

INTRODUCTION

Globally, it was reported that a woman dies in every minute from childbirth complications related issues (Igberase, Isah & Igbekoyi, 2009). Report also shows that almost half a million women die each year as a result of maternal causes with 99% of the deaths taking place in developing countries (Mismay & Richard, 2006). According to the World Health Organization (1993), maternal mortality is referred to as the death of a woman during pregnancy or within 42 days after the termination of a pregnancy, from any cause related to the pregnancy or its management but not from accidental causes. The challenge of reducing maternal mortality remains a major problem in Nigeria. The 2008 Nigeria Demographic and Health Survey (NDHS) estimated maternal mortality ratio (MMR) at 545 /100,000 live-births while 2013 NDHS also estimated maternal mortality ratio as 576 /100,000 live births in 2013. The life time risk of maternal death shows that one in every thirty Nigeria women will have death linked to pregnancy or childbirth, which shows that maternal health situation in the country has deteriorated over the five years' time interval (NPopC & ICF Int'l, 2014). It was established by literatures that utilization of maternal health care services such as antenatal care visits, place of delivery and postnatal care received from skilled health workers are the effective ways of reducing the risk of maternal mortality and morbidity (Mhango, Rochat & Arkutu 1986; Mpembeni, 2007; Anya, Abba & Jaiteh, 2008; Heidi, Emelita & Heidi, 2006; Mpembeni et al., 2007). According to United Nation (2006), adolescent population was projected to be 200 million by 2015. This high proportion of adolescent population is both a potential for development and source of social and public concern. It is believed that the choices they make have implications for their lives today as well as their future (Juarez & Martin, 2006). Almost half of the world's populations are under the age of 25 (United Nations, 2005), it is imperative to consider the issues relating to their rights and wellbeing especially in the areas of education, work, relationships and health as well as sexual and reproductive health. It was established by literature that young people do face a lot of challenges such as early initiation of sex, unwanted pregnancy, unemployment and sexual transmitted diseases (National Council for Population and Development, 2000). Study have shown that most of the young women neither benefited from programmes designed for adolescent nor deriving any joy of motherhood, as a result of their young age, lack of autonomy and inexperience (Nicole, Chong & Bracken, 2004; World Health Organization (WHO) & United Nations Population Fund(UNFPA), 2006). Owing to their

inexperience they need to seek the opinion of their mother-in-law or husband for permission before taking steps on health matters, such as their maternal health and that of their babies. Studies have examined the relationship between women's autonomy and utilization of maternal health care service but focusing on full age reproductive spectrum while little attention has been paid to how women's autonomy influence the utilization of maternal health care services of married youths in Nigeria.

Methodology

Cross sectional data of the 2013 Nigeria Demographic and Health Survey (NDHS) was used for this study. Stata 12 software was used to extract 4, 996 young married women age (15-24) who have at least one child in the last five years preceding the 2013 (NDHS). Associations were explored using binary logistic regression analysis. The theoretical framework used was "Marilyn Frye, The Possibility of Feminist Theory which identifies those forces that maintain the subordination of women to men. The outcome variable is utilization of maternal health care service using place of delivery and number of antenatal care visits. The two outcome variables were dichotomized; those who delivered their babies in Government hospital, Government Health Center, government health post, other public sectors, private health center and other private sector were coded as (1) while those who delivered their babies at respondent home, other home and others are coded as (0). The number of antenatal care visits was also dichotomized as (0) less than four visits, (1) four visits and above. Further, the principal explanatory variables is women's autonomy which was measured using women decision on large household purchase, decision on visits to relative/family and decision on women own health care. In these three indicators and overall Composite score was created to reflect number of decision women participate either alone or jointly. This was achieved by generating new variable called autonomy and the three indicators were adding together which produced a minimum of 0 and a maximum of 3. Respondent who had scored (2 to 4) were classified as "high autonomy" and respondent who scored (0 and 1) were classified as "low autonomy". Other important socio-demographic variables are: wealth index, employment status, highest level of education, religion, place of resident, marital status and age of respondents.

Results

Table1 below describes eight models predicting the odd of utilizing maternal healthcare services. First two Models describe the odd of predicting the effects of socio-economic characteristics and

number of antenatal care visits for both adjusted and unadjusted intervening variables, the odd of the two models shows that there is a significant relationship between socio-economic characteristics and number of antenatal care visits except mothers' religion and marital status. Further, model3 and model4 also show the odd of predicting the relationship between women's level of autonomy and number of antenatal care visits. Adjusting for distance to health facility and exposure to mass media, the results of the models show that those young married women who had low autonomy (OR=0.35, $p<0.05$) are 65% less likely to have four number of antenatal care visits compared to their counterparts who had high autonomy while inclusion of exposure to mass media and distance to health facilities reveals a greater increase from the odd of predicting the number of antenatal care visits. That is, those respondents who were exposed to mass media and reported that distance to health facility is not a problem (OR=3.02 & 2.75, $p<0.05$) respectively, are more likely to have four or more number of antenatal care visits. As expected, model5 and model6 depict the odd of predicting the relationship between socio-economic characteristics of young married women and place where the respondent delivered her babies and found significant relationship between them except mothers' marital status. Adjusting for exposure to mass media and distance to health facility, results show that there is a significant relationship between married young women level of autonomy and place of their delivery. That is, those who had low autonomy (OR=0.32, $p<0.05$) are 68% less likely to deliver their babies at health facility compared to their counterparts who had high autonomy. Incorporation of exposure to mass media and distance to health facilities with level of married young women autonomy, the results show that exposure to mass media and distance to health facility lead to a significant increase in the odd of delivering their babies at health facility. That is, those respondents who are exposed to mass media and reported that distance to health facility is not a problem (OR=2.95 & 2.31, $p<0.05$) respectively, are more likely to deliver their babies at health facility.

In conclusion, although the study has its shortcomings in making causal inference as a result of cross-sectional nature of data used, programme and policy aimed at increasing utilization of maternal health care service in Nigeria should not undermined the influence of women's autonomy. The study hereby recommends that more efforts should be made in addressing level of women's autonomy among married youths in Nigeria.

Table1: Logistic Regression Analysis of Likelihood of Utilization of Maternal Health care Services (place of delivery and antenatal care visits) among Married Young Women (15-24) NDHS, Nigeria (2013)

Variables	Number of Antenatal Care visits				Place of Delivery			
	Model1	Model2	Model3	Model4	Model5	Model6	Model7	Model 8
	OR	OR	OR	OR	OR	OR	OR	OR
Wealth Index								
Poorest	1.00	1.00			1.00	1.00		
Poorer	1.62*	1.45*			1.84*	1.81*		
Middle	2.87*	2.28*			3.53*	3.30*		
Richer	4.21*	3.20*			4.42*	4.10*		
Richest	6.91*	5.16*			7.01*	6.44*		
Employment Status								
Not Working	1.00	1.00			1.00	1.00		
Working	1.3*	1.31*			1.29*	1.26*		
Level of Education								
No Education	1.00*	1.00			1.00	1.00		
Primary	2.15*	2.11*			1.92*	1.87*		
Secondary	3.18*	2.88*			3.03*	2.88*		
Higher	3.94*	3.28*			13.97*	12.63*		
Religion								
Catholic	1.00	1.00			1.00	1.00		
Other Christian	1.17**	1.22**			0.48*	0.46*		
Islam	1.00**	0.97**			0.27*	0.25*		
Traditional	1.00**	1.27**			0.28*	0.29*		
Place of Resident								
Urban	1.00	1.00			1.00	1.00		
Rural	0.73**	0.81**			0.60*	0.63*		
Marital Status								
Married	1.00	1.00			1.00	1.00		
Widowed	2.66**	2.55**			1.78**	1.68**		
Divorced/Separated	0.97**	0.96**			1.33**	1.37**		
Exposure to Mass Media								
Not Exposed		1.00				1.00		
Exposed		1.48*				1.62**		
Distance to Health Facility								
Big Problem		1.00				1.00		
Not a Problem		1.98*				0.62*		
Women's Level of Autonomy								
High Autonomy			1.00	1.00			1.00	1.00
Low Autonomy			0.35*	0.40*			0.32*	0.38*
Exposure to Mass Media								
Not Exposed				1.00				1.00
Exposed				3.02*				2.95*
Distance to Health Facility								
Big Problem				1.00				1.00
Not a Problem				2.75*				2.31*

*p<0.05, **p>0.05