternal health. The tapes and notes from the in-depth interviews were analyzed with the use of content analysis. Responses to each topic were summarized and important quotations were reported verbatim to highlight common individual views.

Results

Table 1 present the social demographic characteristics of the respondents. The age characteristics revealed the mean age of the population as 30 years. The age distribution clearly revealed that women continue childbearing until their early 40s. The implication of these distribution is, the higher woman's age the greater the possibility of complications during pregnancy. The distribution of the respondents by marital status shows that 43 respondents representing 3.2% were single mothers, 1,224 respondents representing 89.9% were married, 45 respondents representing 3.3% were divorced, 22 respondents representing 1.6% were widowed and 28 respondents representing 2.1% were cohabiting. The implication of the marital status distribution is that women still found themselves either taking care of their pregnancy or children alone as single mothers, widows, or divorcees. These situations increased the possibility of not having good health care because most women may not have the economic power to survive alone. The distribution by religion (Table 1 panel 4) showed that Christians accounted for 57.8% of the sample while 40% were Muslims. Adherents of other religions constituted about 2%. Twenty six percent were illiterate, 49% engaged in petty trading, 8.1 percent house wife and 6.0% unemployed.

The income distribution of the respondents (panel 7, Table 4.1) revealed that 23.4% of women reported income of ₦5,000-10,000, 22.5% had income of ₦10,001-30,000, 20.9% had income of ₦20,001-30,000, 11.4% reported income of ₦30,001-40,000, 6.7% reported income of ₦40,001-50,000, 9.8% reported income of ₦50,001-60,000, while 9.2% reported above ₦60,000 income.

Table 1: **Distribution of Respondents by Demographic Characteristics**

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Variables	Frequency	Percent%
Local Government Area of Respondents		
Alimosho	380	27.9
Ikorodu	337	24.7
Ibeju Lekki	311	22.8
Lagos island	334	24.5
Total	**1362**	**100.0**
Age of Respondents'		
15-19	133	9.8
20-24	382	28.0
25-29	589	43.2
30-34	244	17.9
35-39	12	0.9
40 & above	2	0.1
Marital Status of Respondents'		
Single	43	3.2
Married	1224	89.9
Divorced	45	3.3
Widowed	22	1.6
Cohabiting	28	2.1
Total	**1362**	**100.0**
Respondents' Religion		
Christianity	787	57.8
Islam	545	40.0
Traditional	17	1.2
Free Thinker	13	1.0
Total	**1362**	**100.0**
Educational Qualification		
No formal	362	26.6
Primary	70	5.1
Secondary school	160	11.7
Tertiary	737	54.1
Koranic	33	2.4
Total	**1362**	**100.0**
Respondents' Occupation		
Petty Trading	667	49.0

Farming	20	1.5
Civil	297	21.8
Housewife	111	8.1
Unemployed	82	6.0
Other	185	13.6
Total	**1362**	**100.0**
Respondents' Income per month		
5000-10000	319	23.4
10001-20000	306	22.5
20001-30000	284	20.9
30001-40000	155	11.4
40001-50000	91	6.7
50001-60000	82	6.0
Above -60,000	125	9.2
Total	**1362**	**100.0**

Source: Field survey, 2011-2012

Table 2 shows the results of the multivariate analysis of first model prediction of the health condition of mothers given participation in certain household chores. These include shopping alone, share household chores, washing and availability of time to rest. The model indicated that doing all the household chores alone is negatively related to health condition of the mothers. The result shows that women who participate wholly in this type of activities were 0.803 times likely to be deficient in health condition. Pre-occupation with market activities by the wife shows positive correlation with experiencing of maternal health complications. This could be true because those who experienced conflict are 1.089 times more likely to experience health complications compared to the reference category (RC). Also, the result indicates that where there is no adequate time for resting, the women were 0.798 time less likely to have good health condition. This this may be an indication for complication, as a pregnant woman needs more rest and sleep to maintain her well-being and that of the fetus (Insel and Roth, 2004). In that regard, the increase in workloads and decreased attention to rest and relaxation as it had been identified in literature could be harmful to maternal health. These could be true because striving to meet or satisfy multiple roles at home can engender stress (Lu, 2011; Fadayomi, 1991), and, when physical or emotional stress builds up to uncomfortable levels, it can be harmful for pregnant women (March of Dimes, 2010).

Table 2. Logistic regression estimating the odds ratio of maternal health condition given certain indicators of role conflicts

Selected Variables	B	Exp(B)
Share household Chores	RC	-
Do all household chores alone	-0.219	0.803
Don't shop for household	RC	-
Shopping for household	0.085	1.089
Don't undertake washing	RC	-
Undertake washing	0.252	1.287
Have Time to Rest	RC	-
Having no time to rest	-0.226	0.798
Constant	0.826	2.284
2 Log likelihood = 1682.137		Cox & Snell R Square = 0.009
Nagelkerke R Square = 0.012		Overall Percentage = 68.6

Source: Field Survey 2011-2012 RC =Reference Category

In the second model as indicated in Table 3, lack of husband support is negatively related to maternal good health at OR=-0.539 and no in-law or relative support at OR=-0.076. These factors were 0.583 and 0.927 less likely to enhance good maternal health condition. Also, having someone one could turn to for comfort and discussion, and colleague to help on some duties were associated with maternal health complication, with B-value -1.273 and -1.394 respectively. This finding could be true, because, support may help an individual gain, regain, or use personal strength during difficult adaptive periods which demand more energy and resources, thus it can be expected to affect health during pregnancy and social support serves as an environmental mediator and influences a woman's experiences and the outcome of pregnancy (Haobijan, Sharna, and David, 2010).

It is also very important to indicate here that result of the analysis also shows that those who are not attending religious house for support vis-a-vis the reference category (RC) were more likely to have complication with OR= 0.965 and B value 2.624. This result is not strange because it has been found out that religious involvement is related to better mental and physical health, improved coping with illness, and improved medical outcome (Bussing *et al*, 2009).

Table: 3 Logistic Regression estimating the influence of social support on maternal health

Selected Indicators	B	Exp(B)
Get Husband's Support	**RC**	
No Husband's Support	-0.539	0.583
Get Support for Practical Help	**RC**	
No Support for practical help	0.382	1.465
Get in-law/relative Support	**RC**	-
No in-law/relative Support	-0.076	0.927
Someone comfort/listen Support	**RC**	-
No one to comfort/listen Support	-1.273	0.280
Colleagues Help	**RC**	-
No colleague Help	-1.394	0.248
Religion for support	**RC**	-
No to Religion for support	0.965	2.624
Constant	1.760	5.811
Overall Percentage 68.7%, Cox & Snell R Square 0.024, Nagelkerke R Square 0.033, -2 Log likelihood1661.378(a). Hosmer and Lemeshow Test-0.746		

Source: Field Survey 2011-2012 **RC =Reference Category**

Qualitative analysis

A mother who is employed full-time may experience role conflict, because of the norms that are associated with the two roles. She is expected to spend a great deal of time cooking, taking care of her children, and, simultaneously cope with the demands in her work place. This was found to be so significant to maternal health as the findings from the logistic regression analysis indicated a significant influence of role conflict on maternal health.

However, expression of role conflicts varied with educational level. For instance, educated women perceived the situation as more unpleasant and they would like to reduce the pressure if they have the opportunity, while women with low level of education saw it as the duties they must perform. While acknowledging the difficult conditions, they face during pregnancy, one of the mothers said:

> *I must carry out my normal chore. I didn't have a choice. I cannot say am pregnant and not do my duties. Except when my sister is around that is when I decide not to bother myself…. Sometime I want to stay back home to rest, but the problems with the situation is because my source of income is in Eko, Idumota, I am forced to go there every morning, if not there will be no food on the table. (34 years old woman from Alimosho LGA).*

It is also interesting to know that income status may influence control over role conflicts. For instance, the level of husbands' involvement with household chores is related to education and economic status. Educated women with higher income and husbands' support can reduce the work load by employing domestic workers or keeping

relatives that can be of help. When asked how she has been coping with the demands of work and home with pregnancy, a banker and wife responded as follows:

> *Sincerely speaking, it exerts some pressure on me. What I normally do to reduce the stress was that, during the weekends I do call a woman that normally wash clothes for me and clean the house. Also, I have a caterer that I pay to help me to prepare stew and soup that I keep in the refrigerator which can last up to a month at a time. And if my husband gets home before me, he helps to remove the soup or stew rom the refrigerator to hasten the cooking for the night. The only challenge with this is the irregular power supply.* (28 years old mother from Alimosho LGA).

In some cases, the respondents did not have any form of assistance from relatives. The risk is reflects by how much these women become susceptible to miscarriage which is largely attributable to stress in its various forms, that is physical or mental stress. A respondent from Egbeda said,

> *"I had two miscarriages. I don't know why. I went to the hospital when I noticed I felling strange. It (the pregnancy) was like 4-month-old. May be because of my work, I still carried out my normal duties when I was pregnant".*

Women may believe that they cannot afford the "luxury" of taking time out to visit a health centre or to have a period of incapacity because this would represent time and effort lost to other essential, and possibly more important, activities such as making money, child care, and paid employment (AbouZahr 1994; Bhattacharyya and Hati 1995, as cited by Kitts, and Roberts, 1996). For instance, a pepper seller made the following statement;

> *I sell pepper, rest for what! Am I not the one that is looking for money? It is only when it is not market day, that, maybe I can rest, apart from that my pepper will even spoil. …. I don't normally eat at home because from morning till night am in the market so I buy food from sellers around.*

It was also discovered that, experiencing unpleasant marital dissatisfaction can also reduce the support they get from their husbands during pregnancy. Women getting into union illegally may lack conjugal harmony, which can have a sort of pressure on them. Thus, when they move into the marriage and are confronted by a different reality, dissatisfaction may arise. In fact, a woman said she would not support girls to be too engrossed with love and forget to marry properly before packing into the man's house. When asked why she would not support such a situation, she said:

> *I am a victim of that, I got pregnant for him and moved to his house and now am facing the trouble. I was not aware that He had a wife before. I must work hard to sustain myself.*

Furthermore, this finding is consistent with Israel *et al* (2002) that observed that number of emotional supports have a significant effect over and above the effect of stressors. Moreover, the literature has emphasized the importance of strong social supports as important influence of health outcomes (Kodzi *et al*, 2010). There is considerable evidence in the medical literature about the positive effects of community and individual social capital as well as social interaction on various measures of health and well-being

Discussion

The results suggest that women's entry into the labour force, along with their continued role as primary caretakers and its associated domestic responsibilities, were major source of pressure on their health. Role conflict of women

appears to have influence on maternal health, pregnant women carrying out their house chores without helping hands showed higher poor maternal health. Many individuals argue that the reason for this phenomenon has been primarily economic. Most women work because of economic necessity rather than by choice (Fadayomi, 1991). The spillover effect of having difficulty combining work with home chores during pregnancy is a threat to maternal health, as it been identified in the result.

As stressed by Doyel (2002), home is often regarded as a refuge from the pressures of work and the outside world, but for women who are still primarily responsible for home and child care, home often means unceasing demands from children and other family members and the increased burden of household tasks. Not only do they come home late, women after a busy day's work, branch off to the market to get some stuff for cooking and then get back home to perform their socio-cultural role. Lack of constant electricity supply force women to go to market as often as the needs at home demanded.

Also, as revealed in the qualitative results, low level of education, income and lack of amenities also poses a serious hindrance to copping with multiple roles. Women were not able to afford domestic help and create time for rest because of lack of economic power. Azim and Lotfi (2011) found that, association between SES and health stems, in part, from experiencing greater stress, either perceiving that demands exceed abilities to cope, or by exposure to life events that require adaptation. Besides, cultural factors, such as commonly held attitudes and behaviours, like gender roles, and other cultural beliefs constitute concepts that influence role conflicts and social support. For instance, Women perceive their role as a wife as compulsory and which must be done without excuses. Education can be instrumental in shaping individual's interaction with the surrounding worlds, exposure to new ideas and alternative lifestyles which might lead to questioning of traditional norms and motivate greater willingness to adopt innovative behavioral models (Idowu et al, 2011).

This is an indication that maternal health challenges will continue to shape national indicators on health, poverty, and other development issues, if adequate attention is not provided.

Limitations

Maternal health was considered as the existence or absence of complication as Yes or No, limited the ability to conduct complication based statistical analysis; this may be an interesting question for further research. Also, our measures were self-reported and therefore the possibility of respondents giving socially desirable responses.

Conclusion and policy recommendations

This study presents how maternal health can be understood within the context of social networks, and how the type and quality of support can mediate maternal health outcomes. The study therefore concludes that women double roles have negative influence on maternal health. Given the scarcity of resources which lead to women's involvement in economic activities, increased attention should be given to the strengthening of natural social support system to assist women during pregnancy. Because of the disruptive social circumstances, current medical interventions are not effective enough to reduce maternal mortality and morbidity. Therefore, the social, economic, and cultural context should be an important source of complications requiring means of intervention. However, in a bid to providing more social supports to women during pregnancy, the problem needs to be addressed from structural dimension; women alone are not responsible for pregnancy; men's responsibility in such situations also must be addressed. Therefore, this study calls for enlightenment and the education of men on maternal health complications and promotion of men support for their wives during pregnancy as a way of

enhancing maternal health outcomes among pregnant women. There should be targeted health policies toward maternal wellbeing during pregnancy, that enhance protective factors, as well as buffering and moderating risk factors identified in this study.

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