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Attitude and Decisions Regarding Personal Healthcare: The Case of Women under Microfinance in Edo State, Nigeria

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The paper examined women's attitude towards their personal health using the Health Belief Model as theoretical framework. Questionnaire was administered to 750 purposively selected respondents consisting of 400 from 3 branches of a microfinance banks (MBs) with integrated health services (IHS), and 350 from 3 other MBs without IHS in Edo state Nigeria. Key Informant Interviews (KIIs) were conducted with 20 microfinance officials. Questionnaire was administered to 750 purposively selected respondents consisting of 400 from 3 branches of a microfinance banks (MBs) with integrated health services (IHS), and 350 from 3 other MBs without IHS in Edo state Nigeria. Twenty Key Informant Interviews (KIIs) were conducted with microfinance officials. Women displayed positive attitude towards their personal health with mean score for clients in both MBs with IHS and without IHS being 63.9±8.2 and 47.9±5.6 respectively (where mean score for positive attitude is ≥ 40). Furthermore, although 62.0% agreed "they cannot take their health for granted no matter what", those who agreed and were undecided that "they won't make decisions about their health without their spouses" were 47.8% and 32.8% respectively. Women's roles as caregivers and dependants on their spouses make them prioritize their household needs and spouses' decision over their personal health. Enlightening women on the relevance of prioritizing their personal healthcare is recommended to reduce poor health conditions among women.
Keywords: Attitude, Decisions, Integrated Health Services, Microfinance, Personal Healthcare

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I. BACKGROUND

Poverty and poor health are feminized phenomena that continuously interplay, with each being influenced by the other in both directions. While about half of the Nigerian population is constituted by women (Otite and Ogionwo, 2006; NDHS, 2008), over 70 percent of the agricultural sector is contributed to, by them (Aina 2012; Otite and Ogionwo, 2006). Still, women form the bulk of those who are marginalized, vulnerable and dependent in the Nigerian society (Sofo and Toni, 2008). In order to negotiate the undesirable status of women, making them accessible to soft loans and microcredit through microfinance services of over two decades becomes inevitable as a goal in society (Daley-Harris, 2002). While targeting more women, the implication of microfinance services, were anticipated to result in increased social and economic empowerment. This in turn was expected to translate into reduced poverty, increased women's ability to cater for themselves and enhance their contributions to household needs as well enable them make decisions independently even matters that affect their personal lives including their health (Irobi, 2007). To this end, microfinance had extended their initiative into combining financial services with health-related issues such as health education or health insurance products (Nigam and Mohiudim, 2008). Furthermore, scholars have assessed these initiative and discovered that they provide income empowerment and knowledge to address priority health concerns and have also empowered microfinance clients to make informed decisions in matters affecting their health (Littlefield, Dunford, Metcalfe, Reinsc., Gash, and Gray, B. 2011).

While the act of decision making may be seen as something that is supposed to be sure, it is however uncertain and based on trial and errors both on the part of the patient and the health care provider where healthcare issues are concerned. Hence Greenhalgh (1990) perceives it as a "buffoon blundering blithely". A situation whereby decisions on healthcare are not straight-jacketted and sure but are neither here nor there, requiring test and re-test, complains, feedbacks, suggestions from patients, significant others and other health workers. Women are seen as passive when making decisions but are also considered by her as "active strategizers" in decision regarding fertility and reproduction of young ones (Greenhalgh, 1995). Furthermore, aside from the reproductive health challenges faced in the bid to contribute to societal continuity and survival, women are victims' of maternal mortality and more distressed from infant mortality resulting more often from poor health conditions (Nwokocha, 2005) and other poverty-related illness. They are also usually faced with the double tragedy and dilemma of making decision on their personal healthcare because of the positions they

occupy as care-givers and roles they are expected to perform as "good wives and mothers". This is not unconnected with the experience of an average woman in the African setting and Nigeria in particular who has been socialized to be strong, caring, selfless and submissive to their husbands. Thus, decisions on their personal health care can only be viewed as secondary except their husbands perceive it otherwise or the health condition of the woman has deteriorated and is perceived very serious. The secondary value placed on a women's personal plans, dreams and in turn their health is summed up in the general saying in African as well as Nigeria that a "woman's place is in the kitchen", an axiom which has influenced the socialization of the Nigerian girl-child and is highly upheld by the women as well to aspire in life to be an enviable mother and wife who depends on the husband to make the decisions regarding her life. A Nigerian renowned professor summed this up during her inaugural by saying...

"like every young girl of my time, all I wanted was to be married, raise my children and be a devoted wife. I never knew that it was possible to combine the world of academics with raising a God-fearing family. The man that made that possible was my husband" Aina 2012 (pp.1)

The question that comes to mind is what happens in cases where the husbands of the women do not make the achievements possible? Would the woman have been a less achiever? Perhaps yes. From the foregoing, it is obvious that women's role within the domestic domain is emphasized even in scholarly discourse to the extent that an action outside such which is evident in been a working woman, is perceived as "inconsistent with the African stand" (Oludayo and Aderinto 2011) and "a withdrawal of attention from the care of the home and children for which they are really needed" (Erinosho, 2005). Hence a woman is expected to "hang her fate in the balance" in performing the "expected" duties of caring for the home and children as her "traditional African role" (Oludayo and Aderinto 2011). Little wonder why Onyeonoru (2005) insisted that women be paid for carrying out these domestic activities which are not recognized as payable labour in the society. The situation is critical for issues that have to do with the inability of women to make independent decision regarding their personal health even when they are empowered financially through microfinance intervention (Taiwo and Owumi 2014). Hence they hardly utilize health care services (Roberts, 1992) not only due to the fact that they spend most of their income on house hold expenses (Irobi, 2007) but also because they depend on their husbands to make decisions for them on several issues including their health (Ofori-Adjei, 2007; Cheston and Kuhn, 2002). Obaid (2005) buttressed this view by saying:

"we know that poverty is not just about lack of money; it is also about lack of choice. This is particularly true for women. Today, many women cannot make their own choice about seeking medical care. These choices are made for them and in the worst cases, there are simply no choices".

Again, the need to submit in these "seemingly choiceless" situations restricts them to relegate their own health matters to the background until when their bodies can no longer cope. It is against this background that the paper seeks to examine the observed indecision of women under microfinance intervention in making decisions on their personal health, by specifically examining the level of importance women attached to their health compared to other expenses and investigating the attitude of women towards their personal health.

The attitudes of individual to a large extent influence their health-seeking behaviour. Health-seeking behaviour generally refers to the activities carried out by individuals to return back to a state of healthiness from ill-health or maintain/retain a state of healthiness/well-being. Some scholars view health-seeking behaviour as an aspect of health behaviour which includes knowledge, attitudes, belief and practice in the pursuit of quality health care provision (Igun, 1979, Muela, S., Muela J., and Nyam Ongo 2003). It involves decision making processing accompanied by action to ensure a healthy state. According to Jegede (2010), people are faced with a dilemma in their choice of health care services due to several factors which are usually influenced by their health, culture and the role of significant others.

II. THEORETICAL DISCOURSE: HEALTH BELIEF MODEL

The Health Belief Model (HBM) attempts to predict health-seeking behaviours by focusing on the attitudes and belief patterns of individuals. The model was originally introduced in 1950s by psychologists working in the United States Public Health Service. HBM has been adopted to explore a variety of long-term and short-term health-seeking behaviours including sexual risk behaviours and the transmission of HIV/AIDS. The HBM attempts to predict health-related behaviours in terms of certain belief patterns. This model is used in explaining and predicting health behaviour, as well as sick-role and illness behaviour and stipulates that a person's health-related behaviour or health-seeking behaviour and appropriate decisions on healthcare depends on the individual's perception of four critical areas. (Rosentock, Stretcher and Becker, 1988)

Perceived Susceptibility: Each individual has his/her own perception of the likelihood of experiencing a condition that would adversely affect one's health. Individuals vary widely in their perception of susceptibility to disease and in turn decisions they will take regarding their health. Those at low end of the extreme, deny the possibility of contracting an adverse condition or disease and may delay in deciding on what to do. Individuals in a moderate category admit to a statistical possibility of disease susceptibility and may decide faster than those

at the low extreme. Those individual at the high extreme of susceptibility feel there is real danger that they will experience an adverse condition or a given disease and may therefore be more prompted in decision making than the others.

Perceived seriousness: This refers to the belief a person holds concerning the effects a given disease or condition would have on one's state of affairs. These effects can be considered from the point of view of the difficulties that a disease would create. For example pain and discomfort, loss of work time, financial burdens, difficulties with family members, relationships and susceptibility to future condition. It is important to include these emotional and financial burdens when considering the seriousness of a disease or condition.

Perceived benefits of taking action: Making decision or taking action toward the prevention of and seriousness of disease or condition or towards dealing with an illness is the next step to expect after an individual has accepted the susceptibility of a disease and recognized it is serious. The direction of taking action that a person chooses will be influenced by the beliefs regarding the action.

Barriers to taking action: Decision and action for instance may not take place even though an individual may believe that the benefits to taking action are effective. This may be due to barriers related to the characteristics of a treatment which may be considered inconvenient, expensive, unpleasant, painful or upsetting. These characteristics may lead a person away from taking the desired action (Rosenstock, 1974).

The model also incorporates **cues to action**, which refers to cue or a trigger to appropriate action such as decision of one's spouse, information from mass media and opinions from one's relatives. The construct of self-efficacy, or a person's confidence in his or her ability to successfully perform an action, has added to the model (Rosenstock, 1974), perhaps allowing it to better account for habitual behaviours, such as a physically active lifestyle. The HBM relies primarily on the subjective interpretations and meanings that individual assign to symptoms and illnesses.

In summary therefore, the health belief model conceptualizes decision to taking health action as influenced by perceived threat (either susceptibility to a particularly condition, or perception that the condition is severe and judgment about the barriers and benefit associated with specific changes in behaviour). The perception of women about their health will influence their attitudes towards health seeking or preventive measures required to maintain a healthy such as consulting medical practitioners for health care, going for proper check-ups, early visits to health care centre when ill and utilizing healthcare services as part of their priorities. However when symptoms are not perceived as severe or life threatening, women are less likely to utilize healthcare and be less anxious regarding their health status. This they may do, to avoid the high cost of health care (which are barriers to taking action) and utilize income to meet other responsibilities that are considered more important such as repaying their credits without hassles.

Foult *et al*. (1983) further contributed to this model by saying that patients who understand their problems in terms similar to those of their doctors are more likely to follow treatment procedures than patients who believe their illness results from religious, magical or other sources not generally considered valid by modern medicine. Thus, women who do not perceive that their health is at risk will not have an attitude to effect changes even when the doctors suggest so. This is because even when it is proven or suggested that more priority should be given by women to their health to avoid breakdowns in the midst of low income, perception of the individuals need to go in line with such view for attitudinal and behavioural changes to occur. This may explain the reason why some women manage their health conditions even when the disease symptoms are glaring. They prefer to save the cash that would otherwise have been used for hospitals bills to contribute to household expenditures, pay school fees rents, and take care of household members due to the perception that the diseases are not severe or rather expensive to cater for. Except they are probably pressurized by their spouses or relatives and friends to seek treatment from health care centres (cues to action) They may however medical attention when the situation becomes critical and illness symptom is perceived as severe.

III. METHODOLOGY

Edo state which is located in the western part of Nigeria is the capital of Benin city and was chosen as the study area because the headquarters of an internationally recognised microfinance bank (Lift Above Poverty Organization (LAPO) which has a health component integrated into its services is situated in it. The multi-stage sampling techniques were adopted in the selection of the respondents. The state is made up of 18 local government areas in the state out of which three states (Oredo, Esan-West and Edo Central) were purposely selected due to the proliferations of MFIs in them. Six MFIs (that had existed for six years and above) were then purposively selected six communities from the states. The MFIs included three branches of Lift Above Poverty Organizathion (LAPO) microfinance institutions with-integrated health services (IHS) and three others ((Auchi, Jattu, Ekpoma) MFIs-without IHS in Edo state. The study design was both descriptive and cross-sectional survey which involved the use of quantitative and qualitative methods of data collection. A structured questionnaire was administered on 750 purposively selected respondents consisting of 400 respondents in microfinance banks that integrate health-related services in their programmes and 350 respondents in

microfinance banks that do not , Thirty-four (34) interviews consisting of fourteen (14) in-depth interviews and 20 key-informant interviews were conducted with prominent female clients and officials of microfinance institutions respectively, and finally eight (8) Focus Group Discussions (FGDs) one for each microfinance and except LAPO Benin, where two FGDS were conducted. The study population consisted of women who had been clients of selected MFIs for over three years. The FGDs and interviews were monitored by a facilitator and an interviewer respectively. In both events, discussions were tape-recorded along side with note-taking. While quantitative data were gathered through field-assistants (more of whom were females) who had under-gone a two-days training.

Ethical considerations were ensured before and during the data collection process as respondents consent was sought before commencement of their participation and were assured of confidentiality. The rights of withdrawal at any point or withhold of information that are perceived as impingement on their privacy were completely recognised and no physical harm was experienced by respondents for participating in the research.

The quantitative data were cleaned to reduce errors and ensure validity and reliability of results. The data which was generated from pre-coded, fixed choice and open-ended questions were inputted using a Microsoft Access Software so as to ensure effective data management and minimize data error. The statistical package of the Social sciences (SPSS) was then utilized to analyze the data at univariate and bi-variate levels to indicate percentages and test of associations. Qualitative data was analyzed using the computer assisted data analysis (CAQDAS) package in line with the objectives of the study after being translated and transcribed.

IV. RESULTS AND DISCUSSION

The demographic characteristics of respondents for the study are shown in table 1 below. It revealed that nearly half of the respondents in the study fell within the ages of 31-40 years.

Demographic Characteristics of Respondents

Table 1: Demographic Characteristics of Microfinance Bank (MCB) respondents

Characteristics	Total N=750	MBs with IHS N=400	MBs without IHS N=350	Chi-square value
Age of Respondents (%)				
21-30	12.0	12.5	11.4	
31-40	47.1	43.5	51.1	.043**
41-50	27.9	28.0	27.7	
Above 50	13.1	16.0	9.7	
Marital Status (%)				
Single/Never married	6.1	6.1	6.1	
Married	82.1	83.3	80.7	.736
Separated/Divorced	1.7	1.5	2.0	
Widowed	10.0	9.1	11.0	
Residential Type (%)				
Face to face apartment	46.5	46.6	46.3	
One bedroom self-contained	17.1	14.7	19.9	.236
2-3 bedroom flat	32.7	34.9	30.2	
Bungalow/Duplex	3.7	3.8	3.5	
Residential Area (%)				
Low density	3.8	3.3	4.3	
Moderate density	60.3	60.9	59.6	.754
High density	36.0	35.9	36.1	
Dependants above 18 years (%)				
1	17.4	19.5	15.6	
2	38.3	42.2	33.9	.222
3	18.7	18.7	18.7	
4	12.4	10.4	14.7	
5 and above	13.1	13.1	13.1	
Dependants below 18 years (%)				
1	18.7	17.5	20.1	
2	24.0	24.6	23.4	.937
3	30.5	30.4	30.5	
4	19.5	19.8	19.1	
5 and above	7.4	7.7	7.0	

Again, slightly above half of respondents (51.7%) had secondary education while very few (8.7%) had tertiary education with a higher representation (11.8%) of clients of the microfinance banks that offer health-related services. These findings confirmed those of Ehighiamusoe (2009) that many microfinance respondents in Nigeria lack tertiary education and formal skills. Over 80 percent of the women (from both categories of microfinance banks) are married. Women at some point had to be discreet about their status of being a widow, a separated or an unmarried in describing applicable marital status. Again, the high social value placed on the marital status of being "married" is unraveled as women depend on their husbands to guarantee that they will not default in repaying loans collected. The rest 20 percent who fell within the categories of singles and widowed are covered by the strength of the majority who are married/ while almost half of the respondents (46.5%), reside in face to face apartments. The level of dependency on the microfinance clients was observed to be high as majority revealed that they had at least two to three dependants both below and above 18 years of age either as their children or siblings staying with them. This supports the views of Daley-Harris 2002 that the influence of microfinance on the well being of clients extends even to their family members.

Socio-economic Characteristics of Respondents

In Table 2. below, a little above half of the clients (51.7 percent) have secondary education. Also, a few of the respondents (5.9 percent) had no education while just a handful had learnt vocational skills (6.9 percent) ranging from hair dressing, to tailoring, to bead-making. However more clients from microfinance banks without IHS are represented within these descriptions than those from microfinance banks with IHS. The result corroborates the views of Ehighiamusoe (2009) on the fact that most microfinanced women in Nigeria, particularly in Edo state, are just secondary school certificate holders and may have some form of vocational skills.

Furthermore, a handful (above 30.0 percent) of the spouses of the women were into some form trading and artisan jobs , while over half of them earned between N20,001-N30,000 monthly.

Table 2.

Socio-economic characteristics of Microfinance Clients

Characteristics	**Total N=750**	**MBs with IHS N=400**	**MBs without IHS N=350**	**Chi-square**
Educational Qualification (%)				
No education	5.9	2.8	9.4	
Non-formal education (vocational)	6.9	5.8	8.3	.000**
Primary	26.8	27.1	26.6	
Secondary	51.7	52.6	50.6	
Tertiary	8.7	11.8	5.1	
				.
Occupation (%)				
Farming	2.0	2.0	2.0	
Trading	86.8	87.7	85.8	.893
Artisan	9.9	9.0	11.0	
Private employee	0.8	0.9	0.9	
Government employee	0.4	0.5	0.3	
Monthly Income (%)				
10000 and below	18.7	4.5	9.1	
10001-20000	32.8	37.8	38.3	
20001-30000	22.1	28.5	17.1	.000**
30001-40000	10.1	10.5	10.4	
40001-50000	5.0	5.5	5.1	
Above 50000	6.7	9.1	4.5	
				.
Spouse Occupation (%)				
Farming	4.4	3.8	4.8	026**
Trading	33.6	33.1	34.3	
Artisan	40.7	45.4	34.6	
Private employee	8.2	9.7	7.0	
Government employee	10.8	10.8	10.8	

				.003**
Spouse monthly Income (%)	4.6	4.5	4.7	
10000 and below	9.1	7.8	11.3	
10001-20000	11.9	16.3	5.1	
20001-30000	56.6	55.3	58.6	
30001-50000	17.8	16.3	20.3	
Above 50000				

Attitude of respondents towards their personal health

Respondents' attitude was examined using a 20-statements scale. Attitudes were classified as positive or negative depending on type of response given to the statements. The proportion of respondents who gave appropriate response for each category of microfinance was compared to determine the kind of attitude respondents had towards their personal health. The 20-statements bothered on respondents' perception about their health, decisions about their health, preference and behaviours. Responses on attitude were placed on a scale of 5-item scale such as: Strongly Agreed (**SA**)-**1**, Agreed (**A**)-**2** , Undecided (**U**)-**3**, Disagree (**D**)-**4**, Strongly Disagreed **(SD)-5.** These were responses were later re-coded into a 3-item scale undecided (1), Disagreed (2) Agreed (3). The proportion of respondents responses in line with these options were computed for both categories of microfinance banks. Significant differences were observed for every response as indicated by the chi-square value at p=0.05. It was assumed that individuals or group of individuals whose mean response to the question was less than 40 (20x2 i.e number of statements multiplied by the 2nd least response i.e disagreed) were categorized as having **negative attitude** towards their health, while those who scored a mean of 40 and above (were categorized as having **positive attitude.**

The hypothesis tested states **"***Women under microfinance banks that integrate health related services will display more positive attitude towards their health than those that those from microfinance banks that do not integrate health related services"*

Table 3. ***Analysis of variance on respondents' attitude towards personal health care***

Microfinance banks	N	Mean	Std. Dev.	F-Value	Df	P-Value
with integrated health services (MBs with IHS)	400	63.9650	5.5549	20.563	4	.000
without integrated health services (MBs without IHS)	350	47.8914	8.1617			

The above table showed a significant difference between in the attitude of women in microfinance banks with integrated health services and that of women microfinance banks without integrated health services n in (F=20.563, df = 4, P < .05). It could be observed from the above table that the respondents studied have positive attitude towards their personal health considering the mean score of the clients in both MBs with IHS and MBs without IHS being 63.9±8.2 and 47.9±5.6 respectively were both above 40.0. The hypothesis that female clients of microfinance services that integrate health services are likely to display more positive attitude than those from microfinance banks that do not integrate health services is therefore accepted. The implication is that more women from microfinance may likely seek for health care or display better health practices towards maintaining a healthy living considering their higher positive attitude.

Table 4. Distribution of respondents by attitude towards their personal health using perception statements

Statements	Responses	Microfinance clients			X^2	Df	Sig
		MBs with IHS (N=400)	MBs without IHS (N=350)	TOTAL (N=750)			
My contribution to my family needs matters more than my health	Undecided Agree Disagree	13.8 37.3 49.0	24.8 46.5 30.0	18.3 41.6 40.1	19.276	2	.000
No need to spend money in the hospital unless am very sick	Undecided Agree Disagree	11.0 43.5 44.5	14.6 50.7 28.9	12.7 46.5 37.2	15.765	2	.000

I will get well when I am sick even without treatment	Undecided Agree Disagree	15.0 39.8 45.3	22.0 40.6 37.4	18.2 40.1 41.6	12.683	2	.000

At the level of perception, a significant difference was observed between women's attitude towards their health in the two categories of microfinance banks as indicated by the chi-square value ($p<0.05$). More respondents (49.0 percent) in microfinance banks that integrated health service than those (30.0 percent) in MBs without IHS services disagreed with the view that their contribution to their family matters more than their health. Whereas, more (46.5 percent) respondents in MBs without IHS than those (37.3 percent) in MBs with integrated health services agreed to the statement. The proportion of those who however were undecided in responding to their views that their contribution to household-needs was more important than their personal health was 18.3 percent. This shows that women in the microfinance banks studied, contribute to household needs and consider it a necessary role that needs to be performed as related by Sofo and Toni (2008) and Onyeonoru, (2005). The perceived necessity for the performance of these roles could also affect their commitment towards ensuring a healthy living depending on the type of family, level of exposure, level of education and level of income of the woman involved. Looking at the total however, while 40.1 disagreed to this view, a total of 59.9% consisting of 41.6% and 18.3% agreed and were undecided respectively about the view that their contribution to the household needs matter more than their health. The dilemma faced by the average poor Nigerian woman as to which should be considered more important between their health and household needs is again reflected in this response. This is not unconnected to the fact that women are socialized to believe that their success is a function of how well they perform their roles as mothers, wives and care-givers. Their orientation maybe, that the household (husband and children) comes first even before their personal health so that they will not be seen as in a bad light as "irresponsible mothers or wives" when the reason otherwise.

Furthermore, in responding to the statement "no need to spend money in the hospital unless am very ill". A total of 59.2% which consisted of 12.7% and 46.5% were however undecided and agreed respectively to the above view. This view confirms the perspective of Greenhalgh 1995 that women are active strategizes in their decisions; they would rather spend less for their health care except in critical conditions. Again this confirms the views of the health belief model that the perceived severity of an illness influences the health-seeking behaviour of individuals. On the perception that they will get well when sick even without treatment, about the same proportion of respondents agreed and disagreed to this view. The proportions of those who agreed and were undecided were 59.2 percent. While those who agreed to this view were represented by about 40.0 percent and 41.0 percent of respondents in MBs with IHS and MBs without IHS respectively, nearly 20 percent of the respondents were undecided about this view. Again while the proportion of clients who agreed to this view calls for concern in terms of respondents' health seeking behaviour, the perceived severity or seriousness of illness could be responsible for the type response. This may account for the proportion of clients who were undecided about the view. A significant difference was also observed in the decisions of respondents regarding their health as indicated by the chi-square value. However, one striking issue is that the "undecided" responses though small in proportion were more obvious, when statements regarding decision-making about women's personal health, were raised. When posed with the statement "I determine whether to seek medical attention or not", 21.6 percent were undecided about the view, while 41.7 percent disagreed. Those who disagreed were represented by 42.6 and 40.5 of respondents from MBs without and MBs with IHS respectively. The level of depending and indecision or what we may refer to as lack of choice is revealed in this response to this statement as reiterated by Obaid (2005). This is thus depicting the dilemma women face again in their decision on their personal health. The above response is made clearer by the women's response to the next statement where 32.8 percent were undecided about the view that "they will not make decisions about their health without their spouse" while 47.8 percent agreed to the view.

Table 5. Distribution of respondents by attitude towards their personal health using decision statements

Statements	Responses	Microfinance clients			X^2	Df	Sig
		MBs with IHS (N=400)	MBs without IHS (N=350)	TOTAL N=750			
I determine whether to seek medical attention or not	Undecided Agree Disagree	18.7 40.8 40.5	24.8 32.6 42.6	21.6 36.7 41.7	13.610	2	.040
I won't pay much for medical bill when am sick	Undecided Agree Disagree	21.5 22.8 55.7	15.4 42.0 42.3	18.3 32.4 48.8	15.176	2	.000

I cannot take my health for granted no matter what	Undecided Agree Disagree	8.7 70.9 20.3	5.7 54.0 40.3	7.8 62.0 30.2	39.390	2	.000
I must take care of my health even with mild symptoms	Undecided Agree Disagree	10.0 56.5 34.0	11.7 34.6 45.7	10.9 45.3 38.6	60.880	2	.000
I cannot bother about my health, when my family is in need	Undecided Agree Disagree	20.0 51.0 29.0	28.2 36.0 35.7	24.2 43.3 32.6	72.339	2	.001
I won't make decisions about my health without my spouse	Undecided Agree Disagree	35.5 36.3 40.8	29.1 58.3 23.4	32.8 47.8 27.1	54.128	2	.041
I won't pay for medical bills even when I have money	Undecided Agree Disagree	16.5 22.3 60.3	23.7 42.5 33.7	20.8 31.2 44.5	167.631	2	.032
I cannot pay for my health care unless my spouse says so	Undecided Agree Disagree	18.4 37.1 44.5	10.8 62.5 26.3	12.0 56.3 35.6	111.973	2	.042

Although more (58.3 percent) women in MBs without IHS than those (36.3 percent) in MBs with IHS agreed to these view. Following the significant difference in the responses of respondents with reference to decision regarding their personal health, the positive influence of integrating health-related services especially through health education may be seen to account for the difference in response.

Also, over half (56.3 percent) agreed that they cannot pay for their health care unless their spouse says so. This again points attention to the women's high level of dependency on their spouse in decision making even with reference to their personal health. This is not unconnected to the traditional views that men are the head of the home (bread winner) and are expected to make decisions for family. These views are usually passed on to individuals in the society from generation to generation even by the women themselves through the process of socialization. Thus, why the traditional roles of women as the as keepers of the home are constantly changing and getting modified with the advent of women's participation in both the formal and informal work force, the views that men are the decision makers remain unchanged or modified in the Nigerian society. The finding thus reinforces women's perception and conviction about the position of men as the decision-makers in the Nigerian and African society. Again the level of dependency of women on the male counterparts' calls for attention as this has been revealed to influence women's decision even in matter affecting their reproductive health (Taiwo, 2012), thus reinforcing the necessity of male responsibility in reproductive health decisions and action according to Isiugo-Abanihe, (2002) and Jegede (2010).

The proportion of women who agreed to the views that they won't make decision regarding their health or pay for their medical care without their spouse as shown in the table 5 above, points attention to the fact that women recognize, accept and perhaps reinforce the need for men to be actively involved in decisions that affect their health. Also, the proportion of respondents who agreed to the view that they must take care of their health even with mild symptom were 45.3 percent. This proportion was represented by 56.5 and 34.6 percent of clients in MBs with IHS and MBs without IHS respectively. Although a significant proportion (63.4 percent) agreed to the view "I cannot take my health for granted no matter what", the proportion of women (32.4 percent) who agreed that they won't pay much for medical bills when they are sick and those (31.2 percent) who agreed that they won't pay much for medical bills even when they have money, call for concern**.** Such concern is necessary especially when the proportions of those (18.3 and 20.8 percent respectively) who are undecided about these views are considered. Again this may be due to the challenges of poverty, dependency on spouse to pay medical bills, high cost of health care and lack of adequate health education programmes.

Table 9. Distribution of respondents by attitude towards their personal health using preference and behavioural statements

Statements	Responses	Microfinance clients (%)			X^2	Df	Sig
		MBs with IHS (N=400)	MBs without IHS (N=350)	TOTAL N= 750			
I prefer to manage health problems by myself most of times	Undecided Agree Disagree	3.0 41.5 54.9	4.9 58.5 36.6	3.1 50.3 43.6	12.347	2	.000

I suppress my health challenges in order to save cost	Undecided Agree Disagree	2.7 16.3 82.0	4.3 27.4 63.3	3.7 21.3 73.5	12.571	2	.001
I spend most of my income on my family than on my health	Undecided Agree Disagree	4.3 65.3 30.5	11.1 49.4 41.4	6.1 52.3 40.9	9.709	2	.000
I do not bother about my health provided my family is fine	Undecided Agree Disagree	15.5 36.3 50.8	19.1 58.3 33.4	17.2 41.1 42.7	54.128	2	.000
I do not bother about my health except I am very sick	Undecided Agree Disagree	1.3 57.3 40.3	12.3 45.7 43.1	7.1 51.1 41.8	187.60 1	2	.000
I strive to be strong except the illness breaks down	Undecided Agree Disagree	1.0 53.5 45.5	6.5 62.0 34.9	3.6 57.5 40.1	33.849	2	.000
I prefer to spend on my household than on my health	Undecided Agree Disagree	2.6 40.3 53.3	1.7 50.0 48.3	2.0 45.5 51.4	34.521	2	.000
I spend much on my family needs, so I hardly have time to take care of myself	Undecided Agree Disagree	8.9 53.1 38.0	4.2 58.9 26.9	6.7 55.8 32.4	33.849	2	.000
h) I have enough cash to treat myself properly when am sick	Undecided Agree Disagree	24.3 20.3 50.5	8.2 14.6 70.0	16.4 17.2 60.5	9.709	2	.000

Over half (50.3) of the respondents prefer to manage their health problems by themselves most of the times. This was represented by 58.5 percent of clients in MBs without IHS and 41.5 percent of clients in MBs with IHS. The chi-square value ($X^{2=}$12.347, $p<0.05$) revealed a significant difference in the preference of clients in the two categories of MBs with reference to managing their health challenges by themselves. This again could be due to the introduction of health education to respondents in MBs with IHS. Majority (73.5 percent) disagreed to the views that they suppress their health challenges to save cost. More women (82.5 percent) in MBs with IHS than those (63.3 percent) in MBs without IHS disagreed to this view. The preceding findings corroborate the views of the health belief model that women's behavioural disposition towards their health generally depends to a large extent on the perceived severity of illness experienced. For instance, 51.1 percent of the women agreed to the view "I do not bother about my health except I am very sick". Again, 57.5 percent of the respondents agreed to the view "I strive to be strong except the illness breaks me down". This finding confirms the views of Roberts (1992) that women will generally cope with illness symptoms and perceive it as a sign of "just being tired" in order to care for the family until they are completely broken down by the illness.

In addition, 41.1 percent agreed that they do not bother about their health provided their family is fine. Precisely 55.8 percent agreed to the view that they spend much on their family, so they hardly have time to take care of themselves. Furthermore, while over half (51.4 percent) disagreed to the view that they prefer to spend more on their family than on their health, 52.3 percent of the respondents however agreed to the view that they spend most of their income on their family than on their health. This again supports the expression of Erinosho (2005) that women in Nigerian and Africa play the role of wives, mothers and caregivers in their family and society at large. When posed with the statement "I have enough cash to treat myself properly when I am sick", 60. 5 percent of the respondents disagreed to the view. This was represented by 70.0 percent and 50.5 percent of respondents from MBs without IHS and MBs with IHS respectively. This finding supports the views of Garuba, (2008) that many Edo people are faced with the challenges of not having cash available to pay for health care. From the foregoing it could be observed that respondents of microfinance banks that integrated health-related services are more positive in their attitude towards their health. This was again confirmed by the results of the independent sample t-test which compared the mean score of respondents' attitude from both categories of microfinance bank in page 158, where the hypothesis was tested to see if respondents in MBs with IHS will display more positive attitude towards their health than those in MBs with IHS. The result which was significant at $p<0.005$ revealed that respondents in MBs with IHS had a mean score of 63.9±5.4, while those in MBs without IHS had a mean score of 47.9±7.0.

These can intervene in the influence of microfinance services on the health of their clients with or without health-related services. Ideally when women are conscious of their health and attach a great importance to it, they tend to take proper care of their health. However, the average Nigerian is faced with a dilemma of

fulfilling this ideal situation perhaps because of their orientation that they need to be good wives and mothers who take care of their homes and submit to their husbands to be considered successful. Thus, decisions and choices about their personal health care, are not only secondary, but also made for them.

V. CONCLUSION AND RECOMMENDATIONS

Microfinance has been revealed as a strategy that can financially empower women, improve their socio-economic status and in turn influence their health especially when integrated with health services. Women's attitude towards their personal health though positive does not translate into them making decisive and independent decisions about their personal healthcare especially where their household needs and children are concerned. There seem to be a conflict between the personal health interest of the women and their expected role as "caring mothers" and "submissive wives" thus making their personal healthcare secondary. There is need to enlighten women on the need to prioritize their personal health care and empower them to be able to make decision about it as only healthy women can perform such expected roles. This information also needs to be passed on to the younger generation through socialization in other to reduce the circle of dependency and "choicelessness" of women even to the detriment of their health.

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