SOCIO-CULTURAL FACTORS AND UTILIZATION OF HEALTHCARE FACILITIES: IMPLICATIONS FOR MATERNAL MORTALITY IN URBAN AREAS OF EKITI STATE, NIGERIA

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CERTIFICATION

This to certify that this research work tilled **Implications of Socio-cultural Factors and Utilization of Healthcare Facilities: Implications for Maternal Mortality in Urban Areas of Ekiti State, Nigeria** was written by **OWOSENI, Joseph Sina** under my supervision. It has been read and approved as meeting part of the requirements for the award of Doctor of Philosophy (PhD) Sociology in the Department of Sociology, Faculty of Social Sciences, University of Ilorin.

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DEDICATION

This thesis is dedicated to the Glory of God Almighty, whose infinite mercies and favour saw me through, and also to the evergreen memory of my late Father Chief David Owoseni, whose unflagging efforts provided me with a modicum of opportunity to where I am today. May his caring soul continue to rest at the bosom of God Almighty. Also to my wife and children, whose virtues and care were a driving light throughout the study.

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TABLE OF CONTENTS

Title page……... i
Certification…….. ii
Dedication …… iii
Acknowledgement …….. iv
Table of Contents……. vi
List of Tables …..……. vi List of Figures …… viii
Abbreviations…….. ix
Abstract…… x

CHAPTER ONE: Introduction

1.1 Background to the Study ……..... 1
1.2 Statement of the problem …….. 6
1.3 Research Questions ……..... 8
1.4 Objectives of Study…….. 9
1.5 Significance of the Study ……. 9
1.6 Justification for the Study ……. 10
1.7 Operational Definition Terms ……... 11
1.8 Organization of Chapters …… 13

CHAPTER TWO: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 The Concept of Health…… 14
2.2 Maternal Health……... 16
2.3 Maternal Health in Nigeria…….. 18
2.4 Global View of Maternal Healthcare Facilities Utilization …… 20
2.5 Healthcare Service Utilization in Nigeria ……... 25
2.6 Determinants of Healthcare Utilization …….. 28
2.7 Socio-Cultural Factors Influencing Utilization of Maternal Health Facilities…… 30
2.7.1 Traditional Medicine……... 38
2.7.2 Religion and Rituals during Labour ……... 39
2.8.3 Socio-Demographic Factors …….. 40
2.8 Culture Beliefs and Healthcare……..... 50
2.8.1 Belief System ……. 51
2.9.2 Age at Marriage …….. 51
2.9 Types of Maternal Health Services in Nigeria ……..... 52
2.9.1 Traditional Maternal Health Service Providers …….. 52
2.9.2 Orthodox Maternal Health Service Providers ……..... 53
2.9.3 Faith Based Maternal Health Service Providers ……..... 55
2.10 Global Action on Maternal Mortality……. 58
2.11 Reproductive Health Behaviour and Implications for Mortality ……... 59
2.12 Appraisal of Literature …….. 61
2.13 Theoretical Explanation ……. 65
2.13.1 Political Economy Approach ……. 67
2.2.2 Andersen Healthcare Utilization Model …… 61
2.14 Conceptual Framework ……. 70
2.15 Research Hypotheses……. 73

CHAPTER THREE: METHODOLOGY

3.1 Research Design…….. 74
3.2 The Study Area……..... 75
3.3 Justification of Choice of the Study Area…… 79
3.4 The Study Population…….. 79
3.5 Sample Size and Sampling Techniques ……. 80
3.6 Methods of Data Collection and Research Instruments ……. 83
3.7 Validity …….. 79
3.8 Qualitative Research Techniques ……..... 85
3.8.1 Key Informant Interview (KII) …… 85
3.8.2 In-depth Interviewing …….. 86
3.9 Procedure for Data Collection …….. 87
3.10 Methods of Data Analysis……. 87
3.10.1 Quantitative Data…… 88
3.10.2 Qualitative Data…….. 88
3.11 Dissemination of Findings……. 88
3.12 Ethical Considerations ……..…. 89

CHAPTER FOUR: PRESENTATION, INTERPRETATION AND ANALYSIS OF DATA

4.1 Demographic and Socio-Economic Characteristics of the Research Respondent 92
4.1.1 Age ……. 92
4.1.2 Educational level……. 92
4.1.3 Marital Status ……. 93
4.1.4 Ethnic Group …….. 95
4.1.5 Religion …… 95
4.1.6 Occupation ……. 96
4.1.7 Income…… 97
4.2 Level of Utilization of Healthcare Facilities among Pregnant Women In Urban Areas of Ekiti State……. 99
4.2.1 Utilization of Antenatal Care Pregnancy ……. 99
4.2.2 Type of Antenatal Care Service Patronized …… 100
4.2.3 Reasons for Antenatal Care Service Utilization Preference ……. 101
4.2.4 Frequency of Facilities Utilisation …… 104
4.2.6 Supportive Roles Husbands Perform …… 105
4.3 Socio-Cultural Factors That Influence Utilization of Healthcare Facilities ……. 107
4.3.1 Facilities Utilized For Treatment of Diseases during Pregnancy ……. 108
4.3.2 Mode of Decision Making on the Choice of Facilities Utilized for Treatment…. 109
4.3.3 Financing Health Treatment ……..… 110
4.3.4 Reason for Utilizing the Chosen Facilities …… 110
4.3.5 Experience of any Complication by Utilizing Healthcare Faculty…… 112
4.3.6 Health Workers' Attitude in Managing Complications……. 113
4.3.7 Quality of Services Rendered by the Healthcare Facilities Utilized…….. 116
4.3.8 Factors Influencing Utilization of Healthcare Facilities……. 117
4.3.9 Socio-economic and Cultural Factors Considered before Utilizing Healthcare Facilities…… 119
4.3.10 Respondents Distribution on Traditional Practice(s) During Pregnancy…… 120
4.3.11 Consequence(s) of Violating the Traditional Practice(s) Prohibitions during Pregnancy……. 122
4.4.12 Stereotypes Associated With Healthcare Facilities Utilization in Urban Ekiti…… 122
4.3.13 Husbands' Attitude towards Their Wives during Pregnancy……... 124
4.3.14 Effect of Women's Working Conditions on Their Utilization of Maternal Health Services……. 127
4.3.15 The Stage of Pregnancy to Apply for Maternity Leave…… 131
4.4 Implications of Socio-cultural Factor on Maternal Mortality …… 137
4.4.2 Healthcare facilities Where the Death of Pregnant Woman Occurred …….. 140
4.4.3 The Age range of the Deceased ……... 141
4.4.4 Factors Responsible for the Death of Pregnant Woman ……..… 142
4.4.5 Cause(s) Women's Death During Delivery in Urban Areas of Ekiti State …….. 144
4.5 Test of Research Hypotheses ……... 145
4.5.1 Test of Sub-Hypothesis on Age and Utilization of Healthcare Facilities…… 146
4.5.2 Test of Sub-Hypothesis on Marital Status and Utilization of Healthcare Facilities…….. 148

4.5.3 Test of Sub-Hypothesis on Religion and Utilization of Maternal Healthcare Facilities …… 149
4.5.4 Test of Sub-Hypothesis on Educational Status and Utilization of Healthcare Facilities ……. 151
4.5.5 Test of Sub-Hypothesis on Income and Utilization of Maternal Healthcare Facilities …….. 152
4.5.6 Regression Analysis on Socio-Economic and Demographic Characteristics and Utilization of Healthcare Facilities …….. 154
4.5.7 Test of Hypothesis on Cultural Belief and Practices and Complication(s) Experienced During Pregnancy……..……. 158
4.5.8 Test of Hypothesis on Women's Working Conditions and Utilization of Maternal Health Care Facilities …… 160
4.5.9 Test of Hypothesis on Stereotypes and utilisation of maternal health care facilities 161
Regression Estimating The Influence of Socio-Cultural Factors on The Utilisation of Healthcare Facilities …… 163
Discussion of Findings ……. 164

CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS
5.1 Introduction……. 188
5.2 Summary of Findings…….189
5.3 Conclusion…… 180
5.4 Recommendations……. 183
5.5 Contribution of the Study to Body of Knowledge……... 185
References…..…….. 188
Appendix I …… 199
Appendix II…… 208
Appendix III……..... 209
Appendix IV……..... 211
Appendix V…… 212
Appendix VI…….. 213
Appendix VII……. ….... 214
Appendix VIII……... 215

List of Tables

Table 3.1 List of all Health Facilities in Ekiti State …… 80

Table 3.2 Selected Health Care Facilities According to Local Government Areas…. 82

Table 4.1.1 Frequency Distribution of Respondents by Age ……. 92

Table 4.1.2 Frequency Distribution of Respondents by Educational Level……... 93

Table 4.1.3 Frequency Distribution of Respondents by Marital Status ……. 94

Table 4.1.4 Frequency Distribution of Respondents by Ethnic Group ……. 95

Table 4.1.5 Frequency Distribution of Respondents by Religion ……. 95

Table 4.1.6 Frequency Distribution of Respondents by Occupation……. 97

Table 4.1.7 Frequency Distribution of Respondents by Monthly Income…… 98

Table 4.2.1 Frequency Distribution of Respondents by Utilization of Antenatal Care in Pregnancy…… …….. 100

Table 4.2.2 Frequency Distribution of Respondents by Type of Antenatal Care Service Patronized …….. 100

Table 4.2.3 Frequency Distribution of Respondents by Reasons for Antenatal Care Service Utilization Preference ……. 101

Table 4.2.4 Frequency Distribution of Respondents by Attendance of Health care Facilities Utilization …… 104

Table 4.2.6 Frequency Distribution of Respondents by Their Husbands' Supportive Roles 105

Table 4.3.1 Frequency Distribution of Respondents by Facilities Utilised for Treatment of Diseases During Pregnancy…… 108

Table 4.3.2: Frequency Distribution of Respondents by Mode of Decision Making on the Choice of Facilities Utilised for Treatment 109

Table 4.3.3: Frequency Distribution of Respondents by the Financier of Their Health Treatment …….. 110

Table 4.3.4: Frequency Distribution of Respondents by the Reason for Utilising the Chosen Facilities …… 111

Table 4.3.5: Frequency Distribution of Respondents by Whether They Had Experienced Any Complication Since They Have Been Utilising the Healthcare Facilities ….113

Table 4.3.6: Frequency Distribution of Respondents by Health Workers' Attitude in Managing Complications……..... 113

Table 4.3.7 Frequency Distribution of Respondents by the Quality of Services Rendered

by the Healthcare Facilities Utilized…… 116
Table 4.3.8 Frequency Distribution of Respondents by Factors Influencing Utilization of Healthcare Facilities……. 118
Table 4.3.9 Frequency Distribution of Respondents Socio-economic and Cultural Factors Considered Before Utilizing Healthcare Facilities…… 119
Table 4.3.10 Frequency Distribution of Respondents by Traditional Practice(s) During Pregnancy…….. 120
Table 4.3.11 Frequency Distribution of Respondents by Violation of Prohibitions and the Consequence(s)……. 122
Table 4.3.12 Frequency Distribution of Respondents by Husbands' Attitude towards Their Wives during Pregnancy……. 124
Table 4.3.13 Distribution of Respondents by Their Relatives' Role towards Them during Pregnancy……. 127
Table 4.3.14 Frequency Distribution of Respondents Based on Their Working Conditions … 128
Table 4.3.15 Frequency Distribution of Respondents by the Stage of Pregnancy they can Apply for Maternity Leave from Their Place of Work……. 132
Table 4.3.16 Distribution of Respondents' Opinion on Effectiveness of the State Government's Role in the Distribution of Healthcare facilities in Urban Ekiti ……... 133
Table 4.3.17 Distribution of Respondents' Opinion on Short Falls of Ekiti State Government's Contributions to Healthcare facilities……. 134
Table 4.4.1 Frequency Distribution of Respondents by Whether Any Woman Has Ever Died In Pregnancy, During Childbirth or Shortly After Birth ……. 137
Table 4.4.2 Frequency Distribution of Respondents by Where the Death Occurred … . 140
Table 4.4.3 Frequency Distribution of Respondents by The Age Range of the Deceased 141
Table 4.4.4 Frequency Distribution of Respondents by Factors Responsible for the Death Of Pregnant Woman …….. 143
Table 4.4.5: Frequency Distribution of Respondents by the Cause(s) of Death During Delivery in Urban Areas of Ekiti State …… 145
Table 4.5.1: Age and Utilisation of Healthcare facilities ……. 147
Table 4.5.2: Marital Status and Utilisation of Healthcare facilities ……. 148
Table 4.5.3 Religion and Utilization of Healthcare facilities…… 150
Table 4.5.4 Educational Status and Utilization of Healthcare Facilities…….. 151

Table 4.5.5 Income and Utilization of Healthcare facilities……. 153
Table 4.5.6 Regression Analysis of the Effect of Age, Educational Status, Religion and Income on Utilization of Healthcare facilities…… 155
Table 4.5.7 Cultural Beliefs and Practices and Complication(s) Experienced In Pregnancy…….. 158
Table 4.5.8 The Nature Work and the Frequency of Maternal Health Service Utilization ..160
Table 4.5.9: Stereotypes and Healthcare Facilities Utilised ….. ……. 162
Table 4.3.9: Logistic Regression Estimating The Influence of Socio-Cultural Factors on The Utilisation of Healthcare Facilities …… 163

List of Figures

Figure 1	Andersen's Behavioural Model of Health Service Utilization……	69
Figure 2	A Framework of Socio-Cultural Factors and Utilization of Healthcare Facilities…….	72
Figure 3	Map of Ekiti State, the Study area with Nigeria as Inset……...	78
Figure 4	Sample Selection……	81

LIST OF ABBREVIATIONS

EOC	Emergency Obstetric Care
HDR	Human Development Report
ICD	International Classification of Diseases
ICM	International Conference of Midwives
ICPD	International Conference on Population and Development
ICRW	International Centre for Research on Women
MMR	Maternal Mortality Rate
NDHS	Nigeria Demographic and Health Survey
NPCN	National Population Commission Nigeria
PHC	Primary Health Care
TBA	Traditional Birth Attendant
SPSS	Statistical Package of Social Sciences
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development

WHO World Health Organization

ABSTRACT

In Nigeria, maternal mortality remains a social health problem as more than 140 women die daily from pregnancy - related complications. Studies have adduced a number of factors such as lack of skilled birth attendants, household income, education and distance from facilities without considering the socio-cultural factors. This study therefore investigated socio-cultural factors that may influence utilization of healthcare facilities in urban centers of Ekiti State, Nigeria. The objectives were to: (i) identify socio-cultural characteristics of pregnant women in Ekiti State; (ii) examine the level of utilization of healthcare facilities among pregnant women; (iii) assess the influence of socio-cultural factors on the utilization of healthcare facilities among pregnant women in the State; and (iv) examine the implications of this on maternal mortality.

The study utilized Benerji political economy theory and Andersen's Health-seeking behavioural model. Survey design was adopted to achieve the objectives of the study. Quantitative data were generated through the use of structured questionnaire, while qualitative data were sourced from In-depth interviews (IDIs) and key informant interviews (KIIs). With a multi-stage procedure, 100 respondents were sampled from each headquarters of the sixteen Local Government Areas in Ekiti State, totaling 1,600 respondents but only 1580 responded for the analysis. Frequency distribution was used to present the pattern of socio-cultural and behavioural characteristics of the respondents while multiple regression analysis was used to establish the relationship between the socio-cultural factors and respondents' utilization of healthcare facilities at 0.05 level of significance.

The findings of the study were that:

i. pregnant women were between 30-39 years of age (53.4%); 45.3% have tertiary education, 64.5% were married, 63.9% were Christian, 83.8% were employed and 38.3% earn above N50,000 monthly;
ii. the attendance of health care facilities showed that, 54.4% were frequent; 4.8% periodically; 8.0% occasionally; while 32.8% rarely visited the facilities;
iii. socio-cultural factors influencing healthcare facilities utilization among pregnant women were: religious belief (R^2 =0.628); cost of service (R^2 = 0.821); efficacy of the service (R^2 = 0.726); women's working conditions (R^2 = 0.182); stereotypes (R^2 = 0.845) and family customs (R^2 = 0.814) while marital status exhibit an inverse relationship (R^2 = -0.120);
iv. 78.7% of the respondents affirmed that women died during child birth due to complications that arise as a result of socio-cultural practices engaged in during pregnancy;
v. majority of the women needed to get the consent of their husband before they seek health care services; and
vi. majority of the women took herbs during pregnancy and did not utilize health care facilities unless they have complication.

The study concluded that socio-cultural and other factors have significant influence on utilization of healthcare facilities among pregnant women in the study area with their negative consequence on maternal mortality. The study therefore recommended that; women should be educated especially on harmful cultural practices that may affect them, while there should be public enlightenment by government, religious institutions and prominent members of the community.

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CHAPTER ONE

Introduction

1.1 Background to the study

Healthcare facilities are organized facilities provided to cater for the health needs of women during pregnancy, labour, delivery, and puerperal periods so as to reduce morbidity and death (Goodburn and Campbell, 2011). Maternal health facilities utilisation is important for early detection of women, who are at risk of illness and mortality during pregnancy and by extension, 42 days after delivery (WHO, 2007). These services are usually preventive and the patients are not usually ill. The use of maternal health services is an effective means for reducing the risk of maternal morbidity and mortality, especially in places where the general health status of women is poor (Ogunniyi & Faleyimu, 2010).

Over the world, millions of women who die yearly from pregnancy or childbirth related causes occur in developing countries (Bankole, Sedgh, Okonofua, Imarhiagbe, Hussain, and Wulf, 2013) where reproductive health and health care facilities are in most cases grossly inadequate, ill equipped and inequitably distributed (Ozumba and Nwogu-Ikojo, 2008; Galadanci, Ejembi, Iliyasu, Alagh, Umar, 2007; Osubor, Fatusi, and Chiwuzie, 2006; Chiwuzie, Braimoh, Unuigbe, and Olumeko, 2005).

In Nigeria, 145 women die daily and 59,000 women die annually from preventable pregnancy-related or obstetric complications (UNFPA, 2008; WHO, 2007). Currently, maternal mortality ratio (MMR) in Nigeria is 545 per 100,000 live births (NPC and ICF, 2014) and is one of the highest in the world. A recent multi-indicator cluster survey (MICs) conducted by National Bureau of Statistics in 2007 had estimated maternal mortality ratio at 800 per 100,000 live births, World Health Organization's revised estimates indicated a figure twice as high as that reported in the Nigeria Demographic

Health Survey (NDHS) 2014. The high maternal mortality figures reported for Nigeria has been attributed to a significant lack in availability and access to functional health care services particularly in resource poor or urban settings (Ugal, Ugabi and Awah, 2010; Ronsmans, Etard, Walraven, Høj, Dumont, and de Bernis, 2003; FMOH, 2003). Because maternal death is higher in the urban areas relative to the urban (Cham, Sundby and Vangen, 2005), lack of utilisation of health care facilities becomes a highly worrisome phenomenon in the urban Nigeria. A recent data in Nigeria indicated a significant urban urban MMR differential of 823 to 531 (National Bureau of Statistics, 2013).

Literature is replete with complex multiple factors (biological and broad) that are associated with maternal mortality in Nigeria (Omo-Aghoja et al, 2010; Ijadunola, Ijadunola, Esimai, and Abiona, 2010; Bankole et al, 2013; Ugal, Ugabi and Awah, 2013; Ibeh, 2008; Okonofua, 2008; Orji, Fasubaa, Onwudiegwu, Dare and Ogunniyi, 2007; and WHO, 2005, Ijadunola, 2004). The majority of these studies was primarily hospital-based, and concentrated in urban or semi-urban centers. The few conducted in Ekiti State reflected the same urban bias neglecting urban communities of the state. However, studies have paid little attention to these factors in economically restrained communities - urban areas- where prevalence of maternal mortality is highest (National Bureau of Statistics, 2013). This is perhaps the case in urban Ekiti State where barriers to safe motherhood practices are still relatively highly pronounced (Bankole et al, 2013; NPC and ICF, 2008; UNDP, 2006) with unknown level of maternal mortality.

Studies have shown that the geographical nature of the Ekiti State poses a serious barrier to utilising when needed particularly in economically restrained urban enclaves (Nwokocha, 2004; Onokerhoraye, 1999) thereby contributing to maternal mortality. Although, studies on male role in safe motherhood practices have been reported (Isiugo-Abanihe, 2003; Nwokocha, 2004; Orji et al, 2007; Lawoyin, Lawoyin, and Adewole,

2007; Nwokocha, 2008), men's role in safe maternal health practices particularly access to health facilities and their perception of maternal mortality in urban Ekiti State has hardly been documented. The foregoing creates a daunting task for utilisation of health care facilities enshrined in human rights frameworks (Bankole et al, 2013; Cham et al, 2005; MSI, 2004) in urban areas of the state. Thus, there is a need to undertake a consummate systematic study on access to health care in urban communities of a state characterized by volatile, civil and incessant political unrest in order to reduce the scourge of maternal death plaguing women of childbearing age in the area.

A large body of research has indicated the growing trend of prenatal usage and coverage, but still, little is known about the extent to which differences exist between disadvantaged and privileged among urban women dwellers with respect to maternal health care. Lack of nationwide prenatal coverage and the inadequate usage of healthcare by some groups may be a major cause of the high maternal mortality rate in Nigeria when compared with other countries in the world (WHO, 2016).

Recent research on healthcare has pointed out some socio-cultural factors as determinants of healthcare services consumption (Simon, 2014). Research on ethnicity and cultural background in relation to healthcare has shown unequal access to healthcare facilities by less privileged throughout the world (Malin & Gissler, 2009). Studies by Malin and Gissler (2009), and Choté (2011) pointed out various impediments in obtaining health care services by ethnic disadvantaged women in developed countries. The same picture is seen in the developing world where the disadvantaged groups are experiencing a higher risk of adverse pregnancy outcomes (Magadi, Madise, & Roddrigues, 2000; Say & Raine, 2013; Simkhada et al, 2007).

1.2 Statement of the Problem

Basically, as the urban population is growing rapidly, so is the problem of urban poverty and health challenges. Maternal mortality is the most important indicator of maternal health and well being in any country (Henry, 2007). From recent estimates, the number of deaths each year from pregnancy-related causes worldwide decreased from 536,000 in 2005 to an estimated 358,000 in 2013 and 273,500 in 2014 (WHO, 2015). For every woman that dies, approximately 20 more suffer injuries, infection and disabilities in pregnancy or childbirth (UN, 2012; UNICEF, 2013; WHO, 2016). Even though maternal mortality is a worldwide phenomenon, the critical issues associated with it are most profound in developing countries. Hence, the estimated figure for maternal deaths worldwide, developing countries account for 99 percent (WHO, 2013), with an estimated 265,000 maternal deaths occurring in sub-Saharan Africa (UNICEF, 2015).

Owing to inaccessibility of health care facilities (Onokerhoraye, 1999; UNDP, 2006) particularly health care, every year in urban in Ekiti State, women die of preventable pregnancy and childbirth related causes which are sometimes accompanied by high incidence of intrauterine and infant mortality. As a result, families are severely traumatized by the resultant condition of double agony. Maternal death in these urban communities creates social vacuums; potential breadwinners are lost while early childhood socialization suffers. For those who eventually survive, some suffer from physical disabilities and chronic illnesses (Orji, et al, 2007; Bankole et al, 2013) that hinder their contribution to personal and community development.

Socio-cultural factors peculiar to the people of Ekiti State unintentionally constitute barriers to utilisation of health care facilities. Women are constrained by the ethos of traditional festivals from utilising health care facilities during maternal complications (Nwokocha, 2004; 2008; Kinanee and Ezekiel-Hart 2013) thereby

intensifying the delay that contributes to maternal mortality. Moreover, a majority of these women deliver un-assisted, are delivered at home by family members or by traditional birth attendants (TBAs) (NPC and ICF, 2013) who lack the requisite skills to handle delivery complications that arise from the prevailing maternal socio-cultural practices such as Female Genital Cutting (FGC) which results to obstructed and prolonged labour, nutritional restrictions and taboos that leads to anaemia and massage of pregnant women that causes ruptured uterus and hemorrhage. Thus, high maternal death is engendered among the population of urban women.

In Ekiti State, reproductive behaviours of women especially those in the urban communities, are among others a continued reaction to history of persistent high regimes of maternal and child mortality (Obono, 2003) that has led to a stable but high current fertility level (NPC and ORC, 2004; UNFPA, 2005 and NPC and ICF, 2013). Thus, the prevailing pronatalist philosophy coercing the majority of urban women to assure lineage perpetuity induces fertility-enhancing behaviours - unplanned pregnancies and childbearing, high risk births and non-use of modern contraceptive methods or family planning (NPC and ICF, 2013, Bankole et al, 2013 and NPC and ORC, 2004) that in turn exposes them to concomitant risks associated with high fertility. Unfortunately, these behaviours are continually sustained significantly by factors – household demands and non-availability, cost, proximity problem and inefficient and ineffective - hindering access to modern maternal health care services especially health care necessary to reducing maternal and child mortality in the state. In the final analysis, these women become the victims of their own functional prerequisite suffering severe physical, social and psychological damage and in extreme cases, death

Although, studies on male role in safe motherhood practices have been reported (Isiugo-Abanihe, 2003; Nwokocha, 2004; Orji et al, 2007; Lawoyin, Lawoyin, and

Adewole, 2007; Nwokocha, 2008), men's role in safe maternal health practices particularly access to and their perception of maternal mortality in urban in Ekiti State has hardly been documented. Men's knowledge of dangers signs of obstetric emergencies, their influence on female reproductive behaviours and involvement in family decision making have not been adequately examined. The implication of such dearth in knowledge for maternal mortality is that knowledge of such complex but important phenomenon is undermined.

The majority of maternal deaths in urban areas as well as in urban communities in Ekiti State are caused by direct factors which can be prevented by prompt and adequate medical intervention (Maine, 1993; Cham et al, 2005). However, delays associated with health service factors; poor referral systems (Omo-Aghoja et al, 2010), chronic shortages of essential drugs and supplies (Lanre-Abass, 2008), lengthy and delayed decision-surgical intervention time, poor electricity supply, lack of blood for timely transfusion, late arrival of experienced theatre staffs during emergencies (Okoro, 2001; Orji, 2002; Ibeh 2008) as well as inadequacy in the quality and quantity of skilled birth attendants (SBAs) (NPC and ICF, 2013) hinder access to health care in urban in Ekiti State. Moreover, the peculiar environmental and topographical terrain of in the Ekiti State characterized by poor transport and communication means and persistent state of political cum civil unrest (Ikporukpo, 2002; Nwokocha, 2004) is a major barrier to utilising health care. Therefore, there is a need to investigate the level and causes of maternal mortality from this broad perspective by investigating the health service factors in relation to the individual and community level factors.

1.3 Research Questions

The foregoing problem statement raises some pertinent questions. Thus, the general question is: what are the socio-cultural factors influencing utilisation of

healthcare facilities among pregnant women in urban areas of Ekiti State, Nigeria? This central question is decomposable into the following:

(i) What are the socio-cultural characteristics of pregnant women in Ekiti State;
(ii) What is the level of utilization of healthcare facilities among pregnant women;
(iii) How do socio-cultural factors influence the utilization of healthcare facilities among pregnant women in Ekiti State; and
(iv) What are the implications of socio-cultural factors on maternal mortality

1.4 Objectives of the Study

The general aim of this study is to examine the implications of socio-cultural factors on the utilisation of healthcare facilities among women in urban, Nigeria and how this precipitates maternal morbidity and mortality. In other to achieve this, the study seeks to:

(v) identify socio-cultural characteristics of pregnant women in Ekiti State;
(vi) examine the level of utilization of healthcare facilities among pregnant women;
(vii) assess the influence of socio-cultural factors on the utilization of healthcare facilities among pregnant women in the State; and
(viii) examine the implications of socio-cultural factors on maternal mortality.

1.5 Significance of the Study

The significance of this study is primarily underscored by the need to systematically investigate the factors engendering maternal mortality among urban community women in Ekiti State. Causes of maternal deaths can be examined narrowly (biological) or broadly (individual, community and health service factors). Much of the reports on the

maternal mortality in Nigeria, particularly the broad contributing factors, largely exclude the state in Ekiti State; much has not has been done with regard to these contributing factors in the state especially in the urban areas. Moreover, the level of maternal mortality in particularly in the urban areas of the state has hardly been reported. The existence and the state of health care facilities in the state is also unknown, all these create gaps in knowledge which the study would fill by investigating the broad factors – health service, community and socio-cultural - contributing to maternal mortality in urban as well as document the existence and state of health care facilities in the state.

Methodologically, the study would combine a hospital-based design with a community-based design; studies have employed either of the two designs; the methodological advantage of the combined approach has hardly been explored. The synergy of these designs would ensure a more robust design that would capture adequately the three delay factors associated with utilising health care facilities within a single study. Furthermore, the study would add to knowledge by using maternal death review technique. Measuring maternal mortality as a demographic phenomenon is a difficult undertaking whether conceptually or for practical reasons because available methods are complex, resource intensive and mostly unreliable (Cham et al, 2005).

Thus, measuring maternal mortality requires an action-centred strategy to collect data on where, how and □why□ mortality is occurred, and measures taken as well as those necessary (AbouZhar, 2000). Where and how maternal mortality occurred can be easily accounted for compared to □why□ they occurred. Understanding □why□ maternal mortality occurs necessitates an in-depth review process of the causes and the situational factors that would generate a complete knowledge of the phenomenon. Maternal death review technique fulfils this requirement because it combines the strength of a survey, In-

depth interview (IDI), key informant interview (KII) and hospital records in eliciting necessary information in maternal mortality studies.

This study contends that the relationship between utilisation of health care facilities and maternal mortality is better understood when examined within the context of Political Economy of health approach and Health acre Utilisation Model particularly the Health Seeking Behaviour variant. Thus, a theoretically synthesis of these approaches and theory would provide a nuanced and holistic explanation of the study phenomenon and the guide for study analysis. In this way, maternal mortality would be shown to occur as a product of the convergence of individual but related factors that includes political and economic factors underlying health care facilities provision, inadequate and inaccessible functional health care facilities, poor referral system, unavailable, effective and efficient skilled birth attendants (SBA) and a societal constrained individual health seeking behaviour practices.

Practically, a significant policy recommendation if adopted can be to emphasize the dispersal and location of free mobile and stationary health care facilities in coastal and hinterland urban areas of the Ekiti State to improve access to during emergencies. Considering the environmental and topographical terrain of the Ekiti State that constitute a natural barrier to utilising health care, and the inadequacy and inaccessibility of health care facilities in the state, this would go a long way in reducing the scourge of maternal death in the state. This can be complimented with a community based recruitment, training and incentive programme that focuses on attracting indigenes to train as skilled birth attendants, equipped with community monitoring and evaluation skills and live saving skills (LSS) in health care. This would improve patients to skilled birth attendant□s ratio, and may improve perception of the need and benefits of women and their significant others necessary for the reduction of maternal mortality in urban

communities. Finally, it would increase awareness on the broad or non-biological factors influencing maternal mortality in the study area with regard to the difficulty in utilisation of health care facilities. This would encourage further studies in the area.

1.6 Justification for the Study

One of the anticipated focuses of the Millennium Development Goals (MDGs) was the improvement of maternal health and the reduction in maternal mortality by 75% by the year 2015, which has lapsed. With Nigeria's poor record of maternal mortality, it is clear that the global MDG goals could not be achieved without a significant outcome from Nigeria in terms of reductions in rates of maternal morbidity and mortality. Although analyses of recent trends show that the country is making progress in lowering down maternal mortality rates, the rate of reduction still remains too slow to achieve success in 'health for all' goals. Thus, a sociological study of maternal mortality is expedient to gain more insight into those salient socio-cultural barriers to utilisation of healthcare facilities and what can be done to improve the situation. The study of maternal health in Nigeria's urban centers which witnessed the most rapid social and economic change in recent years is important and necessary for several reasons: first, the maternal health status in Nigeria is poor, based on the high rate of maternal mortality (NDHS, 2013). Among the health and mortality indicators, levels of maternal mortality show striking disparities according to the level of development and access to healthcare service utilisation (WHO, 2015).

Maternal mortality is a sensitive indicator of the status of women in society, as well as access to healthcare and adequacy of the healthcare system in responding to their needs. The maternal mortality rate (MMR) result shows the disparity in access to healthcare services in Nigeria and without doubt calls for urgent action. Though recent United Nations' figures place Nigeria second to India on the MMR table (Ogbonnaya and

Olawale 2008), research into this sensitive aspect of life would therefore, shed more light on certain socio-cultural factors that precipitate poor utilisation of healthcare service among women and maternal health challenges, and help to initiate more sensitive intervention strategies.

Moreover, one of the major problems in maternal health outcomes facing this nation is the high level of poor socioeconomic status and low standard of living among women in utilising the available health facilities. Countries are ranked by various health and economic indicators to show how they fare compared with others. Industrialized countries dominate the high human development category characterized by high life expectancy, low infant mortality rate, and low maternal mortality. On the other hand, the statistics of these indices are also generally lower in the medium than in the 'low' human development countries (Gabriel, Sohel, Do, Eriksson, & Persson, 2010). In Sub-Saharan Africa, women's experience of pregnancy and childbirth exert influences far beyond their own health, crucial as this is, to affect their status and empowerment, their children and wider family health, education and wealth and, indeed, their nation's society and economy (UNICEF, 2013). Therefore, addressing maternal health's line of attack in a country in sub-Saharan Africa is not only relevant for women's empowerment, but also for women development in Africa.

1.7 Operational Definition of Terms

For the purpose of clarity, the keywords of this study have been given operational definitions as follows:

Health Disparity: This is the inequalities that occur in the provision of healthcare and access across different racial, ethnic and socio-economic groups. It is a preventable difference, injury, burden of diseases, opportunities to achieve optimal health that are experienced by socially disadvantaged populations.

Maternal Health: This is the physical wellbeing of a mother in relation to her pregnancy, which includes healthcare and postnatal care of the mother and of the child up to the age of five years.

Maternal Morbidity: This describes pregnancy- and childbirth-related illness and injury. Maternal Mortality Rate: This is the number of maternal deaths in a given period per 100,000 women of reproductive age during the same time-period.

Maternal Mortality Ratio (MMR): Number of maternal deaths during a given time period per 100,000 live births during the same time-period, usually a year.

Maternal Mortality: This is the death of a woman while pregnant or within 42 days of a termination of a pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental and incidental causes". This is the way maternal mortality the in this study.

Reproductive Health: In line with this study, reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.

Socio-cultural Factors: These are the surrounding societal and cultural factors or circumstances, which influence or hinder maternal health. They are also the social and cultural framework in which an individual functions.

Urban Area: At the level of this study, the urban areas are the local government headquarters, where most of the secondary healthcare facilities such as State Specialist Hospitals and General Hospitals are located.

Utilization: Based on this study, utilisation is the proportion of women using healthcare facilities available to them. the includes the use of government hospital resources.

Women: The women referred to in this study are the pregnant women and nursing mothers with children below five years of age.

1.8 Organization of Chapters

The thesis is organized into five chapters. Chapter one covers the background to the study, statement of the problem, research questions, aim, and objectives of the study, significance of the study as well as justification of the study. Chapter two contains a comprehensive literature review of the subject under investigation and a presentation of the theoretical and conceptual framework that the study adopted. Chapter three concentrates on the research methodology which includes the study population, sample design and procedure, instrument of data collection, method of data analysis, and the limitations of the study. Chapter four focuses on data presentation, general description of research data, data analysis, and interpretation of results as well as the discussion of the results obtained from the study. Chapter five presents the summary, conclusion and recommendations.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL EXPLANATION

This chapter presents a review of the literature as it relates to socio-cultural factors in utilisation of healthcare facilities among women in urban areas of Ekiti State, Nigeria and how this precipitates maternal morbidity and mortality. The presentation of the review follows a logical sequence by first reviewing how scholars in this field have interrogated the concept of health and implication of such conceptualization on government policies toward the provision of health services. Owing to the fact that the study is concerned with the socio-cultural factors in utilisation of maternal health, an extensive review of literature on important factors that have been identified by scholars would be presented followed by the theoretical explanation.

2.1 The Concept of Health

In an attempt to operationalise health with universal appeal, the World Health Organization (WHO) has defined health as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity (Jegede, 2010). Although this definition has been widely adopted, a number of scholars still identify some problems with it. For example, Badru (2003) has noted that there is a problem of identifying and actually observing such abstract notion as mental and social wellbeing, even though the physical dimension can be subjected to some measurement. In other words, can anyone fulfill all the conditions of health?

Similarly, Asakitikpi (2013) also pointed out the neglect of the spiritual dimension of health especially as it pertains to African societies. It has been observed that most health issues and death in the African society are attributed to spiritual causes (Mensah, 2013). An increasing number of researches have been published within the last 20 years

and reviews have examined the connections between spirituality-religiousity, health and quality of life and its potential to prevent, heal, or cope with diseases (Khama, Oucho, and Mwalali, 2006). Religion and spiritualism are very much alive in Africa, and their influence on health and illness cannot be overlooked in contemporary African societies, since notions of illness causation and healing span the physical and spiritual domains (Mensha, 2013).

Therefore, as noted by Idowu and Asakitikpi (2008), the pervasiveness of spirituality in the lives of an average Nigerian and the belief that the supernatural has profound influence on the physical is of prime importance in defining health. In the same vein, Nwabuaze (2003) refers to a healthy condition as being sound in body, mind or spirit. Health is a situation of being free from physical disease or pain or mental disorder or freedom from emotional or spiritual drudgery. Also, according to Badru (2003), patterns of health and disease vary from one society to the other. Besides, people's perception and definition of ill health and disease vary according to their cultural practices, educational attainment and religious experiences, among others. For instance, as observed by Akintunde (2006), among the Yoruba in Western Nigeria, it is true that "*alafia lo ju, ilera loro, eni ti o ni alaafia lo ni ohun gbogbo"* (health is paramount, health is wealth, whoever is in good health has everything).

The absence of good health is illness and illness is understood in three particular ways. First, it is natural or physical, such as poisoning, pain and so on. Second, it is supernatural or spiritual, including attacks by witches or wizards. Third, it is mystical, which attributed to spirits, divinities, or ancestors for punishment of offences against them. Therefore, to better understand the concept of health, Jegede (2010) claimed that for the WHO definition to be comprehensive and acceptable there must be maintenance of body balance, physical and emotional balance, cultural and political balance, and

spiritual and ideological balance. In this sense, disease is a threat to harmonious functioning of the body system (Akande and Owoyemi, 2009). Hence, there is need for protective mechanism of the body to remain healthy in order to avoid being sick.

2.2 Maternal Health Care

Maternal Health Care refers to the care of women and newborns during pregnancy, delivery and the time after delivery (RAISE Fact Sheet, 2007). It is a reproductive health strategy that emphasizes important interventions targeted at providing the unmet need of health seeking behaviour of disadvantaged women with attendant pregnancy and childbirth complications. This broad maternal health care strategy emerged out of the necessity to address the phenomenon of high incidence and prevalence of maternal mortality particularly in developing countries of the world including Nigeria.

Maternal Health care has been broadly catergorized into two depending on the nature and level of complication suffered by women in the course of pregnancy or childbirth. These are Basic Health Care (BHealth care facilities) and Comprehensive Health Care (CHealth care facilities). The Basic Health care facilities is targeted at providing emergency and specialized health care service to women with specific complications requiring no surgical intervention or blood transfusion. The care provided for maternal pregnancy and childbirth complications include initially six specialized care interventions or signal functions during emergency situations. These include the administration of parenteral antibiotics, parenteral drugs (now urenitonic drugs), parenteral anticonvulsants, perform manual removal of placenta, removal of retained products and perform assisted vaginal delivery (UNICEF, WHO and UNFPA, 1997). However, a seventh signal function was added in 2006; the performance of neonatal resuscitation. The Comprehensive Health

care facilities encompass all signal functions in the Basic Health care facilities to include surgical intervention (caesarean section) and blood transfusion (WHO, 2013).

In the WHO monitoring of health care handbook, the availability and accessibility of Health care facilities is incumbent upon some service provision characteristics which includes that Health care facilities providing facilities exist and function, be geographically and equitably distributed, be used by pregnant women, be used by women with complications, it should provide sufficient life-saving services, and also provide good-quality care. The recommendation for the availability and mixture of per 500,000 populations was at least one comprehensive health care facility and four basic health care providing facilities. However, this has been modified to five health care facilities with at least one comprehensive health care facility for the specified standard population. This is to ensure that women with critical obstetric complications are provided timely surgical interventions and routine blood transfusions that accompany such critical conditions. It has been reported that at least 5 and at most 15 percent of birth proportions of in any given population require caesarean operation. Consequently, the availability and accessibility of CHealth care facilities is important in the strategic reduction of maternal deaths due to inaccessibility to timely and quality caesarean operation. The current United Nations (UN) recommendation for is as follows:

- For every 500,000 population, there should be at least one comprehensive and four basic Health care facilities facilities.
- There should be appropriate geographic distribution of Health care facilities facilities.
- 15% of all births should take place in Health care facilities facilities.
- 100% of obstetric complications should be treated.
- Caesarean sections should be between 5% and 15% of all births.

- Case fatality rate of direct obstetric complications should be less than 1% (RHRCC, 2005).

Basically, there have been two paradigms with regard to provision of specialized maternal health care since the Safe Motherhood movement□s efforts to stem maternal mortality in developing countries and particularly among urban populations. The first paradigm was the Essential Obstetric Care (EsOC) paradigm which emphasized a broad array of services including family planning and antenatal, intrapartum, and postpartum care. It was located within the Primary Health Care provision strategy with emphasis on pregnant women and a strategic aim to predict and prevent obstetric complications that will be conceptualized as □high risk□ (Measham and Kallianes, 1995). Because the initiative was fraught with a few strategic missteps (Resenfeld and Min, 2007) there has been a shift in paradigm from the traditional risk assessment approach and promotion of TBAs assisted delivery to the provision of access to health care services that emphasizes delivery and care under SBAs for all women who are pregnant (Ijadunola, 2010). The relative advantage of the Health care facilities is that focuses on the prompt identification, referral, and treatment of women with obstetric complications (Measham and Kallianes, 1995) that will ensure reduction of maternal mortality. Therefore, the Health care facilities paradigm is designed to specifically and strategically provide the un-met need of women with pregnancy and childbirth complications.

2.3 Maternal Health in Nigeria

Nigeria has experience some progress in the last two decades in reducing maternal deaths, but unfortunately, the number of women that die during pregnancy and childbirth from complications arising from childbirth remains appallingly high. Nigeria is the most populous and one of the wealthiest countries in Africa but with all these wealth, the

country continues to experience high rates of maternal deaths. Nigeria has the highest maternal mortality ratio (MMR) in the world, according to UN estimates, with 630 women dying per 100,000 birth a higher proportion than in Afghanistan or Haiti, and only slightly lower than in Liberia or Sudan (WHO, 2015). An estimated 40,000 Nigerian women die in pregnancy or childbirth each year and another 1 million to 1.6 million suffer from serious disabilities from pregnancy and birth related causes annually (WHO, UNICEF, UNFPA and WORLD BANK, 2015).

The centrality of health care to the successful reduction of maternal mortality has long been emphasized. Notwithstanding this knowledge, availability and more importantly, accessibility to health care service in the most troubled parts of the developing world constitute a perennial public health problem. The conceptualization of the term access is a difficult undertaken considering the multiple factors and dimensions that underlie the concept. However, within the purview of provision of Health care services, access which can be regarded as the right to use a facility without encumbrances associated with availability, affordability and proximity of services within a specified time and for specific purposes. It may be at the individual, group or community, health system and policy levels. A conceptualization of the term using these parameters captures if not totally, but adequately its meaning with respect to Health care services irrespective of geographical location. Since the efforts to reduce maternal mortality was initiated within a framework of guidelines with profound implications for health systems, a cursory look at the policies informed by these efforts will shed light on the concept of access from a policy dimension

2.4 Global View of Healthcare facilities Utilisation

About two and a half decades ago, the Safe Motherhood Movement was launched to tackle the beleaguering effects of maternal mortality on socio-economic and human development in developing countries (Uamai, 2010; WHO, 2013). Coincidentally, the emergence of this movement was triggered by a report published by Harrison (1985) in the British Journal of Obstetrics and Gynaecology on the state of maternal mortality in Nigeria.

Since Nairobi, a number of international initiatives have been developed in different forum to achieve the principal aim of lowering maternal mortality. In Nigeria, the first response to this call was the development of a maternal and child health policy in 1994. However, aside this policy, the government did not develop any significant policy or program between 1988 and 1999 to address the poor maternal health situation in the country, even though it adopted the conference' s call of Nairobi 1987 to reduce maternal mortality by 50 percent in the 2000 (Bankole et al, 2013). Consequently, the large policy and perhaps program gap contributed to inadequate and poor health facilities required to stem the high maternal deaths recoded in the country over time. Moreover, the most affected will be the urban communities where health facilities had remained grossly inaccessible, inadequate and abysmally poor. As result, maternal mortality was higher in these parts relative to the urban.

Bankole et al (2013) observed that since the Health care facilities dispensation in 1999, and the institution of the MDGs at the beginning of the 21st century which has reduction of maternal deaths as one its primary targets, several policies and programs aimed at reducing maternal mortality have been initiated in Nigeria. Since the NHP in 1998, some of the policies developed to address maternal mortality include

- The National Policy on Population for Development, Unity, Progress and Self Reliance developed by the National Population Commission in 1998 (FMOH, 1998).
- National Economic Empowerment Development Strategy (NEEDS) (NPC, 2000) explicitly listed maternal mortality reduction as an objective.
- National Reproductive Health Policy which aimed to " achieve quality reproductive and sexual health for all Nigerians" by promoting all the components of reproductive health (NPC, 2001) aimed to " reduce maternal morbidity and mortality due to pregnancy and childbirth by 50% between 2001 and 2006" (FMOH, 2001).
- National Guidelines for Women' s Health (FMOH and UNICEF, 2001).
- Health Sector Reform policy in 2003 (FMOH, 2003).
- The revised version of the 2004 population policy, the National Policy on Population for Sustainable Development unambiguously called for a 75% reduction of the maternal mortality rate by the year 2015 (FGN, 2004).
- National Family Planning/Reproductive Health Policy Guidelines and Standards of Practice (FMOHN and USAID, 2004).
- A National Strategic Framework and Plan for Vesico- Vaginal Fistula (VVF) Eradication in Nigeria was developed by the federal government partnership with the United Nations Population Fund (UNFPA) with objectives of an 80% reduction of the incidence of obstetrics fistulas and a 300% increase in health care services to reverse the condition between 2005 and 2010 (FMOH, 2005).
- National Health Promotion Policy that (FMOH, 2006) was hinged on a three pronged components of health education, service improvement and advocacy, all of which directly and indirectly help reduce maternal mortality.
- An Integrated Maternal, Newborn and Child Health (IMNCH) Strategy in 2007 through the Ministry of Health , This policy is currently being implemented at all

levels of the health care system in Nigeria and its major aim was to synergize the different programs designed to reduce maternal, neonatal and child mortality in Nigeria (FMOH, 2007)

Notwithstanding all these polices, maternal health outcomes has not improved; significant success has not been recorded because of a number factors. The principal factor is the lack of political will to ensure the successful implementation of the policies. Bankole, et al (2013) and Ijaduanola et al (2010) affirmed that the Nigerian government has not demonstrated the required political will to transform polices to goal achieving actions. According to the World Bank (1993, 2005), reported a dismal performance on health by the Nigerian government; it indicated that spending on health care reduced and amounted to only one-seventh of private-sector spending. In 2004, for the first time, money was allocated specifically for reproductive health in the Nigerian budget; safe motherhood received specific financial attention under the allocation made for reproductive health also for the first time that year. However, only US$800,000 was released for safe motherhood, it is ‘ hardly enough to deal with a crisis of national scope’ (Bankole et al, 2013). Government’ s allocation to health in 2007 totaled 122.4 billion naira (about US$1 billion), reproductive health accounted for just 0.5% (about US$5 million) of the entire budget (FMOH, 2005). Despite this “ only a miniscule proportion of this budget was specifically allocated to reducing maternal mortality” (Bankole, et al, 2013).

From the foregoing, it is clear that policy efforts to curb maternal mortality have increased within the last decade, the political will and the commitment needed to ensure a successful policy outcome is seriously lacking. This hindered policy efficacy thereby negating utilisation of health care facilities and services that are germane to reducing

maternal mortality to the barest minimum especially in resource poor settings. Carolan (2010) followed a group of sub-Saharan women who had migrated to developed countries as refugees. A systematic review of the literature was conducted to examine the pregnancy health status of African refugees after resettling in a developed world. They were among a group at risk of pregnancy with little care access. Poor prior health, co-existing disease, and traditional cultural practices were the determinants of high risk pregnancy. Infant mortality and morbidity were analyzed as possible pregnancy outcomes and were found comparatively high in the sub-Saharan refugee population in the developed countries.

In some countries, 100% of the pregnant women had at least one prenatal visit. Some of those are: Australia, Austria, Barbados, Brunei, Dominica, Finland, Grenada, Kazakhstan, Oman, etc. Most of them are located in the developed parts of the world. Many countries had less than 50% of women attending at least one pregnancy visit, for example, Afghanistan (16%), Chad (39%), Ethiopia (28%), Laos (35%), Nepal (44%), Niger (46%), and Yemen (47%). All of them are listed in the developing parts of the world (UNICEF et al., 2010, 2014). UNICEF's sources of information on healthcare can be found in the Millenium Development Goals (MDG) report. According to the MDG's data from 1990 to 2014, the coverage of skilled birth attendants in developing countries rose from 54% in 1990 to 63% in 2014. When compared with those of the developed countries, the coverage percentages of the developing countries were much smaller. The percentage in 1990 was 93% and rose up to 97% in 2014 in the developed countries.

In 2014, broken by geographic states, European countries had the highest percentage of skilled birth attendance (97%), while in South Asia, it was only 43%. Broken by geographic states and wealth quintiles, the East Asia and the Pacific, excluding China, remained equal between five wealth quintiles. 54% of the poorest poor

and 91% of the richest rich received professional delivery assistance. On the other hand, South Asia showed a disparity in professional delivery consumption. Only 17% of the poorest poor can achieve it, while 83% of the richest rich had a doctor, nurse or midwife take care of their delivery (UNICEF et al., 2010, 2014). Ribeiro, Guimaraes, Bettiol, Lima, Almeida, Souza, Augusto, Silva, & Gurgel (2015) identified risk factors for inadequacy of healthcare utilisation in a metropolitan Northeast Brazil area. Brazil has a wide coverage of healthcare with a high percentage of women participating in healthcare by professional caregivers.

However, high rates of prenatal and maternal mortality and morbidity remained. The negative outcomes of good prenatal health practices raised a discussion on the quality of healthcare provided by caregivers. Results indicated that a significant proportion of women did not receive full care during pregnancy. The explanation was found from the growing socioeconomic inequalities, demographic factors, and behavior risk factors. A large number of adolescent pregnancy found in this area contributed to inadequate maternal health care. Public care seekers also had a higher rate of inadequate use.

In 2013, WHO carried out a worldwide research using recent DHS data for many countries. The research aimed to study the use of healthcare all over the world from 1990 to 2012. Basic information was gathered and informed the utilisation of prenatal health practices in the world. According to the results, most women had some maternal health care. Excluding Sub-Saharan Africa, most women sought healthcare in early gestation. Most of the women having healthcare reported four or more visits. Among them, the proportion of urban women was twice the proportion of urban women. Except Sub-Saharan Africa, educated women had more visits than uneducated or less educated women. The WHO found insignificant differences between age and parity groups, but it

was significantly influenced by wealth. Healthcare was provided by trained healthcare workers. Due to the limitation of interventions collected in the DHS, the WHO acknowledged the importance of having a fully developed theme to study maternal health care.

Urban and wealthier women tended to deliver with skilled birth assistants, while urban and less wealthy women were less likely to seek the help of professionals. However, poor-rich and urban-urban disparities varied between countries. Wealthy women in some countries preferred delivery in medical centers. Wealthy women in other countries did not. Some evidence suggested wealthy women sought healthcare earlier than the poor. In contrast to Simkhada et al.(2007) result , Say and Raine (2007) rejected the importance of place of residence in collaboration with increasing maternal health care.

Researchers using DHS were able to predict the determinants of prenatal healthcare in the developing countries. Houweling et al. (2007) selected DHS for 45 developing countries, from 1990 to 1998. They discussed the inequalities of maternal healthcare. They found that inequalities in professional delivery care were greater than any other forms of care included in the research (professional delivery attendance, maternal health care, immunization, treatment for diarrhea, and acute respiratory infections).

Although population living in the urban area was too small when compared with urban residence in the developing countries, urban area was burdened with the lack of professional delivery care. The study even saw a huge gap between the rich urban dwellers and the poor city citizens in delivery care. Another factor affecting prenatal and delivery care was the unmet demands and the failure of public sectors in indentifying

poor-rich inequalities. Consequently, inequalities in this form of health treatment were larger over the period of development.

2.5 Healthcare Service Utilisation in Nigeria

Lawrence (2015) used the NDHS 2013 to acknowledge the importance of having professional attendants during delivery. He compared the utilisation of skilled birth attendants between public and private sectors. The use of delivery care increased in the NDHS 2013 when compared with the previous one in 2003. The majority of births between 2008 and 2013 were attended by skilled providers. Most of the women gave birth in public hospital/health facilities.

The author explained that many urban areas do not have private hospital/health facilities, or, if there is one, the quality is unable to compete with public sector services. Education, household wealth, and belonging to a certain ethnic group were the significant determinants of whether they chose skilled birth attendants. Among these three factors, education was the most significant. This finding was consistent with other findings about women education and their autonomy and ability to make a decision related to health issues. Both education and household wealth were determinants of having a professional birth attendant from the private hospital/health facility.

Access to quality health care is a fundamental right of every individual which should be guaranteed by government through affordable health care systems. The policies regulating health care system in Nigeria is capitalist in nature (Jegede, 2002), hegemonic and not all inclusive. Cost of health care constitutes a rhealth care services curring dilemma for utilising maternal care (Nwokocha, 2004; Griffiths and Stephenson, 2001; Okafor and Rizzuto, 1994) in the country; the fee-for -service approach characterizing the health care system in Nigeria has been noted to frustrate access to

services particularly during emergencies (Nwokocha, 2004) and especially in urban settings. Moreover, the hierarchical organization of Nigeria' s health system implies that health services that are vital to maternal mortality intervention are hardly available in the lowest tier of care that is mostly prevalent in urban areas. The cost of utilising such services becomes doubly burdensome due to proximity factor and service cost in middle and tertiary health care facilities. The overall implication is delay in utilising or total inaccessibility of timely and specialized maternal health intervention needed by women who develop childbirth or pregnancy complication.

Beyond policy initiation and implementation and the nature of health system dimensions influencing access to health care services including communal orientation defined by belief systems, traditions, customs, norms as well as individual idiosyncrasy determine access to such specialized health facilities. The ethos of patriarchy confers on men folk the authority over daughters and wife' s reproductive rights and wellbeing (Isiugo-Abanihe, 2003; Nwokocha, 2004; 2008). As a result, individual health needs are regulated by an overarching male dominated structure that defines and determine access to health care facilities.

Studies on male role in reproductive issues have concluded that in settings dominated by patriarchal ideology, men exercise and enjoy tacit but superior position in the family decision-making processes (Feyisetan et al, 1998; Isiugo-Abanihe, 2003; Nwokocha, 2004). This has profound implication for the type of health care facility accessed and the time such facilities are accessed. The prerogative to decide on the type of health care (whether traditional or modern) accessed by women even in the event of maternal complications is usually exercised by men. As a result, they may delay utilisation of health care facilities. Additionally, the indication that patriarchal authority

structures regulate women' s access to health care services is evident in some cultures that prescribe that women seek the permission of their husband' s relatives to decide on the choice of health care (Orji et al, 2007). This may affect timely access and use of Health care services.

A different angle to look at disparity healthcare in Nigeria is analysing the individual, household, and commune characteristics as the impacts on prenatal utilization. A study of Ogbu and Agu (2008) provided the knowledge of community effects on individual choices of whether to have antenatal care and whether to choose a health center to give birth. They used the data from the National Household Survey 2002, a large scale survey, to represent the prenatal health practices in Nigeria. The study proposed a modeling framework to better understand the prenatal health practices of Nigerian women. The decision of the delivery place was jointly determined by the individual, household, and community characteristics. On the other hand, prenatal utilisation depended on a single level of individual, household, or community. First, a prenatal visit was influenced by whether or not the woman had health insurance. Having health insurance increased the number of prenatal visits, while it did not affect the choice of seeking care. Middle and higher income women with insurance tended to deliver in a health facility, while it did not show effect for lower income group. A woman's choice for seeking healthcare was affected by the observed household, and the community characteristics, such as income and ethnicity, geographic area, poverty rate, and distance to the closest health facility.

In contrast, the women's choice of place to give birth depended on unobserved community characteristics including quality of health facilities (Idowu & Asakitikpi, 2008). These findings were useful for policy-makers to generate a multi-level approach to enhance healthcare in northern Nigeria.

2.6 Determinants of Healthcare Utilization

In Nigeria, as in most developing countries, reproductive behaviour is a complex phenomenon (Isiugo-Abanihe, 1996). With a total population in excess of 140 million (NPC, 2006), the country continues to reproduce at high but stable rate with a total fertility rate (TFR) of 5.7 (NPC and ICF, 2013). The implication of these TFRs is that Nigerian women will give birth to nearly 6 children by the end of her childbearing age (Isiugo-Abanihe, 1996; NPC AND ICF, 2013). This is characteristic of sub-Saharan African and it establishes it as the state with the highest fertility in the world (Isuigo-Abanihe, 1996).

Recent data from the Nigeria Demographic and Health Surveys (NDHS 1990, 2003, and 2013) indicated that average family size remains high for the country; average family size in the Ekiti State is 4.7, and (5.8) is higher than the national average by 0.1 percent, and it is the highest for the Ekiti State state (NPC and ICF Ekiti State Stateal Fact Sheet, 2013). Current use of contraception has increased nationally including use of modern methods. In the Ekiti State is 26 percent and 16 percent respectively and in it is 8 percent compared to 19 percent in Oyo which is highest in Ekiti State (NPC and ICF Ekiti State Stateal Fact Sheet, 2013). Thus, unmet need for contraception among these women persists as a perennial problem. Unmet need for contraception among married women is 26 percent; 18 percent for spacing and 8 percent for limiting, the highest in country (NPC AND ICP, 2013). The majority of the women of urban Ekiti State are victims of high risk birth, a condition that induces maternal mortality among her population (Bankole et al, 2013). The proportion of women who accessed antenatal services 5 years prior to 2013 survey declined in the states; there was little or no change in the Ekiti State, 2 percent (NPC AND ICF, 2013). This has implications for births assisted by skilled providers and the proportion of women who birthed in modern health

facilities by stateal background and within states. The situation in urban communities is hardly encouraging; 22 percent of urban women will be assisted by a skilled health provider which is also the least in Ekiti State. According to the 1990 DHS data on place of delivery, birth in health facilities rose insignificantly by 2 percent after a 13-year period by a further 2 percent in 2008 (NPC, 2000; NPC and ORC, 2004; NPC AND ICF, 2013). Expectedly, in the core Ekiti State, birth in modern health facilities reflected the aforementioned patterns; in (18 percent) birth in modern health care facilities is one-fourth of figures in Ekiti (Bankole et al, 2013; NPC AND ICF, 2013).

The maternity care situation in the urban Ekiti State is hardly encouraging especially in terms of access to skilled providers' assistance during delivery, births in modern health facilities and postnatal care. The situation in urban communities in Ekiti is the most appalling in the state and may be worse when some salient factors affecting reproductive and maternal health are considered. In the state, there is relatively highly urban communities and as result, amenable to socio-cultural and environmental factors that impinge negatively on safe motherhood practices. A study published by West African Insight on Nigerian vision on key opportunities for safe childbearing also identified these problems, it said, " Some of the factors driving maternal mortality in Nigeria include low quality of health delivery, poor attitude to antenatal and postnatal care, delay in seeking professional services and harmful traditional practices" (Ezehi, 2010). A situation where women cannot control their fertility constitute human right abuse (Bankole et al, 2013; MSI, 2004), this unequivocally leads to high maternal mortality especially among urban women. Hence, urgent and adequate attention is required to tackle this perennial problem.

2.7 Socio-Cultural Factors Influencing Utilisation of Maternal Health Facilities

Fertility in sub-Saharan Africa is generally underpinned by pronatalist belief system regulated by patriarchal ideological structures (Caldwell and Caldwell, 1987; Ocholla-Ayayo, 1997; Obono, 2002 and 2003). This functional prerequisite " takes place within the context of complex social organization and under the influence of multiple social, cultural, and ideological realities" (Isiugo-Abanihe 1994:237). In this context, fertility of individual women reflects mostly the preferences of the men folk that regulate their childbearing behaviours within the framework of patriarchy. The bias created and reinforced by patriarchy in favour of men extends their dominance over health including reproductive health where their decisions are regarded as final (Isiugo-Abanihe, 2003; Nwokocha, 2008). Patriarchy as a system fosters total dependency of women on men in the family " like when to conceive, number of children, utilising antenatal and postnatal care and seeking professional help during emergency situations' when they are directly affected by such decisions" (Nwokocha, 2008). Male reproductive motivation underpin fertility in African societies (Obono, 2002; 2003) however, failures to realize the implicit role men play in female reproductive behaviours that characterize the continent, especially among the urban populace, as contributed significantly to poor health status of women. The need to give adequate attention to male role was captured by Isiugo-Abanihe (2003), he writes:

Before the current concern for male involvement began, reproductive health issues and services had become synonymous with women' s reproductive health, and men will be assumed to have no special interest in such matters. However, the tacit exclusion of men from active involvement in these issues represents a lack of appreciation of the social reality of daily living in most developing societies, particularly in Africa. Indeed, the

characteristic lack of male involvement in reproductive initiatives, including family planning, is a major obstacle to a speedy fertility decline in sub-Saharan Africa given the considerable authority and power vested on men as decision makers in the home and society (Isiugo-Abanihe, 2003:8)

Fertility especially in countries with high regime like Nigeria exposes women to reproductive health problems – the risk associated pregnancy and childbirth related complications – that promotes maternal mortality. Hence, achieving any meaningful reduction in maternal mortality in settings like urban Ekiti State implies understanding and giving adequate attention to the role of men in the reproductive health of women. This will provide the necessary insights on issues such as decision making prerogative and the attitude of men towards maternal morbidity and mortality.

In Africa, tacit male control of maternal health practices remain a bane to achieving desired safe motherhood behaviours that can reduce maternal morbidity and especially mortality to the barest minimum. Writing about maternal crisis on the continent, Nwokocha (2008) observed:

Maternal events in Africa are prone to crises for several reasons. Women are subjected to repeat childbearing at short intervals either to satisfy husbands' quest for large family size or as a means of adjusting to very high infant morbidity and mortality in the continent. The situation is exacerbated by cultural beliefs and practices during emergencies. In some communities, women's socio-economic status is significantly low to enable them contribute meaningfully to family discourse. Consequently, men take sole decisions that affect members of their families. This exclusivity notwithstanding, it has

been noted that a large majority of men in Africa are indifferent to reproductive health . The implication of such attitude in a male dominated society, is that activities that influence maternal outcomes are taken for granted, ultimately resulting in maternal crises typical of the situation in Africa (Nwokocha, 2008:36).

The pervasive nature of patriarchal elements on the African continent continue to produce and reproduce age long relationships (Sen et al, 1994) that subjugates women by men (Barrett, 1988) even when the former' s life is at stake.

In a recent study in Ile-Ife, Osun State, Orji et al (2007), found men to be the major decision-makers regarding safe motherhood practices. This is line with Bankole et al (2013) and NPC AND ICF (2013), they found men to be the major determinants of when to have children and how many to have, a situation long ago observed by Isiugo-Abanihe (1994).

The study by Orji et al (2007) corroborating Stock (1983) also revealed that in the face of health condition, women either wait for their husbands implying that male authority structures are dominant even in emergencies. This has profound repercussion for maternal health and the occurrence of mortality. The way men perceive maternal mortality is unavoidably consequential for the role they play in safe motherhood practices. For instance in Lawoyin et al (2007), reported that proper knowledge of maternal risk factors among their respondents and many attributed maternal death to spiritual causes and felt death could have been averted if traditional doctors /herbalist had been sought. Moreover, some of them see maternal mortality as an outcome of predestination while others felt it is a form of punishment due to infidelity. The

perception of men about the capacity of women to reproduce has been reported to have untold consequences for maternal health and in the extreme, mortality. The Safe Motherhood Newsletter reported that in a study conducted in Republic of Benin, none of the men interviewed perceive the number of pregnancies a woman has as potential or actual health or life threatening risk. This perception was captured in one of the numerous responses; " If my wife wakes up in the morning that means she is well" (Safe Motherhood Newsletter, 1996). Perceptions of this nature which are especially fatalistic have a tendency to be prevalent in urban areas and this will continue to frustrate efforts at reducing incidence and prevalence of maternal death.

Socio-cultural factors are factors associated with the traditions, norms and values of people that affect the way and manner in which they seek medical help on health related problems. The community beliefs and norms are reflected in an individual's health decisions; behavior is influenced by how a person thinks the community views his or her actions. (Rutenberg and Watkins, 1997) For example, traditional beliefs about childbirth, coupled with misconceptions and fears of medical institutions, have led many women to maintain reliance on home births in India (Basu, 1990). Results from a study in Benin found that women giving birth unassisted were silently admired, (Sargent, 1990) and in West Africa childbirth is considered a woman's battle (Diallo, 1991). Culture incorporates belief-system that underlies the perception and interpretation of diseases and illness in societies. Erinosho (1998), argued that, unlike in the western societies where the concept of disease is largely based on the germ theory, hence patients perceive disease in terms of organic malfunction, which can be effectively, diagnosed using scientific and clinical techniques and the acceptance of a scientific notion of disease therefore oblige patients to use modern orthodox or western-style healthcare service. In Africa and most

developing countries that is not the case. The persistence of high maternal morbidity and mortality is inextricably linked to socio-cultural practices that are peculiar to most traditional African societies. Social and cultural norms, gender roles, social networks, religion and local beliefs influence peoples' choices (Bosveld, 1998). To a large extent, these community norms determine individual reproductive health practices including childbearing preferences, sexual and reproductive behaviour (Oladeji, 2008) and access to and use of health facilities. With regard to maternal health care, the influence exerted by communal culture, norms, values and practices particularly urban communities are enormous even in the face of life threatening situations that require urgent and timely interventions.

Globally, in economically restrained settings, the incidence and prevalence of maternal mortality remains a daunting and fundamental unmet public health challenge (Lawoyin et al, 2007). In such settings like the urban Ekiti State, the condition is greatly enhanced by socio-cultural practices that characterize this environment. Writing about pregnancy outcomes, and the role of African men in maternal crises, Nwokocha (2004; 2008) reported that among the Ibani of Rivers State in South-South, pregnant women are prohibited from coming out of their homes during a popular festival (Nwaotam) which lasts for three days even when they develop pregnancy-related or delivery complications that requires emergency and specialized care. Kinanee and Ezekiel-Hart (2013) reported that similar festivals such as the New Yam festival graced by the Agaba masquerade exist in the Ogoni Kingdom and some other riverine communities in the state with similar restrictions on women and when violated, the women or girl could be severely beaten even though she may be pregnant. In African societies, women are victims of traditional culture not because of what society do to them but rather, what society fails to do

(Bwakali, 2001). However, Kinanee and Ezekiel-Hart (2013) are of the opinion that the injustices from traditional culture are from both sides. Thus, in emergency situations, practices which prevent women from utilising modern health care particularly specialized care provided by health services, compound pregnancy and maternal birth related crises that may frequently lead to mortality.

Thus, access to treatment and the decision to use health facilities remain largely undermined by beliefs, norms and values as well as the socio-economic condition of women, which is dependent largely on patriarchal ethos in relatively highly ' traditionalized' environment.

2.7.1 Traditional Medicine

Traditional medicine, which is often preferred as a first source of healthcare is a cultural practice that is common among most of the Nigerian ethnic groups. For instance, according to Odebiyi (1989) among the urban Yoruba in Ile-Ife almost all sicknesses are first treated traditionally before modern medical treatment. In addition, the health status of most African societies can only be understood in the light of a given socio-cultural background of folk medicine and the environment of formal health system. Although there is variation in the health practices within these systems in the respective societies, it tends to be the major source of health provider. In spite of the spread of formal health systems as well as the expansion of health services, one reason why women bypass the formal system in favour of folk medicine is seen in their negative attitude towards the former, which, in many cases, results from bad experiences as reported by many of them.

The situation occurs especially in relation to childbirth, when it becomes so complicated that the traditional midwife cannot handle. The woman is therefore

transferred to a clinic, when, in most cases, it is too late. The resulting death/complications are consequently associated with the service providers at the clinic, hence the negative attitude towards it. In addition, the reason why they bypass the modern formal health institution for the traditional providers, is because of socio-cultural belief among most people/societies in the third world countries which favours traditional medication as against modern orthodox healthcare system - with its personnel's (doctors, nurses and midwives) derived from different socio-cultural background, religion and tradition; the services they provide are associated with foreign alien culture of the west etc (El-Safty, 2001).

Furthermore, Ried (1982), in her work *'Patient/healers interaction in Sukuma Medicine' in African Healing Systems* cited by El-Safty (2001), argued that in the first place, traditional healers are part of the culture of the society or community, characterised by social proximity to the clients (as such, a strong affinity exists between patients and healers) in comparison to the formal health system which represent an impersonal and 'alien' approach to health care. She sums up the relationship in her study in Tanzania this way: Traditional health practitioners are people oriented with a personal approach; most modern health practitioners are western oriented with impersonal approach (Ried 1982)

In addition, what strengthens the role of tradition medicine in this type of societies is seen in the clients' perception of causation in illness. In this type of society, causation is rooted in the interpersonal world of tradition, magic, and the supernatural, while in the 'scientific-modern medicine' it is rooted in the non-personal observable, and manipulative laws of nature. Traditional healers, therefore, interacts with the client through the channel of a shared belief system which is strongly rooted in their culture, and shapes the way of thinking of both the healer and the patient.

2.7.2 Religion and Rituals during Labour

Many studies have shown that the use of modern health services is often influenced by individual's perception of the efficacy of modern health services and the religious beliefs of the individual woman (Adetunji, 1991). According to Baley (1997) and Mekonnon (2002) there is a significant variation in the utilisation of healthcare by religion. Furthermore, Addai, (1998) and Mekonnon (1998) in their study in Ethiopia revealed that religion has emerged as an important predictor of maternal care utilisation in urban Ethiopia.

In Borno state it is common among the Muslim ethnic groups for religious rituals to be performed in order to assist a woman in labour. Mallams and their grown up students *(Almarjirais*) would come and read the Holy Quran to the woman for protection against all evils relating to pregnancy and childbirth. And after that, a drink of Quranic verses particularly *Aya-tul Kursiyu* are written on plate and washed and given to her to drink for safe delivery (Waziri 2004, El-Nafaty, 1998). Adamu (2001) also revealed similar rituals among the Hausa people of Kano state in Northern Nigeria. Consequently, women tend to remain in the house instead of going to the health facilities for delivery because of the psychological satisfaction and assurance of nothing wrong would happened derived from the rituals.

2.7.3 Socio-Demographic Factors

In Nigeria, only 39 percent of women have access to skilled birth attendants (SBAs) which comprise of medical doctors, nurses and mid-wives, and only 35 percent of births will be delivered in a health facility (NPC and ICP, 2013). This is 7 and 2 percent up on 1990 and 2003 figures respectively (NPC and ORC, 2004; Bankole et al, 2013). The

elitist nature of the medical profession has implication for the ratio of doctor to patients in health facilities. According to Jegede (2002:217):

Physician ratio in Nigeria is about 1 to 10,000 persons. Even the very few ones available are concentrated in the urban areas at the neglect of the urban areas where more than 65 percent of the Nigeria populace reside. As a result the class people have no adequate access to qualified physicians, hence the patronage of quack doctors, herbalists and spiritual homes (Jegede, 2002:217).

The above submission is true of the situation in urban Ekiti State, especially urban Ekiti, where only a few women have access to skilled birth attendants during delivery (NPC and ICF Ekiti State Stateal Fact Sheet, 2013).

In a study by Onorkerhoraye, (1999), he observed that compared to other states, medical health care facilities in Ekiti State particularly are not only relatively poorer, but are inequitably distributed within the state. Worse still, in a state that is largely urban with about 67 percent of the population living in villages of less than a 1,000 population, and are mostly farmers, the ratio of skilled births attendants is one of the poorest in the country. As at the time of the study, there will be only 39 medical practitioners of which 25 will be located in the state capital (Ekiti State) with a physician ratio of 1 to 53, 977 compared to a national average of 1 to 12,492. The ratio of nurses/midwives was 1 to 8,418 compared to a national average of 1 to 2,125 and the hospital bed ratio was 1 to 6,500 compared to 1 to 1,700 nationally. Similarly, 196 of the 323 beds and 70 percent of the 328 nurses/midwives are concentrated in the state capital and three other local governments with relatively lower population density respectively. Thus, in emergency situations, survival of those that are able to access relevant facility in these urban areas is

largely diminished by the non-availability of trained personnel as expressed above and as result, maternal mortality becomes inevitable.

The global burden of maternal mortality especially in developing countries that led to a global Safe Motherhood initiative to reduce the scourge was fraught with a few strategic missteps (Resenfeld and Min, 2007). Ijadunola et al, (2010) observed that emphasis was unduly placed on antennal care (ANC) including screening for risk factors and training of TBAs to employ safe hygienic practices but neither proved sufficient to significantly reducing maternal mortality. This necessitated a paradigm shift from antenatal risk assessment approach and promotion of TBAs assisted delivery to health care services that emphasizes delivery and care under SBAs. However, little progress has been made. For instance, Ijadunola et al, (2010) in a study among skilled health providers in Osun state reported that the general knowledge of health care services was lacking, the delivery of ANC contents that ensures safer pregnancy outcome was poor, there was poor awareness and knowledge of Life Saving Skills (LSSs) that are important during obstetric emergencies, the inability to use routine obstetric protocols and staff is largely made up of " de-facto" unskilled birth attendants" or Community Health Extension Workers (CHEWs) who take the place of SBAs was common. Consequently, " in resource-poor settings, life threatening obstetric complications still often go unidentified and pregnancy complications are frequently not properly managed" (Ijadunola et al, 2010).

According to a national survey in Nigeria, on essential obstetric care, less than one-third of public sector referral facilities in the country met the standard for comprehensive essential medical care (FMOH, 2003). However, when these facilities meet the health care services standard, due to some salient factors, health care is sometimes rendered ineffective. For instance, it has been reported that the decision-surgery interventions are sometimes delayed with intervals ranging between 30 minutes to 6 hours (Ibeh, 2008)

while delays at other times may be due to unavailability of blood, electricity, sterilized instruments, ambulance late arrival experienced theatre of staffs and unhealthy hospital policies (Okoro et al, 2001. Orji et al, 2012).

The situation in urban Ekiti State may not be definitely different or far from those reported above considering that the health system within that state is relatively poor. Due to the peculiar tropical nature of that environment, delays attributable to health service factors are likely to constitute a major barrier to utilising and utilizing health care services to avert serious pregnancy complications and maternal deaths.

2.10 Global Action on Maternal Mortality

There are a number of previous declarations, as well as stateal, national and international initiatives on maternal health. In 1987, two independent initiatives drew attention to the continuing high levels of maternal mortality and morbidity in developing countries (Ravindran & Berews, 2000). The Safe Motherhood Initiative was launched by the World Health Organization (WHO) and other international agencies in 1987 and was immediately supported by International Confederation of Midwives (ICM, 2012). The second was the International Day of Action for Women's Health on 28 May 1988, launched by the Women's Global Network for Reproductive Rights and the Latin American and Caribbean Women's Health Network through a „Call to Women for Action to Prevent Maternal Mortality', which had been endorsed by participants at the 5th International Women and Health Meeting in 1987 in San José, Costa Rica (Ravindran & Berews, 2000). At that time the number of women suffering maternal deaths worldwide was estimated to be at least 600,000 each year - with 99% of deaths occurring in the developing world (ICM, 2012). More countries have now made a commitment to Safe Motherhood than ever before – through the Programme of Action of the International Conference on Population and Development (ICPD) in Cairo in 1994, the

Technical Consultation on Safe Motherhood in Colombo, Sri Lanka in 1978 and the ICPD review process in New York in 1999. At the ICPD in 1994, all governments agreed to reduce maternal mortality by one half of the 1990 levels by the year 2000, and by a further half by 2015.

2.11 Reproductive Health Behaviour and Implications for Mortality

In Nigeria, as in most developing countries, reproductive behaviour is a complex phenomenon (Isiugo-Abanihe, 2003). With a total population in excess of 140 million (NPC, 2006), the country continues to reproduce at high but stable rate with a total fertility rate (TFR) of 5.7 (NPC and ICF, 2013). The implication of these TFRs is that Nigerian women would give birth to nearly 6 children by the end of her childbearing age (Isiugo-Abanihe, 2003; NPC AND ICF, 2013). This is characteristic of sub-Saharan African and it establishes it as the state with the highest fertility in the world (Isuigo-Abanihe, 2003).

Recent data from the Nigeria Demographic and Health Surveys (NDHS 2003, 2008 and 2013) indicated that average family size remains high and average family size in the Ekiti State is 4.7%, which is higher than the national average by 0.1 percent. Currently, the use of modern methods of contraceptives has increased nationally. Thus, the unmet need for contraception among southwestern women persists as a perennial problem. Unmet need for contraception among married women southwest is 26 percent; 18 percent for spacing and 8 percent for birth limit, which the highest in country (NPC AND ICP, 2013). The majority of the women of urban Ekiti State are victims of high risk birth, a condition that induces maternal mortality among her population (Bankole et al, 2013). The proportion of women who accessed antenatal services 5 years prior to 2013 survey declined in the states; there was little or no change in the Ekiti State, 2 percent

(NPC AND ICF, 2013). This has implications for births assisted by skilled providers and the proportion of women who birthed in modern health facilities by stateal background and within states. The situation in urban communities is hardly encouraging; 22 percent of urban women were assisted by a skilled health provider which is also the least in Ekiti State. According to the 1990 DHS data on place of delivery, birth in health facilities rose insignificantly by 2 percent after a 13-year period by a further 2 percent in 2008 (NPC, 2000; NPC and ORC, 2004; NPC AND ICF, 2013). Expectedly, in the core Ekiti State, birth in modern health facilities reflected the aforementioned patterns; in (18 percent) birth in modern healthcare facilities is one-fourth of figures in Ekiti (Bankole et al, 2013; NPC AND ICF, 2013).

The maternity care situation in the urban Ekiti State is hardly encouraging especially in terms of access to skilled providers' assistance during delivery, births in modern health facilities and postnatal care. The situation in urban communities in Ekiti is the most appalling in the state and may be worse when some salient factors affecting reproductive and maternal health are considered. In the state, there is relatively highly urban communities and as result, amenable to socio-economic and environmental factors that impinge negatively on safe motherhood practices. A study published by West African Insight on *Nigerian vision on key opportunities for safe childbearing* also identified these problems, it said, "Some of the factors driving maternal mortality in Nigeria include low quality of health delivery, poor attitude to antenatal and postnatal care, delay in seeking professional services and harmful traditional practices" (Fadeyi, 2007). A situation where women cannot control their fertility constitute human right abuse (Bankole et al, 2013), this unequivocally leads to high maternal mortality especially among urban women. Hence, urgent and adequate attention is required to tackle this perennial problem.

2.12 Appraisal of Literature

Healthcare remains a major challenge to the global healthcare delivery system, especially in developing countries. Likewise, improving women's health issues pertaining to pregnancy and delivery has become the centerpiece of national development efforts in developing countries. However, despite this significant stride, there is little evidence to prove that maternal mortality has declined significantly in African countries, including Nigeria. Review of related studies throws more light on why Nigeria as a country is held back on maternal mortality reduction. Studies reported that although women were generally worried about their health, the cultural background of gender roles blinded them from recognizing their right to maintaining good health. These women considered the right to good health as contingent on fulfilling their purpose of taking care of and meeting the needs of "others" (such as husbands) at the expense of their own physical health and well-being. There is a religious and socio-cultural dimension for this consideration. In a study, it was found out that the most important factors contributing to maternal deaths include some cultural beliefs that undervalue women; a perceived social needs for women's reproductive health capacities to be under strict male control and the practice of purdah (wife seclusion), which restrict women's medical care; almost universal female illiteracy; marriage at an early age and pregnancy often occurring before maternal pelvic is complete and harmful traditional medical practices among others.

A study also found out that women's decision-making autonomy may be explained in relation to their lack of education and limited influence over material resources. Women's land rights in particular have been a major focus of empowerment efforts, yet only in a few countries do women constitute even one-quarter of the landowners. This gender disparity in land ownership impacts the economic status of women and further

perpetuates a high level of dependency on their husbands, leading to male dominance. It was observed that although women may have access to land or retain control over their own income, many have no influence on the use of their husband's income. This may mean that women are particularly unlikely to make independent decisions about how money should be spent on high-expenditure items, including healthcare services.

Traditional practices based on patriarchal beliefs also affect women's psychological and physical health. Polygamy, a common marital practice in many African countries, is deeply engrained in Nigerian culture, where multiple partners are considered part of masculinity. This practice has resulted in men abandoning older wives for younger ones, leading to a vicious cycle of abuse toward women. Many studies have shown that women in polygamous unions, especially senior wives, may suffer from more psychological disorders, as well as more familial and economic problems, compared to their counterparts in monogamous marriages. Taken together, these issues highlight the consequences of women's living conditions in relation to their disadvantaged experiences, which are also connected to the gendered effects of socio-cultural practices affecting utilisation of healthcare facilities.

It has been revealed from previous studies that there are some socio-economic and cultural factors responsible for poor utilisation of healthcare facilities. The physiological ability of the body to carry pregnancy successfully is dependent on the age. It is also a fact that age is associated with decision-making and rationality. The study considered the current age of the respondents and age at marriage as vital variables, among others, for the analysis to understand the socio-cultural context of maternal health.

This study assumed that education increases the ability to think critically and analyze situations before acting. Education is a key determinant of maternal health. Not only does education invariably lead to higher income and greater awareness of important

maternal health indicators it enhances value for healthy life style. Studies have shown that educated women are more likely to take measures to protect themselves. Education accelerates behaviour change and makes women more receptive to prevention messages. Therefore, education was selected as one of the factors to be considered in understanding the socio-cultural context of maternal health.

Culture is the totality of the way of life of a people and it includes among others, beliefs, knowledge, customs, and habits acquired by man as a member of society. Religious observances shape ideologies and life style. Religion is pervasive in Nigeria. The religious beliefs and cultural taboos can have a powerful impact on how pregnant women care for their health and the treatments they choose to accept. This can prevent early detection of problems and warning sign related to pregnancy complication, lack of awareness of pregnant women's needs and different views of pregnancy, with varying perceptions of why complications occur and treatment required. This might be more pervasive among the less educated woman. Therefore, the influences of cultural beliefs and stereotypes need to be incorporated in the analysis of maternal health.

Economic situation is measured by occupation and income and are important indexes for measuring quality of life. Poor economic situation might lead to undernourishment. Women who are undernourished are prone to vitamin deficiency diseases during pregnancy, which lead to anemia. Anemia can be harmful to both the mother and the baby. The economic influence also derives from economic pressure. Engagement in tedious activities because of economic demand for a pregnant woman, especially for the one that has not been feeding well, can be dangerous. Economic demands affect attitude and value. As a consequence of poor maintenance, women are extremely susceptible to stress-related diseases, and have poor resistance to infections and other stressors. Economic status also determines the level of support they get during

pregnancy. Therefore, the linkage between the economic status and maternal health should be considered appropriately.

It was also assumed that, most women workers work in precarious and vulnerable conditions because of economic pressures. Women are affected by unfavourable working policies that demand more time. Therefore, women face maternity related threats to their health and economic security, and this was considered as necessary for analysis in understanding the socio-cultural context of maternal health.

The health impact of stressful events not only depends on the nature of these events but also on the individuals' ability to cope. This study assumed that the support from others, such as relatives, friends, and neighbours can play an important role in fostering the physical and psychological health of women.

These variables are often mutually reinforcing and directly linked to socio-cultural and economic situations; creating pressure on pregnant women precipitates the medical proximate determinants of maternal health complications

2.13 Theoretical Explanation

The theoretical explanation in this study is hinged upon Polical Economy Approach and Andersen's Behavioural Model of Health Service Utilization.

2.13.1 Political Economy Approach

Basically, this approach provides a holistic view of societal development (Omideyi, 1990; Owumi, 2002, Aina, 2012). It has two basic schools of thought; the liberal variant that stresses the role of free market forces in resource allocation and distribution including those of health care, and the radical school based on Marx's doctrine of production and relations of productions (Owumi, 2002). This paradigm considers the structural and socioeconomic determinants of healthcare utilization.

However, a neo-Marxian variant of Benerji (1984) would be adapted for the purpose of this study.

In this perspective, Benerji submits that healthcare systems and provision in the Third World remain problematic and beyond the reach of the under-privileged and deprived sections of the state's population because government and policymakers have been unable to ensure democratization of healthcare systems. This he attributed to half-hearted efforts by the political leadership of developing countries to severe links with the inroads made by western approach to healthcare provision in the states. Consequently, due to lack of proper scrutiny, a viable alternative that involves an inclusive or people oriented decision-making approach to healthcare provision has not been developed, and where developed, has not been adequately implemented (Benerji, 1984). He concludes that developing countries lack the political systems that would allow the type of democratization that would ensure adequate provision of context-specific healthcare systems. This is true of Nigeria; healthcare system and provision is capitalist in nature (Jegede, 2002), hegemonic and not all inclusive.

The system of healthcare delivery imposed on Africans by Christian missionaries and colonial masters laid the foundation for a capitalist oriented healthcare system in some countries including Nigeria. Thus, healthcare development in Nigeria was lopsided, advantaged urban centred and capitalist or market driven. Because the healthcare development of Africans particularly disadvantaged urban Africa was not prioritized (Banerji, 1984; Ityavyar, 1987), the ruling post-colonial elites in Nigeria have done little in that regard. Healthcare policies in Nigeria - except until recently or in the last decade – have failed to achieve desired development within the sector and thus, facilities were not adequately provided, and where available, are not evenly decentralized nor properly democratized. More so, urban elites continued to influence government decision on development and distribution of these facilities evident in the "half-hearted attention paid to the disadvantage urban healthcare and by extension maternal...care" (Owumi, 2002: 230). The primary healthcare (PHC) strategy which can be regarded as the mid-wife of

emergency obstetric care, and designed to serve the health needs of communities and disadvantage urban areas , suffered the same fate (Stock and Anyinam, 1992).

The foregoing has been attributed to lack of political would on the part of government either at the federal, state or local level who allocated an abysmal portion of their respective budgets to healthcare and maternal reproductive health in particular (Feyisetan & Bankole, 2002; World Bank, 1993; 2005; Bankole et al, 2013). Additionally, economic corruption at levels of government coupled with poor economic planning and recurrent expenditures incurred by policymakers, and political ambition are contributory factors. They expend the better part of the allocation on health on a single facility located usually in the state capital, and beyond the reach of the disadvantage urban and urban populace whose unmet need for maternal health - emergency healthcare facilities – is greater, and of public health concern (Ijadunola et al, 2010; Lawoyin et al, 2007; WHO, 2007).

The exposition above vividly highlights the underlying political cum economic factors bedevilling access to healthcare facilities in urban communities in Ekiti, Nigeria. Inability of some urban women in this state to access healthcare is a further confirmation of the vivid marginalization suffered at large (Idris 2010). Consequently, maternal mortality inducing conditions especially in emergency cases is enhanced by difficulty in utilising modern healthcare thereby heightening delay and as a result, maternal deaths.

Although, political economy allows for a distillation of the factors affecting access at structural level, it does not account for the individual or group idiosyncrasies that may influence access to these facilities during crisis situations which are sometimes or for the most part dictated by socio-economic factors in disadvantage urban areas . To this end, Andersen Healthcare Utilisation Model would provide the needed explanation on the access and utilisation of modern healthcare facilities.

Additionally, it provides the basis for the conceptual framework to be employed in the study. Thus, the theories provide explanations on health provision generally and maternal

health system in particular and factors influencing access and its implication for maternal health /mortality.

2.2.2 Andersen Healthcare Utilisation Model

The Andersen Behavioral Model of Health Services Use is a conceptual model aimed at demonstrating the factors that lead to the provision and use of health services. According to the model, usage of health services (including maternal care, inpatient care, physician visits, etc.) is determined by three dynamics: predisposing factors, enabling factors, and need. Predisposing factors can be characteristics such as race, age, and health beliefs. For instance, an individual who believes health services are an effective treatment for an ailment is more likely to seek care. Examples of enabling factors could be family support, access to health insurance, one's community etc. Need represents both perceived and actual need for healthcare services. The original model was developed by Ronald M. Andersen, a health services professor at UCLA, in 1968. The original model was expanded through numerous iterations and its most recent form models past the use of services to end at health outcomes and includes feedback loops (Andersen and Ronald, 1995).

According to Anderson and Newman (2005), utilisation of health services can be regarded as a type of individual behaviour. In line with this, several frameworks for analysing health services utilisation were found in the literature. These include Rosenstock's health belief model, Young's choice-making model and Anderson's health behavioural model (Rebhan, 2005). Of all these models, only the latter analyses differences in health services utilisation from a socio-demographic perspective. This tallies with the objectives of this study; hence, the study is conducted based on Anderson's model and is explained below.

Andersen's (1968) Health Behavioural Model assumes that certain characteristics contribute to, or determine, an individual's use of health services. He divided these characteristics into three categories, and proposed that utilisation of health services is

dependent on: 1) Predisposing characteristics; 2) Enabling characteristics; and 3) Need based characteristics.

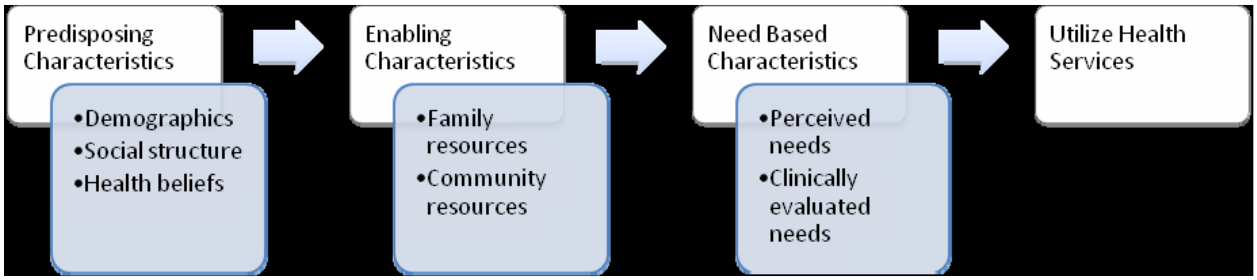
1. Predisposing Characteristics. It is postulated that some people are more likely to use services than others and this likelihood can be predicted by individual characteristics. People that possess certain characteristics have been found to be more disposed towards health services use, even though these characteristics are not directly responsible for the utilization. These characteristics include demographic factors, such as age, sex, parity, etc; social structural factors, which is a reflection of the individuals social standing or status and is measured by characteristic such as educational attainment and occupation of the head of the family; and attitudinal-belief factors, where individuals who have stronger faith in the efficacy of treatment are more inclined toward healthcare utilisation (Rebhan, Anderson and Newman, 2005).

2. Enabling characteristics. Certain resources need to be available to an individual in order to actualize health services utilisation even in the presence of predisposing factors. These resources are defined as enabling as they make health services available to the individual and are found both at the family and community levels. Family resources include income (economic status), health insurance coverage and location of residence (Anderson and Newman, 2005). Family income is an important enabling factor as it determines the amount of funds available to an individual to cover healthcare and related costs, e.g. physician consultation, drugs, transportation costs, etc.

Resources at the community level include the number of health facilities and health personnel available for use to an individual. A greater number of health facilities and personnel reduce the unpleasantness of queuing-up for limited services and might be used more frequently by individuals. Community level resources also include the nature of the area where an individual resides, i.e. state of the country or whether residence is in the urban/urban area. This is because local norms and values influence an individual's behaviour towards the practice of medicine (Anderson and Newman, 2005).

3. Need-based characteristics. Measures of this characteristic include perceived needs i.e. the perception of illness and its severity or the probability of an illness occurring; and needs as evaluated by a health professional (Rebhan and Burgard, 2004; Anderson and Newman, 2005). A woman's need for care may be influenced by past experiences in pregnancy and childbirth or personal preferences. Thus, perceived need serves as a stimulus for the access to and use of health services. Perceived illness can be measured by the number of disability days, and symptoms experienced by the individual during a specified time frame (Anderson and Newman, 2005).

Figure 1: Andersen's Behavioural Model of Health Service Utilization.



Source: *Andersen's Health Service Utilisation Model, 1968*

2.14 Conceptual Framework

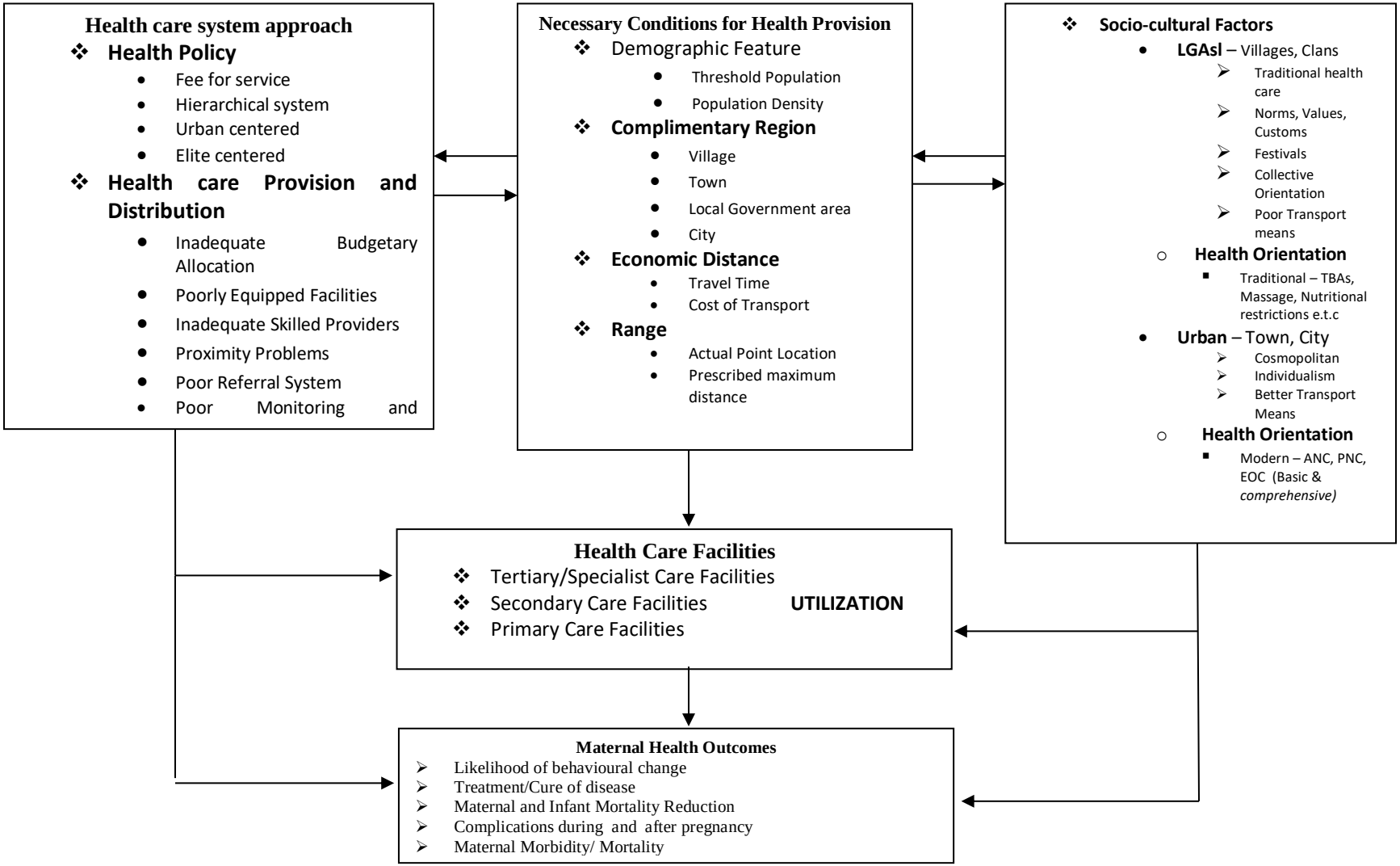
Maternal mortality remains a daunting twenty-first century unmet public health challenge particularly in economically restrained and marginalized communities (Lawoyin et al, 2007). This problem is more pronounced in urban parts of Africa including Nigeria. Hence, this conceptual framework highlights factors responsible for the persistence of maternal mortality; it focuses on the overall effects of health provision approach, conditions necessary for the spatial location of healthcare facilities and social factors affecting peoples' psychosocial behaviour and beliefs about the significance and importance of utilising healthcare facilities - healthcare – within a social and physical environment. The framework demonstrates vividly the ensuing interaction among several

variables that engenders access or inaccessibility to healthcare and the likely maternal health repercussions.

The healthcare system of any society is a reflection of its political cum economic philosophy; healthcare policies, provision and programmes emanates from a society's overall ideological viewpoint and practices. To a large extent, healthcare policies has implications for access to health facilities and the quality of care available to members of the society including those providing emergency services and specialized care for pregnancy-related and childbirth complications. A healthcare ideology characterized by fee for service approach and hierarchy of specialized facilities and services with elitist and urban biases have a strong tendency to hinder access in economically restrained settings or highly urban communities.

Typically, in most urban communities, available health facilities are predominantly ill-equipped and services are usually poor, skilled birth attendants are mostly grossly inadequate, referral system is relatively terrible and healthcare funding is abominably inadequate (Lawoyin et al, 2007). Moreover, to a large extent, the political Would of the policy and decision makers determine the necessary conditions for the location and spatial distribution of healthcare facilities but a majority of settlements in urban settings unintentionally fail to satisfy the necessary conditions. Most of them are unable to meet the demographic requirement necessary for the location and proper spatial distribution of these facilities while other conditions such as transport cost and travel time in deeply marginalized communities are highly burdensome. In addition, the maximum distance between healthcare facilities or service outlets location and urban settlements is usually not at par with the desired point-location among urban populace. Hence, in these locales, proximity is generally and largely unfavourable to access and utilisation of available healthcare services such as obstetric facilities during maternal related emergencies.

Fig 2: A framework of Socio-cultural Factors and Utilisation of Healthcare Facilities



Source: Illustration by the Author, 2017

The deplorable condition of health facilities and in accessibility problems is aggravated by socio-cultural factors influencing peoples' health and illness behaviour and beliefs about the significance of Utilising healthcare facilities. In the selected local government areas, collective orientation predominate the healthcare continuum, popular use of traditional health facilities (TBAs) combined with other ancillary cultural beliefs (women in post-menopausal period are seen as experts on childbirth and pregnancy) about maternal reproductive health is common. The prerogative of the male authority structure in decision making even in emergencies and the compulsory observance of gender based traditional festivities engender delay in utilisation of healthcare services. Besides, the capitalist nature of healthcare provision cum economic distance reinforces unfavourable health beliefs and practices characteristic of many urban areas. Consequently, the overall maternal health outcome is poor; women suffer from avoidable morbidities and in extreme cases mortality

2.15 Research Hypotheses

Generally, in line with the theoretical framework, four study hypotheses were drawn, which include:

i. There is a significant relationship between the women's socio-demographic characteristics and utilisation of healthcare facilities in the study setting
ii. Socio-cultural beliefs and practices during pregnancy significantly influence delivery complication
iii. Women's working conditions are likely to influence health care facilities utilization.
iv. There is a significant relationship between stereotypes and utilisation of healthcare facilities.

CHAPTER THREE

METHODOLOGY

This section presents the methods used in the study and the structural framework of the research. It deals with the generation of data, sampling procedure and techniques, data collection and the statistical techniques that were used to analyze the data collected.

3.1 Research Design

The survey method was employed as the research design for this study, based on the fact that it allows the collection of information from a representative sample of a target population. The study utilised structured questionnaire, in-depth interview and key informant interview for primary data collection. The secondary data were sourced from review of books, journals, magazines, Nigeria Demographic Health Survey (NDHS), reports from relevant articles on-line libraries etc. The data were triangulated method Both quantitative and qualitative research approaches were employed independently and complimentarily in this study to harness the strength of both approaches in order to generate robust data for a holistic presentation of the subject matter of the study.

The study made use of two important variables namely: the independent variables of the study, which are the socio-cultural factors while healthcare facilities utilisation is the dependent variables. These variables were collected based on the experience of the respondents. The variables to be used in the study include (1) Level of utilisation of healthcare facilities among pregnant women in urban areas; (2) socio-cultural factors that influence utilisation of proximate healthcare facilities; (3) effects of stereotypes associated with maternal health service utilisation on maternal mortality in urban areas of Ekiti State; (4) women's working conditions affect their utilisation of maternal health services; and (5) effectiveness of the state government's role in the distribution of

healthcare facilities in urban. These categories of variables reflected in the questionnaire used to collect the research data.

3.2 The Study Area

The study area is Ekiti State which located in the Ekiti Stateern part of Nigeria. The State is a sprawling urban and urban centres in where unique endowments and strategic location have created an attraction for domestic and international immigration, producing a mega city of immense dynamism, complexity and opportunities. Rapid economic growth in some towns in the state has attracted people to the State through the creation of opportunities for employment, education, cultural experiences and services. These opportunities attract people to Ekiti. In turn, the concentration of people in Ekiti brings together a range of skills and new ideas, leading to improvements in the economic performance of Ekiti State. As a result, the population increases further.

Population growth in cities like Ado Ekiti, Ikole Ekiti and Ikere Ekiti is therefore often regarded as a positive development. This perhaps is not a new phenomenon. What is new, however, is the growing failure of the city to fulfill much of the expectations both of those who live in it and those who have to depend on it for services (Afolabi, 2012). Although Ekiti State is one of the smallest states in Nigeria, with an area of 56,861 hectares of which 5,755 hectares are wetlands, the population is about 20,000,000 according to the National Population Commission 2009. It is majorly a Yoruba speaking area, although there are different dialects even within the same state. The Yoruba are known for having an extraordinarily high rate of multiple births.

There is also a high maternal and infant mortality rate: half of the twins die shortly after birth (WHO, 2012). The weather conditions vary between the two distinct seasons in Nigeria; the rainy season (March - November) and the dry season (November - February). The dry season is also the bringer of the Harmattan dust; cold dry winds from the northern deserts blow into the southern states around this time (Ogbu, 2009).

The major occupation and the main source of income in Ekiti State is agriculture. Agriculture provides income and employment for about 75% of the populace and they produce both food and cash crops (NDHS, 2013). The food crops are: rice, yam, cassava, maiza and cowpea while the cash crops are: cocoa, oil palm, kolanut, plantain, Banana, cashew, citrus and timber (Aladejana, 2009).

There are two tertiary health facilities in the State – one each owned by the State and the Federal Government, located at Ado Ekiti - the State capital and Ido Ekiti respectively. There are other many health facilities in the State (Primary, and Secondary Health Care, and private Health facilities) out of which many are not functioning (Ministry of Health, Ado Ekiti, 2015) and those that function are not affordable.

However, Ado Ekiti, the state capital has remained the economic nerve centre of Nigeria since time immemorial (Adeyemi *et al*, 2009; Amoo, *et al*, 2010). The state therefore, serves as a socio-economic melting pot attracting both Nigerian's and foreigners alike. The issue of live ability has become very pressing, especially with the increasing environmental deterioration. According to Mordi (2011) this involves not only living conditions but also ease of circulations in the city. There is tremendous pressure of population on limited facilities and this is manifested in the growth of squatter settlement, overcrowded habitation, inadequate water supply and generally poor environmental sanitation.

The problems of achieving health for all in the cities of Ekiti are common features of all urbanizing societies in Nigeria. Urban center do not necessarily improve living standards. Even the structure sometimes result in a relative decline in health levels in urban areas , and these health levels are closely related to the quality of urban living environments (Brigida, 2002). Urban growth has affected different groups of people in the city in different ways.

Although urban life is most fascinating it is also demanding especially on pregnant women who do not only contend with their own health but also with the life they are foisted to carry for nine months. Such experience is especially daunting for pregnant women in Ekiti State, Nigeria, who are faced with poor provision of social amenities and infrastructural decay. Healthcare facilities and services are concentrated in the cities of Ekiti, but a big hospital does not improve any one's health, as maternal mortality rate in Ekiti State would be put at 650 per 100,000 live births and expressed the government's worry at the high rate. Rather, healthcare is about identifying the health problems of a population and designing an integrated health policy to improve the challenge (National Mirror, 2012).



Adapted from Google Earth, 2016

Figure 3: Map of Ekiti State, the Study Area with Nigeria as Inset

3.3 Justification of Choice of the Study Area

All the sixteen (16) local government areas headquarters of the state were purposively selected for this study because they have social amenities especially healthcare facilities and have a heterogeneous population that cut across all ethnic and religious groups that are available in Nigeria. This cultural mix places them at positions that enable us to have an overview of socio–cultural factors and utilisation of healthcare facilities among pregnant women in Ekiti State

3.4 The Study Population

The setting for this research work is Ekiti State with the population size of 2,377,562 (Population Reference Bureau, 2013). The study population comprised women aged 15-49 years, which is 128,470 of the total population. This is because this age bracket represents reproductive years of women as defined by WHO (2006). Eligible participants included all women that have given birth in the last one year, pregnant and/or would be pregnant and resident in Ekiti State. Every eligible woman in Ekiti State was given equal chance of being selected for the study. It is estimated that women constitute about half of the Ekiti State population while those who were within the research age category constituted 76.6% of the number of women in the state(National Population Commission, 2013).

The respondents were either married, single, divorced, separated or widowed. The general denominator of the population was that they were of reproductive age and have a child below one year and/or pregnant.

Ekiti State is made up of Sixteen (16) Local government Areas. For the purpose of its administration, this research work saw it as a thing of necessity and convenience to follow this path of demarcated local government areas based on healthcare facilities available in order to get the study sample. There are two tertiary health facilities (teaching hospitals) in the State. One of them is located in Ado-Ekiti, the State capital

and controlled by Ekiti State government; while the other is situated in Ido-Ekiti and managed by the Federal Government of Nigeria. There are at list sixteen general hospitals located in all the LGAs headquarters across the state and many other health facilities such Primary Health Centres and Private Health facilities. This showcases that there are enough healthcare facilities in the state.

Table 3.1: List of All Health facilities in Ekiti State

S/N	Name of LGA	No of PHC	No of Secondary	No Tertiary	No of Private	Total
1	Ado	32	1	1	42	75
2	Efon	12	1	0	10	23
3	Ekiti East	14	1	0	11	26
4	Ekiti South West	21	1	0	4	26
5	Ekiti West	25	2	0	3	30
6	Emure	12	1	0	15	28
7	Gbonyin	17	2	0	6	25
8	Ido/Osi	17	1	1	8	27
9	Ijero	29	1	0	5	35
10	Ikere	17	1	0	9	27
11	Ikole	22	2	0	4	28
12	Ilejemeje	10	1	0	2	13
13	Irepodun/Ifelodun	18	1	0	11	30
14	Ise/orun	14	1	0	4	19
15	Moba	15	1	0	4	20
16	Oye	18	3	0	5	26
	Grand Total	**293**	**21**	**2**	**143**	**459**

Source: ***Ekiti State Ministry of Health, Ado Ekiti (2016)***

3.5 Sample Size and Sampling Techniques

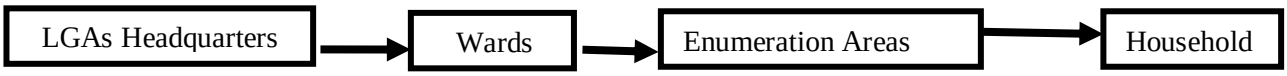
The target population of this study consisted of all users and non-users of healthcare facilities in Ekiti State, Nigeria. The data for this study came from a sample size of the total population of women of reproductive age range of 15-49. As published by the National Population Commission (2013), there are 128,470 women aged 15-49 years in

Ekiti State. This figure shows an average of 8,029 women aged 15-49 years in each of the 16 Local Government Areas of Ekiti State. To select a sample for the study, multi-stage sampling techniques were employed.

The study adopted a multi-stage sampling technique, to select a representative sample from the study population. The sampled population was drawn from households and the maternity section of existing hospitals and health centres in each LGA

The stages are graphically represented in figure 4 below;

Fig. 4: Sample Selection



Source: Illustration by the Author, 2017

The first stage involved the purposive selection of all the Local Government Areas Headquarters, because of their urbanized structures. This was to give the study a state – wide spread and for technical ease, the state's sixteen (16) Local Government Areas were used as the sampling frame from which respondents were randomly selected for the study using stratified random sampling procedure. Therefore, all the sixteen (16) Local Government Areas were covered.

At stage two, simple random sampling techniques were used to select two healthcare facilities from each of the sixteen (16) Local Government Areas Headquarters. Simple random sampling method is an unbiased process for selection of a sample from population in such a way that each member of the population has equal chance of being selected (Oluwadare, 2014). In line with this, every member of the target population has implicit chance of selection. The healthcare facilities that were randomly selected are presented in Table 3.2.

Table 3.2: Selected Healthcare Facilities according to Local Government Areas

S/N	Name of LGA	Name of Selected Healthcare Facilities
1	Ado-Ekiti	➢ Ekiti State University Teaching Hospital, Ado-Ekiti ➢ Comprehensive Health Centre, Oke-Eyinmi, Ado-Ekiti
2	Efon	➢ State Specialist Hospital, Efon-Alaaye Ekiti ➢ Basic Health Centre, Efon-Alaaye Ekiti
3	Ekiti East	➢ General Hospital, Omuo-Ekiti ➢ Comprehensive Health Centre, Omuo-Ekiti
4	Ekiti South West	➢ General Hospital, Ilawe-Ekiti ➢ Basic Health Centre, Ilawe-Ekiti
5	Ekiti West	➢ General Hospital, Aramoko-Ekiti ➢ Comprehensive Health Centre, Aramoko-Ekiti
6	Emure	➢ General Hospital, Emure-Ekiti ➢ Maternity Health Centre, Emure-Ekiti
7	Gbonyin	➢ General Hospital, Ode-Ekiti ➢ Basic Health Centre, Ode-Ekiti
8	Ido/Osi	➢ Federal Teaching Hospital, Ido-Ekiti ➢ General Hospital, Ifaki-Ekiti
9	Ijero	➢ State Specialist Hospital, Ijero-Ekiti ➢ Comprehensive Health Centre, Ijero-Ekiti
10	Ikere	➢ State Specialist Hospital, Ikere-Ekiti ➢ Comprehensive Health Centre, Ikere-Ekiti
11	Ikole	➢ State Specialist Hospital, Ijero-Ekiti ➢ General Hospital, Ijesa-Isu Ekiti
12	Ilejemeje	➢ General Hospital, Iye-Ekiti ➢ Basic Health Centre, Iye-Ekiti
13	Irepodun/Ifelodun	➢ State Specialist Hospital, Igede-Ekiti ➢ Comprehensive Health Centre, Igede-Ekiti
14	Ise/orun	➢ General Hospital, Ise-Ekiti ➢ Basic Health Centre, Ise-Ekiti
15	Moba	➢ General Hospital, Otun-Ekiti ➢ Maternity Health Centre, Otun-Ekiti
16	Oye	➢ General Hospital, Oye-Ekiti ➢ Comprehensive Health Centre, Oye-Ekiti

At the third stage, purposive sampling technique was employed to select Twenty-five (25) respondents that utilised selected healthcare facilities totaling Fifty (50) respondents

per Local Government Areas. Furthermore, at the fourth stage, Fifty (50) households were purposely selected to represent the non-users in the localities of selected facilities at the Local Government Area Headquarters. Finally, within each selected housing unit, a household comprising one woman of reproductive age that was currently pregnant, or who had given birth in the last one year was interviewed: Where there was a household that did not fulfill the criteria, the next household was chosen for replacement. Also, any household where there was more than one eligible woman for selection, a simple random sampling was used to select a respondent. The justification for the adoption of purposive sampling was to ensure that users (those that utilise healthcare facilities) and non-users (women that utilise others healthcare services, eg. TBAs) were considered for the research work by the researcher because it is a form of non-probability sampling technique, which is characterized by the use of judgment and deliberate effort to obtain representative samples by including presumable typical groups (Users and Non-users) in the sample (Addai, 2005)

From the forgoing, the sample size for those that use healthcare facilities sum up to eight hundred (800) respondents while the non-users also amount to eight hundred (800) respondents. This gave a grand total of One Thousand Six hundred (1,600) respondents as the sample size of the study from the total population of 128,470 women aged 15-49 years in Ekiti State.

3.6 Methods of Data Collection and Research Instruments

This segment deals with a detailed account of the instruments and methods that were adopted in the study to obtain the information required. The main purpose of the study was to investigate the implications of socio–cultural factors that influence utilisation of healthcare facilities in urban areas of Ekiti State. Therefore, data collected for this study were both primary and secondary, and were quantitative and qualitative in nature.

The primary data consisted of the information retrieved from the completed 1,600 questionnaires, which were administered to respondents drawn from the selected healthcare facilities and households. Owing to the nature of the problem, other sources of primary data were obtained through questionnaire and key informant interviews. The questionnaire employed both close and open-ended type of questionnaire to allow for standard answer and to compare opinion from a respondent to the other.

The questionnaire contained two sections: The first section covered the socio-economic and demographic characteristics of the respondents such as age, marital status, education, religion, occupation and income level. The second section contained questions on socio-cultural variables that influence utilisation of healthcare facilities. All questions in both sections of the questionnaire were developed by the researcher using information gathered from the literature. The answers that were derived from the questionnaire therefore formed the basis on which analyses were made.

The respondents comprised both literate and non-literate women, who are married or unmarried but have given birth and/or are pregnant. Due to the fact that some of the respondents might lack the ability to read and write, the questions were read out and interpreted to them with the help of trained research assistants. In the case of the educated group in the sample, the questionnaires were distributed to them to be completed. The procedure that was followed to retrieve the questionnaire from the literate respondents is as follows;

i. The respondents were requested to complete and return the questionnaire to the healthcare provider(s) on duty during their next ante-natal or an appointment with the doctor in case they could not complete it at the moment they were given or at the end of their treatment and/or ante-natal for that day. Respondents on admission were requested to return it to the research assistants, who were there daily to collect completed questionnaires.

ii. In ensuring that there was no loss of questionnaires from the respondents, who might not be able to complete the questionnaires immediately, their phone contacts were collected by the research assistants in order to remind them about the questionnaires and how to retrieve them.

3.7 Validity:

The questionnaire was pilot tested by administering it to some respondents before the main administration. This helped to determine the necessary changes in terms of re-phrasing and the logical sequence of the questions in the questionnaire.

3.8 Qualitative Research Techniques

3.8.1 Key Informant Interview (KII)

There are common characteristics about the Key Informants across the Local Government areas; therefore a purposive sampling technique was employed to select three Local Government Areas for the Key Informants Interviews (KII). Thus Ado Local Government Area from Ekiti Central Senatorial District and being the State capital with teaching hospital, Ido/Osi LGA, representing Ekiti North Senatorial District where Federal teaching hospital is located and Ikere LGA from Ekiti South Senatorial District, where there is State Specialist Hospital and Ekiti State College of Education Clinic.

The Four (4) Informants were selected from each of the LGA as follows;

i. Head of facility (1)

ii. Head of Obstetric Service Units (1)

iii. Nursing office (1)

iv. An experienced nursing mother or pregnant woman (1)

An interview guide was used. The interview guide was structured to elicit information on their experiences of pregnancy complications. Questions were asked on pregnancy related complications commonly reported at the center/or hospital, the causes of those complications, the socio-cultural factors that make women to be susceptible and the characteristic of those who are mainly suffering from those complications. It probed on why maternal mortality continues to be at alarming rate in the state and the place of biomedical in its reduction and also to connect the relationship between medical and socio-cultural factors in maternal health complications.

The process involved in conducting the key informant interview can best be described as the process of inquiry involving a gradual clarification of the research problems. Rather than being too committed to the interview guide, the issues that were raised brought about sprout matters which were followed up in consecutive questions. This is referred to as a process of "progressive focusing" (Hammersley, 2006; Asakitikpi, 2004).

3.8.2 In-depth Interviewing

In-depth interviews were used to compliment the questionnaire in eliciting information that mostly border on the research subject matter. The primary objective of the interviews was to explore people's thoughts, feelings, and behaviour on key issues regarding socio-cultural factors influencing utilisation of healthcare facilities. Twelve (12) In-depth interviews were purposively conducted in three (3) selected LGAs namely; Ado-Ekiti LGA, Ido/Osi LGA and Ikere LGA to cover all the three Senatorial Districts in Ekiti State (four women from each selected Local Government Areas). These LGAs were purposively selected based on their population and number of health facilities.

Respondents for the in-depth interviews were purposively selected. The interviews were conducted at different times and locations. Some interviews were conducted in the maternity centers/hospitals in all the selected LGAs, while some were conducted immediately after the questionnaires were administered.

The in-depth interview question guide was designed in a way that the informants were encouraged to discuss in details on specific themes that were indentified for in-depth understanding. There was an interview guide; the researcher served as the facilitator, while a tape recorder was used to record the interview, which was later transcribed for the purpose of analysis.

3.9 Procedure for Data Collection

To ensure speedy collection of accurate and reliable data, some steps were taken. These included the selection and training of field assistants, administration of questionnaire, conducting of the key informant interviews and conducting focus group discussions.

Four research assistants were recruited for the purpose of administering the research questionnaire as well as to assist with the conduct of in-depth interviews. Although, the assistants were graduates, there was still the need to give them instructions regarding interview techniques and field procedures and a detailed review of the items on the questionnaire for clarity. They were very conversant with Ekiti State and could speak both English and Yoruba languages and even Ekiti dialect. This enabled them to communicate effectively.

3.10 Methods of Data Analysis

3.10.1 Quantitative Data

The data generated through quantitative technique were analyzed using the Statistical Package for the Social Science (SPSS). Univariate and Bivariate statistical procedures were adopted in the data analysis. Descriptive statistical technique such as simple frequency distribution table, percentages, mean and mode, and charts were used, while chi-square and correlation were used for bivariate to explain the relationship.

Univariate analysis

The univariate analysis involved the use of simple statistics to examine and describe the variation in a single variable. The univariate analysis involves describing and examining the background characteristics and distribution of respondents according to the socio-demographic characteristics. Frequency distribution tables and percentages were employed to highlight the responses of the respondents according to individual characteristics. It was also used to determine the variability of the variables used in further analysis,

Bivariate Analysis

This entailed the examination and description of the relationship between the variables. The tests employed were cross tabulation and Chi-square. Chi-square test is a non-parametric statistical method that deals with the difference between frequencies observed in the sample and expected frequencies obtained from the distribution. Given that the correlation is the most common test for significance of the relationship, it was therefore used in this study to verify the relationship between the socio-demographic characteristics of respondents and the respondents' utilisation of healthcare facilities.

3.10.2 Qualitative data

The qualitative data collected through IDI, KIls and FGD were sorted and involved the categorization of responses into the objective of the study which they match. The researcher utilised ATLAS to analyze thematically.

3.11 Dissemination of Findings

All participants in this research were given a report of the findings, and were encouraged to comment on them. The dissemination of the results took place by three methods;

1. Production of a report that would be sent to Ekiti State Ministry of Health, all the Local Government Areas headquarters, the selected Hospitals and the selected community health committee heads.
2. Publishing papers in specialist and general, national and international journals.
3. Presentation of papers at both national and international conferences

3.12 Ethical Considerations

The purpose of this study was to investigate the implications of socio-cultural factors on utilisation of healthcare facilities in the study area with a view to reducing maternal mortality. In order not to violate individual rights and societal values, ethical issues bordering on the rights and consent of participants were highly considered and respected. To this end, ethical approval was obtained from relevant institutional authorities such as the University of Ilorin Ethical Review Committee, relevant tertiary medical facilities in the study areas, ministry of health and traditional authorities. Informed consent was obtained from each participant in the study.

Participants in this study would benefit from the outcome of the study in such that policy and intervention programme(s) recommended from the study findings, if adopted, would serve to sensitize stakeholders in safe motherhood movement including government, relevant local and international agencies and non-governmental organizations (NGOs) to address the need for improvement on healthcare that would benefit participants in the long run. This could reduce maternal deaths among the study population and its entire state.

Participants in the study would not be subjected to any risk; discussing or finding out maternal mortality may elicit some emotional discomfort. Woulding participants' identity was protected and their emotional feelings respected during and after the conclusion of the study.

An informed consent form was given to participants with content detailing consent to participate. Therefore, upon the agreement to participate in the study, the participants were expected to give needed information inquired from them to assist the researcher achieving the major purpose of conducting the study. All information collected in this study was given absolute confidentiality and the respondent's identity would not be used in any publication or reports from the study. Participation in the study was entirely voluntary. Participants were duly informed that they could choose to withdraw from the study anytime they deem fit. Participation in this research was totally free.

CHAPTER FOUR

PRESENTATION, INTERPRETATION AND ANALYSIS OF DATA

This chapter, in relation to the title is about the presentation, interpretation and analysis of data gathered from the field through the use of research methodology earlier discussed in chapter three. The data used in this presentation and analysis were drawn from the 1580 retrieved questionnaires from the 1600 copies of questionnaire, which were administered to the sampled respondents in the research setting.

The main purpose of this study was to examine implications of socio–cultural factors and utilisation of healthcare facilities on maternal mortality in urban areas of Ekiti-State, Nigeria. The secondary purpose was to determine cultural beliefs and stereotypes that are associated with maternal health. This study intends to estimate the level of maternal mortality in Ekiti State, explore the effects of stereotypes associated with healthcare service utilisation on maternal mortality in Ekiti State and also investigate safe maternal health practices including utilisation of healthcare facilities in urban areas of Ekiti State. However, data collected from questionnaire and interview methods were organized, classified and analyzed. The trends, and patterns and relationship among data were identified and interpreted. The data classification has been carried out on the basis of both nursing and pregnant women hypotheses formulated for this study guided the arrangement of the tables. A summary of the main findings follows each hypothesis.

Findings are presented in line with the study objectives. Necessary inferences are drawn from some of the findings in light of theoretical framework of the study, while observed similarities and differences between the present study and extant literature are reconciled using appropriate sociological explanation.

4.1 Demographic and Socio-Economic Characteristics of the Research Respondents

In the first part of presentation of data, the research seeks to know frequency distributions of the respondents used in this study in terms of the following socio-economic characteristics; age, educational status, marital status, ethnic group, religion, occupation and income.

4.1.1 Age

An examination of the age distribution of the respondents from the data collected shows the respondents age range between 15-49 years which is in line with reproductive age for women. The percentage frequency distribution of the respondents with respect to age shows that 148 (9.4%) respondents were below 25 years. The highest percentage of the respondents (53.4%) 844 out of 1,580 was between the ages of 30-39 years. Less than two tenth (9.1% and 7.0%) of the respondents were within 40-44 and 45-49 age range respectively. (See table 4.1.1)

Table 4.1.1: Frequency Distribution of Respondents by Age

Age (Years)	frequency	percentage %
Less than 20	71	4.5
20-24	77	4.9
25-29	333	21.1
30-34	455	28.8
35-39	389	24.6
40-44	144	9.1
45-49	111	7.0
Total	**1580**	**100.0**

Source: Fieldwork: (2017)

The data indicated that in the study area, older women are indifferent to family planning. Those below 30 years constitute less than one tenth of the total respondents. This is an indication that early marriage is uncommon among Ekiti women, which might be as a result of their love for education that consumes many years. In the main, the

findings showcased that women still give birth at age 45 years and above, which may culminate in complication during delivery.

4.1.2 Educational Level

On the basis of educational level, there were seven groupings: respondents with no education constitute 2.3% while 9.7% and 15.1% had primary and secondary education respectively. Respondents with tertiary education 45.3% are greatly higher than both primary and secondary education while 24.4% of the respondents went to technical and vocational schools. (See table 4.1.2)

Table 4.1.2: Frequency Distribution of Respondents by Educational Level

Educational Level	frequency	percentage %
No formal Education	36	2.3
Some primary	51	3.2
Completed primary	153	9.7
Completed secondary	239	15.1
OND/NCE/Grade II	379	24.0
HND/BSC/Postgraduate	337	21.3
Technical and Vocational Schools	385	24.4
Total	**1580**	**100.0**

Source: Fieldwork: (2017)

Table 4.1.2 revealed that 1,544 out of 1580 of the respondents attained one form of education or the other. The finding is expected because Ekiti people are known for acquiring formal education. In the main, most of the old women in Ekiti did enjoy free education in the old Western State. In the main, the results also revealed that varying levels of educational attainment contributed to our respondents' behaviour of utilisation of healthcare facilities.

4.1.3 Marital Status

The percentage frequency distribution of the respondents in respect of their marital status showed that 13.3% of the respondents were single and never married while the majority 1019 (64.5%) were married. 7.2% and 6.8% were Separated and Divorced

respectively. had primary and secondary education respectively. 5.0% of them were widowed while 3.2% of the respondents were cohabiting. (See table 4.1.3)

Table 4.1.3: Frequency Distribution of Respondents by Marital Status

Marital Status	frequency	percentage %
Single and Never Married	210	13.3
Married	1019	64.5
Separated	113	7.2
Divorced	108	6.8
Widowed	79	5.0
Co-habiting	51	3.2
Total	**1580**	**100.0**

Source: Fieldwork: (2017)

The data presented in table 4.1.3 on the marital distribution of the respondents revealed that married women are more likely to use health facilities for maternal/child health than other categories of women. This signifies that married women with the support of their husbands and relatives are more likely to utilise healthcare facilities as compared to the separated/divorced mothers 14.0% and widowed 5.0%, who lack the resource to support themselves not to talk of Utilising health services during pregnancy through delivery period. Though, the percentages of separated and divorced women were very low in the study setting. This may not be unconnected with the fact that Nigerian society discourages and attach greater importance to marriage while separation or divorce is discouraged, hence it is likely to find more married women in the society than any other part of the world.

4.1.4 Ethnic Group

The finding revealed the percentage frequency distribution of the respondents in respect of their ethnic group. Majority of the respondents 64.2% were Yoruba, followed by Igbo 13.2%, Hausa 7.9% and 14.7% were from other ethnic groups in Nigeria. (See table 4.1.4)

Table 4.1.4: Frequency Distribution of Respondents by Ethnic Group

Ethnic Group	frequency	percentage %
Yoruba	1014	64.2
Hausa/Fulani	125	7.9
Igbo	209	13.2
Others	232	14.7
Total	**1580**	**100.0**

Source: Fieldwork: (2017)

From the table 4.1.4 above, more than half of the respondents were from the Yoruba ethnic group. Finding was expected because the study was conducted in the Yoruba speaking community. The proportion of the Yoruba women attending antenatal and postnatal was higher compared to other ethnic groups.

4.1.5 Religion

The respondents were examined relatively to their religious belief. The percentage frequency distribution in this regard indicated that 63.9% (1010) were Christians; 33.2% were Muslims; while 2.7% (43) of the respondents claimed to be Traditional religion believers. (See table 4.1.5)

Table 4.1.5: Frequency Distribution of Respondents by Religion

Ethnic Group	frequency	percentage %
Christianity	1010	63.9
Islam	524	33.2
Traditional belief	43	2.7
Others	3	0.2
Total	**1580**	**100.0**

Source: Fieldwork: (2017)

The data presented in table 4.1.5 above showcased that Christians were numerically more than the adherents of the other religions in the study setting. This distribution could be explained by the fact that there are more Christian adherents than both Muslim and Traditional religion adherents in the study setting. There is no doubt that Ekiti State is a

Christian dominated state and the majority of the Muslims are those from other ethnic groups or states.

In corroboration of the above, many studies have shown that the use of modern health services is often influenced by individual perceptions of the efficacy of modern health services and the religious beliefs of the individual woman (Adetoro, 2011). According to Becker, Peters, Gray, Gultiano, and Blake (2013) there is a significant variation in the utilisation of maternal health care by religion. Furthermore, Addai, (2000) and Murray et al (2012) in their study in Ethiopia revealed that religion has emerged as an important predictor of maternal care utilisation in urban Ethiopia.

In Borno state it is common among the Muslim ethnic groups for religious rituals to be performed in order to assist a woman in labour. Mallams and their grown up students (Almarjirais) would come and read the Holy Quran to the woman for protection against all evils relating to pregnancy and childbirth. And after that, a drink of Quranic verses particularly Aya-tul Kursiyu are written on plate and washed and given to her to drink for safe delivery . Adamu (2015) also revealed similar rituals among the Hausa people of Kano state in Northern Nigeria. Consequently, women tend to remain in the house instead of going to the health facilities for delivery because of the psychological satisfaction and assurance of nothing wrong would happened derived from the rituals.

4.1.6 Occupation

An examination of the percentage distribution of the respondents by occupation revealed that 9.1% (143) were full-housewives; 33.4% (528) of the respondents were Small Private Business owners; 39.9% (631) of the respondents were civil servants; while 10.5% (166) of them were artisans and 7.1% (112) were unemployed. (See table 4.1.6)

Table 4.1.6: Frequency Distribution of Respondents by occupation

Occupation	frequency	percentage %
Full-Housewife	143	9.1
Small Private Business	528	33.4
Public servants	631	39.9
Artisan	166	10.5
Unemployed	112	7.1
Total	**1580**	**100.0**

Source: Fieldwork: (2017)

This research finding revealed that 1468 (92.9) respondents were gainfully engaged in one type of occupation or the other. It is however pertinent to stress those respondents that indicated being engaged in Small Private Business 33.4% (528) forms an appreciable percentage of the entire respondents. On the whole, this finding indicated that most of the women that had tertiary and little education worked in the local government secretariats across the state

Basically, it could be noted in the literature that the type of occupation that one is engaged in can precipitate one's level of wellness and the ability to utilise healthcare facilities. Furthermore, those engaging in small businesses are likely having low level of educational qualification or may not have attained educational above primary school certificate. This may consequently indicate that they are not well enlightened about the danger of not Utilising healthcare facilities during pregnancy. Also, the type of occupation a pregnant woman engages in may determine the level of the disease she may contact. For instance, the types of business that these respondents do are likely to be the one that is not dignifying, which may eventually culminate into depression, which is major cause of cardiovascular diseases such as hypertension.

4.1.7 Income

An examination of the monthly income reveals that the population consists of low income earners. The result shows that majority of the respondents earned between the average income of ₦31,000 - ₦50,000 were 26.5%, those with income below ₦10,000

were 11.8%. Pregnant women and mothers with income between ₦10,000 - ₦30,000 and ₦51,000 – ₦80,000 constitute 20.6% and 23.4% respectively while income earner between ₦80,000 and above were 17.7%. (See table 4.1.7)

Table 4.1.7: Frequency Distribution of Respondents by Monthly Income

Monthly Income	frequency	percentage %
Less N10,000	186	11.8
N10,000 - N30,000	326	20.6
N31,000 - N50,000	419	26.5
N51,000 - N80,000	370	23.4
N80,000 and above	279	17.7
Total	**1580**	**100.0**

Source: Fieldwork: (2017)

Table 4.1.7 revealed that majority of the respondents is low monthly income earners. It is of high interest to note that most of the respondents (931) representing 58.9% earn below N50,000 per month. This was not expected since the study is conducted in the urban areas. Conversely, it is expected since many of the respondents engage in low pay jobs such as small businesses. This shows that the pregnant women and nursing mother may not have enough financial capability to attend modern health centre. The pregnant women and nursing mothers with low income, that had little or no support from their husbands would surely prefer TBAs health facilities to health centres due to the low cost. Also, a lesser percentage (17.7%) of the respondents belongs to high economic status by earning more than N80,000 monthly. This is quite expected since stratification of any society usually indicates fewer people on the high level of economic leader, which certainly affects their healthcare facilities utilization.

Furthermore, to support this, it is well known that increased income has a positive effect on the utilisation of modern health care services (Elo, 2012; Fosu, 2014). Husband's occupation can be considered a proxy of family income, as well as social status. Differences in attitudes to modern health care services by occupational groups depict occupation as a predisposing factor. Alternatively, viewing occupation as proxy to

income, which enables acquisition of more and better health care, depicts it as an enabling factor (Fatusi & Ijadunola, 2016).

4.2: Level of Utilisation of Healthcare facilities among Pregnant Women in Urban Areas of Ekiti State

Maternal and child health, an indicator of the health status of a nation is very crucial and researchers have therefore attempted to identify factors that affect or influence the utilisation of one health facility to another. Factors such as maternal demographic and socio-economic variable were found to be important determinant of maternal and child health (Owoseni & Owumi, 2012).

Studies on healthcare utilisation in developing countries found seven groups of factors affecting the usage of maternal and infant healthcare services. They were: Socio-demographic factors, availability, accessibility, affordability, health service characteristics, position of women in the household and the society, and women's knowledge, attitudes, beliefs, and the culture they are living in. Among these factors, some had stronger impacts than others (Simkhada & et al 2007). Despite this, people's socio-cultural beliefs and perception about diseases and health care, also influence the type of health facilities to be adopted. Therefore, the study examines the socio-cultural status and utilisation of health care facilities by examining the level of utilisation of healthcare facilities and maternal mortality among pregnant women in urban areas of Ekiti State, Nigeria.

4.2.1 Utilisation of Antenatal Care Pregnancy

An examination on the utilisation of antenatal care by the respondents the result revealed that 97.3% of the respondents agreed that they had utilised healthcare facilities while 2.7% of the respondents had never utilised healthcare facilities for antenatal care when pregnant. (See table 4.2.1)

Table 4.2.1: Frequency Distribution of Respondents by Utilisation of Antenatal Care in Pregnancy

Ever go for Antenatal Care when Pregnant	frequency	percentage %
Yes	1537	97.3
No	43	2.7
Total	**1580**	**100.0**

Source: Fieldwork: (2017)

The table 4.2.1 above shows the frequencies and percentages of respondents that had utilised antenatal care facilities when pregnant in urban areas of Ekiti State. Majority of the respondents agreed that they had utilised antenatal care services while only few of the respondents had never healthcare facilities for antenatal care when pregnant in their locality. This percentage shows that they also make use health facilities for antenatal care.

4.2.2 Type of Antenatal Care Service Patronized

An examination on the type of antenatal care patronized by the respondents, the finding revealed that (52.2%) of the respondents had patronized both Health clinics and TBAs/Spiritual Home while 28.3% of the respondents visited Health clinics, those that utilised Traditional Birth Attendants were 14.6% and 4.7% of them visited others (Spiritual home, Chemist/medicine store and Home /self). (See table 4.2.2)

Table 4.2.2: Frequency Distribution of Respondents by Type of Antenatal Care Service Patronized

Antenatal Care Service Patronized		
Health clinic	447	28.3
Traditional Birth Attendants	230	14.6
Spiritual home	44	2.8
Chemist/medicine store	1	.1
Home /self	29	1.8
Both Health clinic and TBA/Spiritual Home	829	52.5
Total	**1580**	**100.0**

Source: Fieldwork: (2017)

From the above table, the highest percentage of the respondents that had utilised healthcare facilities patronized both health clinic and TBA/Spiritual Home. This indicates that they go to the hospital and at the same time patronize TBAs of Faith Based Clinic for spiritual reasons.

4.2.3 Reasons for Antenatal Care Service Utilisation Preference

Finding depicted that 37.5% of the respondents declared that they did have not money, which dictated the reason for their utilisation of antenatal care facilities. 14.4% of them were of the side that the Inaccessibility of health centres close to them has instigated their preference in antenatal care service. 19.9% of the respondents said that inadequate care given at the health centres dictates their preference for other source of antenatal care over modern health centres. The minima number of the respondents (13.2%) was of the opinion that they preferred using the facilities they patronized for antenatal care service. (See table 4.2.3)

Table 4.2.3: Frequency Distribution of Respondents by Reasons for Antenatal Care Service Utilisation Preference

Reasons	Frequency	Percentage %
No money	592	37.5
Inaccessibility of health centre	227	14.4
Inadequate care in health centres	315	19.9
Spiritual Reason	209	13.2
Others	237	15.0
Total	**1580**	**100.0**

Source: Fieldwork, 2017

The above table depicts that most of the respondents declared that lack of financial capability has been the major reason for their antenatal care service utilisation preference preferring. This might be true due to the economic recession the country is being faced. Some of them were of the side that the inaccessibility of health centres close to them has instigated their preference in antenatal care service. Though, the health facilities are

available but not accessible to the health consumer, which might be as a result of lack of money.

Furthermore, many of the respondents indicated that inadequate care given at the health centres dictates their preference for other source of antenatal care over modern health centres. Minima number of the respondents was of the opinion that they preferred using the facilities they patronized for antenatal care service. This particular preference might be for those who mainly patronize TBAs or utilise both TBAs and modern health centres simultaneously purposely for spiritual reason.

The finding above is corroborated by the in-depth interview conducted with a community health committee leader in a selected LGA. Community health committee members are generally older people who "care" about younger members of the community. They also take care of those women that are not able to pay for delivery and are therefore also seen as benevolent members of the community. Below is a claim about attending to spiritual issues that may occur;

> "*It is good for pregnant women to patronize both hospital and church. To my own knowledge, hospital does not handle any spiritual issue. As for me, I advise pregnant women to make use of church for prayer and hospital for immunization and medical check-up.* **(IDI/ Community Health Committee Member, 2017)**

In support of the above, (Joesoef, Baughman and Utomo, 1988) observed that the role of TBAs on maternal and child health care cannot be undermined. Exiting literatures have shown that when the TBAs are cooperative and supportive in child health care, it has good impact on the mother and child health of the urban dwellers.

Despite the high level of awareness about maternal and child high mortality rate, the number of the respondents that still do not make use of hospitals facilities for antenatal care was still high. The reason for this is not farfetched; public health care facilities that are supposed to provide basic prevention and health promotion services that include

immunization, health education, promotion of adequate nutrition and management of malaria, diarrhoea, acute respiratory infection and other common illness are not available, which make the urban dwellers make use of the available health facilities such as TBAs (Simpson 2004). This is corroborated by the interview of a healthcare provider;

> *People prefer home delivery or TBAs for antenatal care or delivery instead of going to teaching or general hospitals for proper care. This may be as a result of high cost of services at the health centres. If any woman wants to deliver in the teaching or general hospital now, she must prepare up to ₦30,000 if not more without complication but if it by caesarean, it would cost nothing less than ₦150,000.***(IDI/ healthcare Provider /Ido-Ekiti, 2017)**

In relation to above, one of the pregnant women attending antenatal care at both health clinic and TBA/Spiritual Home said that as long as they know that both the federal and State teaching hospitals are not affordable during delivery, they are comfortable with attending both hospitals and TBAs for antennal care.

> *It is very expensive to deliver at the teaching hospitals. At the same time, the health centres are very far from my place. I have been attending TBA for long time and it is good for me. The TBAs are really taking care of us. **(IDI/Female/Ikole, 2017)***

To ascertain the level of utilisation of antenatal care services, a woman interviewed was of the opinion that:

> *It is better to utilise both hospitals and mission house for antenatal care and deliver at the mission house or Ile-Agbebi than in hospitals. I also go to health centre for my child immunization but for delivery, I prefer mission house to hospitals. In fact, all my four children were delivered at mission house and home.**(IDI/Female/Ado-Ekiti, 2017.)***

In the main, it was obvious from the findings that some factors precipitate the level of antenatal care service patronage. These factors are age, occupation, educational attainment and income. The justification of this is that the period of pregnancy before Antenatal visit has been found to be a strong factor predicting presence or absence of complications during delivery and after birth.

4.2.4 Frequency of Facilities Utilisation

The percentage distribution of respondents by frequency of facilities utilisation showed that majority 860 (54.4%) of the respondents frequently utilised health care facilities in the study area. Those that utilised it periodically were 4.8%; while 8.0% of the respondents utilised it occasionally. 518 (32.8%) of the respondents rarely utilised health care facilities in the study setting. (See table 4.2.4)

Table 4.2.4: Frequency Distribution of Respondents by Attendance of Health care Facilities Utilization

Frequency of Facilities Utilization	Frequency	Percentage %
Frequently	860	54.4
Periodically	76	4.8
Occasionally	126	8.0
Rarely	518	32.8
Total	**1580**	**100.0**

Source: Fieldwork, 2017

Table 4.2.4 is an indication that most of the respondents utilise health facilities on frequent basis. This result is in line with the weekly antenatal of activities among the pregnant women. Periodically, only 76 (4.8%) of these women utilized the available health care facilities while those that visit health facilities occasionally 8.0%. On health care facilities utilization, 518 (32.8%) of the respondents claim to rarely visit health care facilities in the study area.

4.2.6 Supportive Roles Husbands In Utilising Health Care Facilities

The frequency distribution of respondents by the supportive roles husbands perform, finding revealed that majority (28.4%) of the respondents got the support of their husband by taking them to hospital. 20.3% of them revealed that their husband take good care of them especially their children. Their husbands (17.8%) cook for them during this period of health challenge and their pregnant condition. 14.2% get their hospital bill paid for by their husbands. (See table 4.21)

Table 4.2.6: Frequency Distribution of Respondents by Their Husbands' Supportive Roles

Husbands' Supportive Roles	Frequency	Percentage %
Cook food	281	17.8
Pay bills/Buy drugs	224	14.2
Take her to the hospital	449	28.4
Care for the wife and the children	321	20.3
Pray	16	1.0
Others	289	18.3
Total	**1580**	**100.0**

Source: Fieldwork, (2017)

The bar chat above shows the respondents' view on the type of supportive roles husbands perform when their pregnant wives fall sick. The finding revealed that majority (28.4%) of the sample women were of the opinion that the major supportive roles perform by their husbands is to take them to hospital. This particular role is highly required to avert maternal mortality, when sick pregnant women are quickly taken to the hospital for proper medical attention. Furthermore, 20.3% of them revealed that their husband take good care of them especially their children. This care may include bathing for their children, cooking for them and also taking them to school. Their husbands (17.8%) of the respondents reported that their husbands cook for them during period of health challenge or pregnant condition. 14.2% get their hospital bill paid for by their husbands.

In support of the above, the health impact of stressful events not only depends on the nature of these events but also on the individuals' ability to cope with the crisis and on

the extent to which they receive social support from relatives, friends and other members of their social network (Stroebe, 2000).

In an impressive early survey, a relationship between social support and mortality was demonstrated. Berkman and Syme (2009) studied social and community ties among a random sample of both women and men whose age varied from 30-69. Each of the four types of social relationship that was assessed at that time independently predicted the rate of mortality over the succeeding nine years. Individuals who were low on an overall Social Network Index, and which weighted the intimate ties more heavily, had approximately twice the mortality risk of individuals who were high on this index over the nine-year period.

That conjugal relations have a bearing on other aspects of a woman's life in particular and on the well-being of the family in general cannot be disputed (Babalola, 2013). Indeed, such aspects of conjugal relations as the intimacy between spouses and decision making process can be expected to influence women's health. Studies have shown that conjugal role deprivation, which was reflected in strained relationships within marriage, was felt among the women either because they did not secure the kind of husband or the type of marriage they wanted or because of divorce or an unhappy current marriage (Omideyi, 2016). Recently, findings from India also mirror the previous findings, in acknowledging the fact that, women who experience violence from their husbands are also less likely to have control over sexual activity or to be able to make decisions about the timing of childbearing, particularly in such a highly gender-stratified setting (Stephenson, et al, 2008). The feelings and fears experienced during pregnancy are intense and varied. These feelings and concerns are a normal part of pregnancy. Each woman comes to terms with the changes in her own way, with the support of her partner or family (Kitts and Roberts, 2016). The extent to which individuals perceive that supportive others are available would affect the copping process. There is evidence that

individuals who have a great deal of social support suffer a lower risk of physical impairment and mortality than individuals who have little social support (Stroebe, 2000).

4.3: Socio-cultural Factors that Influence Utilisation of Healthcare Facilities

This section analyses the data obtained from the questions raised from objective two (2) stated in chapter one.

In Nigeria, the choice to deliver outside hospital settings could be motivated by varying factors such as economic, social, physical, cultural, or institutional (Ahmed et al. 2005). These factors can be grouped into Socio-cultural, social demographical and socio-economical factors.

Socio-cultural factors are factors associated with the traditions, norms and values of people that affect the way and manner in which they seek medical help on health related problems. The community beliefs and norms are reflected in an individual's health decisions; behaviour is influenced by how a person thinks the community views his or her actions. (Rutenberg and Watkins, 1997) For example, traditional beliefs about childbirth, coupled with misconceptions and fears of medical institutions, have led many women to maintain reliance on home births in India (Basu, 1990).

According to Raju (2000) some of the socio-cultural practices and superstitious beliefs and practices relating to the concept of causality in which illness and other misfortunes are attributed to evil spirits are wide spread among many ethnic groups in Nigeria. Traditional perception of events may tie followers to the use of traditional medicine and encourage use of formal system only when the traditional option fails.

In an investigation of the above literature, this section seeks to investigate the socio-cultural factors that influence utilisation of proximate healthcare facilities in urban centres of Ekiti State.

4.3.1 Facilities Utilised for Treatment of Diseases during Pregnancy

The percentage of respondents showed that about 619 (39.2%) of the respondent utilised Government hospital for treatment of diseases during pregnancy. 271 (17.2%) of the respondents were of the opinion that they prefer to utilise Private hospital/clinic to any other healthcare facility while 29.8% of the respondents patronized Traditional Birth Assistants (TBAs); one out of ten (10.4%) of the respondents patronized Faith/Spiritual based clinics for the treatment of health challenges. (See table 4.3.1)

Table 4.3.1: Frequency Distribution of Respondents by Facilities Utilised for Treatment of Diseases During Pregnancy

Facilities Utilised for Treatment of Diseases During Pregnancy	Frequency	Percentage %
Government hospital	619	39.2
Private hospital/clinic	271	17.2
Traditional Birth Assistant home	471	29.8
Faith/Spiritual home	165	10.4
Others	54	3.4
Total	**1580**	**100.0**

Source: Fieldwork, 2017

Table 4.3.1 revealed the level of healthcare facilities utilisation among pregnant women and nursing mothers in urban areas of Ekiti State. It is highly shocking that about four (39.2%) out of ten respondents, which is below average utilised Government hospital for treatment of diseases during pregnancy or after delivery. This percentage was obviously unexpected at the urban centres, where there are available hundreds of healthcare facilities to be patronized. Furthermore, 29.8% of the respondents patronized Traditional Birth Assistants (TBAs), this finding was also surprising that women living in the urban areas could still patronize TBAs. Though, many of these women utilise pluralized healthcare facilities. In the same vein, one out of ten (10.4%) of the respondents patronized Faith/Spiritual based clinics for the treatment of health challenges.

In supporting this finding, previous studies revealed that the persistence of high maternal morbidity and mortality is inextricably linked to socio-cultural practices that are peculiar

to most traditional African societies. Social and cultural norms, gender roles, social networks, religion and local beliefs influence peoples' choices (Bosveld, 1998). To a large extent, these community norms determine individual reproductive health practices including childbearing preferences, sexual and reproductive behaviour (Oladeji, 2008) and access to and use of health facilities. With regard to maternal health care, the influence exerted by communal culture, norms, values and practices particularly communities are enormous even in the face of life threatening situations that require urgent and timely interventions.

4.3.2 Mode of Decision Making on the Choice of Facilities Utilised for Treatment

The percentage frequency distribution of respondents showed that about 6 out of 10 (59.9%) of the respondents rely on the decision of their husband before making a choice of facilities to utilised; just few 131 (8.3%) of the respondents took decision on their own while 15.9% of the respondents took joint decision on the facilities to use. 252 (15.9%) of the respondents took to the decision of their Friends or family members. (See table 4.3.2)

Table 4.3.2: Frequency Distribution of Respondents by Mode of Decision Making on the Choice of Facilities Utilised for Treatment

Who Decide On The Facilities Utilised for Treatment	Frequency	Percentage %
Husband	946	59.9
Me	131	8.3
Joint decision	251	15.9
Friends or family members	252	15.9
Total	**1580**	**100.0**

Source: Fieldwork, 2017

In examining the mode of decision making on the health facilities utilised by women, result showed that about Six (59.9%) of the Ten of the respondents claimed that their husbands make decision on the facilities utilised when they fall sick. This result was never in doubt since Ekiti State is part of Yoruba land that culturally believes in patriarchal system. It also affirmed the weakness of gender equality crusade among Ekiti dwellers. Finding also indicated that only 131 (8.3%) out of 1580 respondents decided on

where to patronized for treatment of diseases. These women might be among the single parents, who are divorced, widowed, separated or never married. 15.9% of the respondents jointly take decisions with their husbands and those who rely on the decisions made by friends or family members were also 15.9% of the respondents.

4.3.3 Financing Health Treatment

The percentage frequency distribution of respondents with respect to who provides the finance for the treatment showed that 52.7%) of the respondents' health treatment was financed by their husbands; 205 (13.0%) of the respondents paid for their health treatment by themselves; while 34.4% of the respondents financed their health treatment by both husband and wife. (See table 4.3.3)

Table 4.3.3: Frequency Distribution of Respondents by the Financier of Their Health Treatment

Who Provides The Finance For The Treatment	Frequency	Percentage %
Husband	832	52.7
Me	205	13.0
Both	543	34.4
Total	**1580**	**100.0**

Source: Fieldwork, 2017

The data presentation in table 4.3.3 indicated that 52.7%, that is, the majority of the respondents (N = 832) claimed that their husbands were responsible for the financing of their treatment as they utilised the healthcare facilities for the treatment of their sickness. This depicted that majority of the respondents rely on the resources of their husbands to take care of themselves.

4.3.4 Reason for Utilising the Chosen Facilities

An examination of the percentage distribution of respondents by the reasons for Utilising the chosen facilities showed that 393 (24.9%) of the respondents chose the facilities based on its Close proximity; 869 (55.0%) of the respondents chose the facilities as a result of quality of healthcare service provided; while 17.0% of the respondents chose the facilities utilised due to its affordable cost. (See table 4.3.4)

Table 4.3.4: Frequency Distribution of Respondents by the Reason for Utilising the Chosen Facilities

Reason for Utilising the Chosen Facilities	Frequency	Percentage %
Close proximity	393	24.9
Quality of service	869	55.0
Affordable cost	269	17.0
Other	49	3.1
Total	**1580**	**100.0**

Source: Fieldwork, 2017

Table 4.3.4 showed the reasons for using the chosen health facilities, more than average (55%) of the respondents declared that they utilised the selected healthcare facilities based on the quality of service rendered. This result was corroborated by the FGD among nursing mothers in Ido-Ekiti;

> *There is nothing like Utilising government hospitals especially the teaching hospitals. There is availability of qualified healthcare providers that are ready to do everything for you to get well quickly. Though, teaching hospitals bills are killing but there is assurance of quality health service* ***(FGD/Female/Ido-Ekiti/, 2017.)***

Conversely, the FGD conducted among women that patronized others health facilities revealed that;

> *The TBAs' environment is conducive. They do deliveries at due time. I once went to health centre and experienced some problems after giving birth through caesarean. In fact, they are really trying for us in this community. They organize prayers for us.* ***(FGD/Female/Ikole-Ekiti/ 2017.)***

In the main, 24.9% of the respondents utilised the chosen healthcare service because of its closeness to their residences while 17% of them utilised the chosen healthcare service based on the affordability of cost required.

Theoretically, to support this finding with the Political Economy Approach, the healthcare system of any society is a reflection of its political cum economic philosophy;

healthcare policies, provision and programmes emanates from a society's overall ideological viewpoint and practices. To a large extent, healthcare policies has implications for access to health facilities and the quality of care available to members of the society including those providing emergency services and specialized care for pregnancy-related and childbirth complications. A healthcare ideology characterized by fee for service approach and hierarchy of specialized facilities and services with elitist and urban biases have a strong tendency to hinder access in economically restrained settings or highly urban communities.

Typically, in most urban communities, available health facilities are predominantly ill-equipped and services are usually poor, skilled birth attendants are mostly grossly inadequate, referral system is relatively terrible and healthcare funding is abominably inadequate. Moreover, to a large extent, the political would of the policy and decision makers of health determine the necessary conditions for the location and spatial distribution of healthcare facilities but a majority of settlements in urban settings unintentionally fail to satisfy the necessary conditions. Most of them are unable to meet the demographic requirement necessary for the location and proper spatial distribution of these facilities while other conditions such as transport cost and travel time in deeply marginalized communities are highly burdensome. In addition, the maximum distance between healthcare facilities or service outlets location and urban settlements is usually not at par with the desired point-location among urban populace. Hence, in these locales, proximity is generally and largely unfavourable to access and utilisation of available healthcare services such as obstetric facilities during maternal related emergencies.

4.3.5 Experience of any Complication by Utilising Healthcare Facility

The frequency distribution of respondents by ever experienced any complication Utilising healthcare facility; finding revealed that majority (62.0%) of the respondents affirmed that they had experienced complication by utilising the chosen healthcare facilities. 38.0% of them revealed that they had never experienced complication by utilising the chosen healthcare facilities. (See table 4.3.5)

Table 4.3.5: Frequency Distribution of Respondents by Whether They Had Experienced Any Complication Since They Have Been Utilising the Healthcare Facilities

Ever Experienced Any Complication	Frequency	Percentage %
Yes	980	62.0
No	600	38.0
Total	**1580**	**100.0**

Source: Fieldwork, (2017)

Table 4.3.5 above indicates that majority of the respondents have ever experienced one complication or the other by utilising chosen healthcare facility. This might be as a result of some latent or manifest factors for which this study was conducted.

4.3.6 Health Workers' Attitude in Managing Complications

The frequency distribution of respondents by health workers' attitude in managing complications; it was indicated that majority 601 (38.1%) of the respondents revealed that the health workers' attitude in managing complications is very good. 29.0% of them that the health workers' attitude in managing complications is bad; while 16.6% of them were of the opinion that the that the health workers' attitude in managing complications is fair. 16.1% of them were indifference (See table 4.3.6)

Table 4.3.6: Frequency Distribution of Respondents by Health Workers' Attitude in Managing Complications

Health Workers' Attitude in Managing Complications	Frequency	Percentage %
Bad	459	29.0
Fair	263	16.6
Good	602	38.1
No comment	255	16.1
Total	**1580**	**100.0**

Source: Fieldwork, (2017)

Finding revealed that majority (38.1%) of the pregnant women and nursing mothers sampled gave the health workers pass mark on the good attitude towards tackling any

complication arisen during delivery. On the same page, 16.6% of the respondents were of the view that the attitude of the health workers is fair. The good and fair recommendations are not enough to give explicit credit to the health workers since about 3 (29.0%) out of 10 of the respondents were of the opinion that the bad attitude of some if not all health workers is not helping women in managing complications.

Many corroborating opinion were noted during the FGDs with the different groups of pregnant women and nursing mothers in the management of complications by the health workers

The above finding was supported by one of the nursing mothers in 30-49 years old group that:

> *It is very common among the health workers in the Primary Health Centres to delay women in their centres anytime they perceived any difficulty in the delivery. Instead of quickly referring the complicated delivery to general or teaching hospitals, they would still want to try their luck at the expense of the lives of the women and their babies. Such an attitude is bad.*
>
> ***(FGD/ Nursing Mother/39/Ikole/ 2017)***

Another FGD with another group the participants indicated that;

> *Managing complication is the major challenge facing the health workers. Many at times, they don't know what to do when the delivery situation changes. This is very challenging especially for those Utilising TBAs or Faith Based Clinic. I remember when one of my co-tenants died at the mission house of their church during delivery. When there was over bleeding, the birth attendants did not know what to do so the woman died in a pool of blood without holding or feeding her twin babies. She registered at the mission house because her husband had no money to pay a doctor or a clinic. If he had money, he would have taken her to the teaching hospital*
>
> ***(FGD/ Pregnant Woman/31/Ikere/ 2017)***

A group of pregnant women also addressed the fact that, often times, complications occur because the health workers are not well equipped and they do not have a suitable environment for delivery. The anecdotes included below highlight this fact:

> *No! The health workers' attitude is fair. The major issue is that the environment at some of the hospitals is not suitable and people are complaining. Many of these hospitals are having outdated equipment, which may not with stand the test of complication challenges. Many women, who were supposed to be thoroughly monitored after delivery would be asked to go home few minutes after delivery because there are no enough beds or accommodation to keep them.* ***(FGD/ Pregnant Women /28/Emure-Ekiti/ 2017)***

Another group, whose view tends to negate the view above, stipulated that;

> *There is a conducive environment to manage any complication arisen but the attitudes of the health workers are not good at all. They don't want to stress themselves during delivery. They always complain and blame the pregnant woman, who is undergoing serious pain as if being pregnant is a great sin. I once went to one of the teaching hospitals but experienced some problems after giving birth through caesarean. I was in a coma for a week and was sick for six months. But I have decided to be Utilising both hospital and TBA centre because I don't want any problem. In fact the TBAs are really trying for us in this community. They organize prayers for us.* ***(FGD/ Pregnant Woman /36/Ido/ 2017)***

In another view, a health worker was of the point that complications sometimes occur. She reiterated that;

> *When we realized that the situation of a pregnant woman is getting to a point that we cannot handle, we quickly call upon other experienced Nurses if Doctors are not available in the vicinity to render assistance. If there is no improvement, the ambulance would help us carry the woman to general hospital. (****IDI/Health Worker/Ikere/2017****).*

To support the above findings since women consider patronizing both orthodox and alternative healthcare services, (Owoseni & Owumi, 2012) emphasizes the need to educate TBA's on improved hygiene, explained that midwives who have been trained in child delivery in hospitals abound within the communities. "If you must patronize a traditional birth attendant, you must make it a point of duty to visit a trained midwife or go to a hospital for pre and postnatal care to avert any occurrence of complication. Again, the TBAs need to be educated on the importance of hygiene. This is very important. Hygiene is important because infections are major the cause of most deaths in expectant mothers. And they must be referred at the early stage when they develop complication. Where TBAs continue to assist at deliveries they must be trained to identify and make early referral of complicated obstetrics problems.

4.3.7 Quality of Services Rendered by the Healthcare Facilities Utilised

On the examination of the quality of services rendered by the health clinic, result revealed that 38.7% of the respondents indicated that the services rendered by the health clinics are poor. 36.8% of the respondents claimed that the services rendered at the health clinics are of good quality (See table 4.3.7).

Table 4.3.7: Frequency Distribution of Respondents by the Quality of Services Rendered by the Healthcare Facilities Utilised

The Quality Of Services Rendered By The Health Clinic	Frequency	Percentage %
Poor	611	38.7
Fair	300	19.0
Good	582	36.8
No comment	29	1.8
Total	**1580**	100.0

Source: Fieldwork, (2017)

Table 4.3.7 indicated the level of the quality of services rendered by the health clinic, result revealed that almost 4 out of 10 of the respondents indicated that the services

rendered by the health clinics are poor. This finding might be inextricably linked with poor equipment of the hospitals. The instruments at their disposal would definitely determine the quality of their services. 36.8% of the respondents claimed that the services rendered at the health clinics are of good quality.

To theoretically corroborate the above result, resources at the community level include the quality of health facilities and health personnel available for use to an individual determine the level of healthcare facilities utilization. A greater number of health facilities and personnel reduce the unpleasantness of queuing-up for limited services and might be used more frequently by individuals. Community level resources also include the nature of the area where an individual resides, i.e. state of the country or whether residence is in the urban/urban area. This is because the quality of healthcare service provided influences an individual's behaviour towards the utilisation of such services (Anderson and Newman, 2005).

4.3.8 Factors Influencing Utilisation of Healthcare Facilities

Examining the reasons for the preference for visiting the health facility utilised, majority (35.4%) of the women sampled preferred the healthcare facilities patronized because of the affordable services. 294/1580 of them indicated spiritual reason as a major factor for Utilising their choice healthcare facilities. A reasonable percentage (32.9%) of these women utilised the preferred health facility because it saves time. Few (8.3%) of them patronize the health facilities as a result of cultural reasons (See table 4.3.8).

Table 4.3.8: Frequency Distribution of Respondents by Factors Influencing Utilisation of Healthcare Facilities

Factors Influencing the Preference for the Health Facility	Frequency	Percentage %
Services are affordable	559	35.4
Spiritual reasons	294	18.6
Saves time	520	32.9
Cultural reasons	131	8.3
Other	76	4.8
Total	**1580**	**100.0**

Source: Fieldwork, (2017)

The table 4.3.8 above indicated that some of the respondents utilised their choice of healthcare facilities as a result of their affordable services. 294/1580 of them indicated spiritual reason as a major factor influencing the healthcare facilities utilised.

The finding above is corroborated by the in-depth interview conducted with pregnant women in the selected communities. Faith based clinic or Spiritual homes are generally spiritual institutions that care about pregnant women and nursing mothers in their churches and the communities at large. They also take care of those women that are not able to pay for delivery and are therefore also seen as benevolent institutions in the community. Below is a claim about attending to spiritual issues that may occur;

> *The Faith based clinics or Spiritual homes are capable of fathoming and/or addressing the spiritual issues that women may have. There are some problems/complications that can only be addressed by the Faith based clinics or Spiritual homes especially those involving witchcraft. For instance, I was introduced to a church seven months ago by one of my relatives because I got married for over 14 years with no child. I was later made to understand the cause; it was my mother-in-law that was behind the scene in which no hospital can understand. Though, my mother-in-law is no more alive but as you can see now, I am pregnant* ***(IDI/Pregnant women/Ido Ekiti/2017)***

4.3.9 Socio-economic and Cultural Factors Considered Before Utilising Healthcare Facilities

Finding indicated that more than half (58.5%) of the respondents claimed that they usually consider the facilities based on their religious belief; 13.2% of the women sampled consider cost required before taking concrete decision on Utilising a particular facilities. Those who utilise the chosen facilities as a result of proximity to the available facilities were 8.9% while 9.7% of them consider the efficacy of the services provided at the healthcare centre before concluding on whether to utilise the facility of not. 6.9% of the respondents asserted that their customs influence the preference of their health facility utilisation (See table 4.3.9).

Table 4.3.9: Frequency Distribution of Respondents Socio-economic and Cultural Factors Considered Before Utilising Healthcare Facilities

Factors Considered Before Utilising The Preferred Health Facility	Frequency	Percentage %
The cost	208	13.2
Religious Belief	924	58.5
Efficacy	140	8.9
Proximity	154	9.7
Custom	109	6.9
Experience	45	2.8
Total	**1580**	**100.0**

Source: Fieldwork, (2017)

On the factors considered before utilising the preferred health facility, table 4.26 showcased that about 6 of 10 of the respondents claimed that they usually consider the facilities based on their religious belief. Furthermore, 13.2% of the women sampled consider cost required before taking concrete decision on Utilising a particular facilities. Those who utilise the chosen facilities as a result of proximity to the available facilities were 8.9% while 6.9% of the respondents asserted that their customs influence the preference of their health facility utilisation

In corroboration to the findings above, studies revealed that the use of modern health services is often influenced by individual perceptions of the efficacy of modern health services and the religious beliefs of the individual woman (Adetunji, 1991). According to

Baley (1997) and Mekonnon (2002) there is a significant variation in the utilisation of healthcare by religion. Furthermore, Addai, (1998) and Mekonnon (1998) in their study in Ethiopia revealed that religion has emerged as an important predictor of maternal care utilisation in urban Ethiopia.

In Borno state it is common among the Muslim ethnic groups for religious rituals to be performed in order to assist a woman in labour. Mallams and their grown up students *(Almarjirais*) would come and read the Holy Quran to the woman for protection against all evils relating to pregnancy and childbirth. And after that, a drink of Quranic verses particularly *Aya-tul Kursiyu* are written on plate and washed and given to her to drink for safe delivery (Waziri 2004, El-Nafaty, 1998). Adamu (2001) also revealed similar rituals among the Hausa people of Kano state in Northern Nigeria. Consequently, women tend to remain in the house instead of going to the health facilities for delivery because of the psychological satisfaction and assurance of nothing wrong would happened derived from the rituals.

4.3.10 Respondents Distribution on Traditional Practice(s) During Pregnancy

An investigation on the traditional practices by pregnant women during pregnancy, 50% of the respondents were of the view that they are always prevented from eating some types of food or prohibited from taking some drinks. 29.5% of the respondents revealed that there are some other traditional belief practices. 10.4% and 10.1% claimed that they are always prevented from engaging in some activities and prohibited from taking some medicines respectively (See table 4.3.10).

Table 4.3.10: Frequency Distribution of Respondents by Traditional Practice(s) During Pregnancy

Factors Considered Before Utilising The Preferred Health Facility	Frequency	Percentage %
Food/Drinks prohibition	790	50.0
Activities Prohibition	160	10.1
Medicines Prohibition	164	10.4
Other beliefs	466	29.5
Total	**1580**	**100.0**

Source: Fieldwork, (2017)

Table 4.3.10 showcases that exactly half (50%) of the respondents were of the view that they are always prevented from eating some types of food or prohibited from taking some drinks. 29.5% of the respondents revealed that there are some other traditional beliefs that curtail them from doing things in pregnancy such as walking alone in the hot sun, going to river side around 12 noon and/or using some sticks for firewood..

To corroborate the above findings, IDI revealed that;

> *I am married to a royal family member and no pregnant woman is allowed to eat any type of soups aside from white okra soup. From the day one to delivery of the pregnancy, the pregnant woman must not eat soup with pepper and palm oil. I did not know that such a tradition still existed even in this modern era until I found myself in it* ***(IDI/Pregnant women/Ikole Ekiti/2017)***

In support, it has been revealed that culture influences health behaviour in so many dimensions. For instance, culture influences the way in which illness is acted upon in Nigeria (Erinosho, 2005). Cultural factors include gender norms, child marriage and early pregnancy, nutritional taboos particularly during pregnancy, certain birthing practices, female genital mutilation, and widow inheritance.

4.3.11 Consequence(s) of Violating the Traditional Practice(s) Prohibitions during Pregnancy

Investigating the consequences of going against the traditional practice(s) prohibition by pregnant women, 30.9% of the respondents reported that violation of the family tradition usually leads to serious complication during delivery; while 29.2% of them declared that diseases are the consequences of violating traditional prohibition. 16.9% of them claimed that violating the family traditional prohibitions result in delay in delivery. 11.1% of the respondents revealed that death is the antidote of going against the laid down paradigm (See table 4.3.11).

Table 4.3.11: Frequency Distribution of Respondents by Violation of Prohibitions and the Consequence(s)

Consequence(S) Of Violating Such Prohibitions	Frequency	Percentage %
Complication during delivery	488	30.9
Disease	461	29.2
Delay in Delivery	267	16.9
Death	176	11.1
Others	188	11.9
Total	**1580**	**100.0**

Source: Fieldwork, (2017)

Investigating the consequences of going against the prohibition, about 4 out of 10 the respondents reported that violation of the family tradition usually leads to serious complication during delivery. This apprehension can make women to be culturally abiding to the family taboos. These women believe to suffer now and enjoy later than to enjoy what they are prohibited from and suffer later. Almost 30% of the sampled women submitted that disease is the aftermath of violating the institutionalized norms for pregnant women. The most terrible consequence aspect of violating prohibition among the pregnant women is death. 176 / 1580 of the respondents revealed that death is the antidote of going against the laid down paradigm. This would really make the concerned to be norm abiding because no one wants to die.

In corroboration of the above, the FGDs among nursing mothers between 30-49 years age range revealed that;

> *In my husband family, pregnant women must not eat Water Yam (Ewura) and if she secretly eats it, she would die of stomach-ache. It is better you don't eat the forbidden food because the consequence is death without remedy. Immediately you are married to the family, you would be told everything you needed to do if your husband failed to tell you before wedding. No matter how religious you are, you must obey the instruction. Also, if you are living abroad, since you are married to one of the family members, you must adhere to the laid down rules in pregnancy* ***(FGD/Nursing Mother/Ado-Ekiti/2017)***

When interviewed further on the reason why she avoided some of food items, a 38 year old woman in the second trimester of her third pregnancy was of the view that;

> *I cannot eat snail in pregnancy because it would make my baby to be sluggish in life and spit too much saliva.* ***(IDI/Pregnant woman/Ido-Ekiti/2017)***

A 30 year old woman in the last trimester of her second pregnancy stated that;

> *In our family, a pregnant woman must not eat bush meat like Grasscutter because it would cause her labour to be difficult and prolonged during delivery.*

During the Focus Group Discussion, another 40 older woman who has had five babies narrated thus;

> *I avoid starchy food like 'garri' (cassava flakes) and nodules in pregnancy because they would make my baby to have excess weight which would be difficult to deliver except by operation.*

There has not been any established link between snail consumption and sluggishness and grasscutter consumption with prolonged labour. On the contrary, snail has been shown to be a rich source of protein, trace elements and minerals which are needed for proper growth and development in human beings (Ijadunola, Ijadunola, Esimai, & Abiona, 2010). In the same vein, the grasscutter is also a known source of rich animal protein (Jori, Mensah and Adjanohoun, 1995). These foods are cheap and can serve as commonly available sources vital nutrients for a balanced diet in developing countries. Their consumption could therefore reduce maternal malnutrition if utilised fully. On the whole, if cultural beliefs impede pregnant women to eat all these nutritional assisting foods, maternal mortality might still be on the increase.

4:3.12: Stereotypes Associated with Healthcare Facilities Utilisation in Urban Ekiti

In this modern era, particularly in the urban communities, stereotypes are the unfavourable or hostile attitude toward other people based on their membership in the social setting. However, stereotypical attitudes often have proved extremely difficult to eradicate, even when integration is enforced by law. As the African countries are recognized by the nature of patriarchal system, it is pertinent to examine the stereotypes attached to family life especially in the area of healthcare services utilization.

There were stereotypes identified among women. These stereotypes include their perception about sharing the same room with their husbands during pregnancy, husband's role in helping them during pregnancy, their perception about pregnancy agreement with their husbands and perception on the role played by their relatives.

As part of the socio-cultural factors influencing utilisation of health care facilities, this section seeks to analyze the stereotypes associated with maternal health service utilisation by pregnant women in urban areas of Ekiti State.

4.3.12 Husbands' Attitude towards Their Wives during Pregnancy

In an examination of the stereotypes associated with maternal health service utilisation in urban areas of Ekiti State, 89.3 % of the respondents claimed that their husbands usually got irritated with them during pregnancy (See table 4.3.12).

Table 4.3.12: Frequency Distribution of Respondents by Husbands' Attitude towards Their Wives during Pregnancy

Husband Get Irritated With Their Wives During Pregnancy	Frequency	Percentage %
Yes	1411	89.3
No	169	10.7
Total	**1580**	**100.0**

Source: Fieldwork, (2017)

The table 4.3.12 indicated that stereotypical attitude towards women is not explicitly strong in Ekiti State. The remaining percentage that was of the contrary view might be the single mothers that were never married, separated, divorced or widowed.

Furthermore, majority (89.3%) of the respondents claimed that their husbands usually got irritated with them during pregnancy. This might be as a result of symptom displayed at this period.

In supporting the above finding, reports from FGDs indicated that;

> *My husband is the type that gets irritated at little issues. He does not like me spiting around, which has been my usual pregnancy symptom. I use to spite throughout my first trimester (first three months of pregnancy). This makes my husband gets mad with me. Most of the time, my husband doesn't eat at home.* ***(FGD/Pregnant Woman/Ikole-Ekiti/2017).***

In the main, pregnant women have different types of pregnancy symptoms or illness. What happens to one might be different from the others. During the FGDs, pregnant women poured out their minds on how their husbands feel or treat them during pregnancy. These women were of the view that;

> *My husband has been very difficult. Any time I feel ill, he says I am lazy and not sick. He compares me to his brother's wife all the time. Today he got angry with me for telling him that one of my legs was paining me. He almost pushed me to the floor and then slammed the door on me. What should I do? He doesn't come with me to the hospital anytime I am sick. I have to come alone* ***(FGD/Pregnant Woman/Ikole-Ekiti/2017).***

Another woman iterated that;

> *My husband is the best. He always assists me to do some domestic chores especially cooking and washing of my cloths. He does not want me to stress myself but he seems to act so distant when I am sick from pregnancy* ***(FGD/Pregnant Woman/Ido-Ekiti/2017).***

During the Focus Group Discussion, another 27 years old woman declared that;

> *My husband is getting very frustrated that I am not helping out as much around the house. Yes, I see the dirty dishes, but do no have*

> *the energy to do them. I am so frustrated with myself. I hate that I feel sick all the time because all that I want to do is lay down on bed. This definitely does not help when you have a husband who is pissed that you are not cleaning the house. It is like he thinks I am faking it. He thinks I am just being lazy. I wish he could understand how I feel* ***(FGD/Pregnant Woman/Ikere-Ekiti/2017).***

In affirming the above, Studies show that men's roles in safeguarding maternal health have gained increased interest in recent years (Addai, 2005). Men can affect pregnancy and childbirth through responding to relating with them in any condition, complications, seeking medical help, paying for transport, assisting in domestic chores and allocating household resources (Mullany, 2006).

In Sub-Sahara countries, study has established that men possess little knowledge and experience regarding maternal health. A lack of knowledge regarding complications and danger signs during pregnancy and delivery has been frustrating for husbands and has prevented their involvement (Mullany, Becker and Hindin, 2007). This lack of knowledge undoubtedly affects maternal health outcomes. For example, Brunson's (2010) study shows that despite the fact they may not be knowledgeable about birth, in emergencies men control the situation through their decision making.

Although traditionally, a women's attitude, studies have shown increasing desire of women for their husbands' involvement, including during labour (Mullany, Becker and Hindin, 2007). Mumtaz and Salway (2009) suggest that there is a need to move away from seeing men as "oppressors" and instead recognise them as partners in this realm.

The majority (86.1%) of pregnant women and nursing mothers across the study areas reached an agreement with their husbands before getting pregnant. Since pregnancy is an agreement between the partners, husbands should see pregnancy as a thing of joy sine both planned for it. Against this background, men must endure ever necessary and unwarranted symptom from their pregnant wives conditions. Only few (13.9%) of them

never discuss having children together but since they leave together with men, pregnancy emanated. This category of women might include the cohabitant (See Table 4.3.13).

Table 4.3.13: Distribution of Respondents by Their Relatives' Role towards Them during Pregnancy

Any Support From Mother In-Law/Relative During Pregnancy	Frequency	Percentage %
Yes	1438	91.0
No	142	9.0
Total	**1580**	**100.0**
Anyone to Turn to if in Need of Comfort or to Share Your Experience		
Yes	1398	88.5
No	182	11.5
Total	**1580**	**100.0**

Source: Fieldwork, (2017)

Findings on the investigation on the roles played by the pregnant women' relatives towards them during pregnancy, Nine (91%) of Ten of the respondents asserted that they get full support from their mother-in-laws and other relative members while only 142/1580 (9%) could not get any assistance from any of their relatives. On whether they have someone to turn to if in need of comfort or to share their experience during the pregnancy period, 88.5% of the women have people to turn to in order to share their pregnancy condition with while 11.5% of them have no one to share their experience with.

4.3.14: Effect of Women's Working Conditions on Their Utilisation of Maternal Health Services.

In the main, as a result of the current economic recession facing Nigeria and high level of economic pressures on the households, including a rise in male unemployment, have led more women especially pregnant women and nursing mothers to engage in extra work.. Many households find that two incomes are required in order to sustain a desired lifestyle (Giddens, 2002). In a bid to seek more paid jobs, pregnant women and nursing mothers may find little or no time to utilise maternal health services, which may precipitate complications or death.

Table 4.3.14: Frequency Distribution of Respondents Based on Their Working Conditions.

Nature of work	**Frequency**	**Percentage %**
Full-Time	1398	88.5
Part-Time	182	11.5
Total	**1580**	**100.0**
Relationship With The Co-Workers	**Frequenc**	**Percentage**
Good	328	20.8
Fair	1252	79.2
Total	**1580**	**100.0**
Distance of Your Place Of Work From Your Residence		
Very Far	164	10.4
Far	436	27.6
Not Far	437	27.7
Not Applicable	543	34.4
Total	**1580**	**100.0**
Actual Time It Takes To Get To The Place Of Work		
Less 10 minutes	220	13.9
10-20 minutes	490	31.0
21 -30 minutes More than 30 minutes	162	10.3
More than 30 minutes	165	10.4
Not Applicable	543	34.4
Total	**1580**	**100.0**
Means Of Transportation To The Place Of Work		
Official/private car	109	6.9
Public transport	384	24.3
Okada/Tricycle	326	20.6
Trekking	218	13.8
Other	109	6.9
Not Applicable	434	27.5
Total	**1580**	**100.0**

Source: Fieldwork, (2017)

On an examination on the nature of work, almost Nine (88.5%) out of Ten of the respondents declared that they work on full-time basis. Finding from data on the level of the relationship that existed between the co-workers and the pregnant women questioned showcased that 20.8% of them enjoy good relationship with their co-workers while the majority 79.2% viewed the relationship existing with their co-workers to be fair. This cordiality can assist pregnant women to get help from their co-workers if the necessity arises. Furthermore, to understand the distance of their place of work from their residence,

the highest percentage of the respondents said that the distance covered is not far while 10.4% of them claimed that their place of work is very far from where they live.

This finding corroborates previous studies on the effect of women's working conditions on their utilisation of maternal. Countless women lack access to decent work that would enable them to rise above poverty and work in safe conditions. Many women workers have traditionally been concentrated in poorly paid, routine occupations.

Many of these occupations fall outside traditional legal and social protection systems that safeguard against vulnerability and provide access to healthcare (ILO, 2010). However, in sub- Saharan Africa and South Asia, where the highest rates of maternal mortality are reported, more than 80 percent of women workers are considered to be working in precarious and vulnerable conditions, mainly; either in the informal economy, lacking maternity protection at work, or certain industries, like, medium size baby food, beverage and wine production companies that are always predominantly staffed with women. Not only are these women low paid, conditions in these factories are terrible. Women in these factories are mostly part time workers. The nature of these part time jobs is such that women work longer hours for less pay. The need to bring in or supplement family income forces women to submit to these conditions. This is nothing but double exploitation (Cheeqitita, 1999; ILO, 2010).

On the actual time it takes to get to the place of work, 13.9% said it takes them less than 10 minutes to get to their place of work while 10.4% claimed that it actually takes them more than 30 minutes to get to their place of work everyday. This can make them to be so weak to the extent of skipping their antenatal visitation or health service utilization. Majority (34.4%) of the respondents that were not concerned was actually those that are not gainfully employed or women that are full housewives.

Furthermore, the means of transportation of many of the respondents were public transport such as taxi (24.3%) or motorcycles popularly known as *Okada* or tricycles (20.6%). 13.6% of them trek to work.

In corroboration of the findings, from the Focus Group Discussions conducted among the pregnant women, one of them indicated that;

> *Anytime I ask my husband money for transport fare to my place of work or even to the clinic, he would complain that he doesn't have money, but at the same time, you would see him spending money on other things. I either have to borrow or use my own saving if I have it. Or else ask my immediate family members, my brother, to help me. If nothing is forthcoming, I need to trek for more than 3o minutes before getting there* ***(FGD/Pregnant Woman/Ado-Ekiti/2017).***

Another woman stated:

> *Whenever I want to go to my work place or to the antenatal care, if I ask my husband for money for transport, his complaint is that he has no money, and if I insisted, it resulted in problems. He gets annoyed easily and would start to insult me* ***(FGD/Pregnant Woman/Ado-Ekiti/2017).***

Several participants said that asking for money might even bring about incidents of domestic violence, which they normal avoid because of their conditions.

These statements show that as female members of the household, pregnant women do not enjoy privileges such as taking sick leave from ordinary work or receiving assistance in having antenatal check-ups. Part of the problem is their lack of economic independence, but other reasons may contribute to their unfavourable position within their work place or household.

Indeed, poor working condition; such as low wage, 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 (ILO, 2010). It is more elucidated with following quotation:

> *Working during pregnancy is no a risk. But women around the world continue to face considerable maternity related threats to their health and economic security. Work place environments can pose hazards (e.g. exposure to pesticides, solvents and other chemicals); requirement of physically demanding work, and irregular or long working hours; all can have potentially negative effects for the health of pregnant women and their fetuses, including greater risk of preeclamsia and hypertension, complications during pregnancy, miscarriage and stillbirth, foetal growth retardation, premature birth and other problems. Tasks requiring being in one position for long period of time, can adversely affect reproductive health (ILO, 2010. www.2.ohchr.org/englis/issues/women/docs).*

As stated by Oxaal and Baden (1996), the last three months of pregnancy should be a time when the mother rests and gains weight. However, many women in developing countries continue with their full workload right up until the time of labour, and resume work shortly after giving birth. This can have an extremely detrimental effect on health.

4.3.15 The Stage of Pregnancy to Apply for Maternity Leave

Finding indicates that 34.3% of respondents apply for maternity leave a week or 2 weeks before delivery. About 31% of them apply for maternity leave after delivery. 27.7% of the respondents apply for their maternity leave when it is a month to the delivery date. The others (7.3%) are those that do not need to apply for any leave. (See table 4.3.15)

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Table 4.3.15: Frequency Distribution of Respondents by the Stage of Pregnancy they can Apply for Maternity Leave fro Their Place of Work

Stage for Maternity Leave Application	Frequency	Percentage %
1-2 weeks to delivery	444	28.1
A month to delivery	641	40.6
After Delivered and sent application letter	416	26.3
Other	79	5.0
Total	**1580**	**100.0**

Source: Fieldwork, (2017)

Table 4.3.15 above showcases the period at which pregnant women can apply for maternity leave before or after delivery. Finding indicates that majority of respondents apply for maternity leave a week or 2 weeks before delivery. At this period, they might have been feeling some un-comfortableness within their system. About 31% of them apply for maternity leave after delivery. This might be influenced by the nature of their jobs. On the whole, 27.7% of the respondents apply for their maternity leave when it is a month to the delivery date. The others (7.3%) are those that do not need to apply for any leave. That is, the unemployed or full-house wives.

In order to gain deeper knowledge of the above, some of the interviews conducted indicate that;

> *I am 39 weeks and still working, and plan to be working until I deliver. I don't really want to but as a single mother and I don't really have a choice. If I don't work, how would I feed my other 2 children and myself? It is really getting hard but I only need to go. It is really a personal decision when you want stop working.*

Another 42 years old pregnant woman also asserted that;

> *I am pregnant with my fourth child and my husband is not really assisting us. I used to work until I delivered. With this one, I am only 19 weeks and have been experiencing complications with this pregnancy. In fact, it is actually very hard to be on my feet for a long period of time. I go through a lot of stress at work and have to be on my feet for most of the day. I don't think I would be able to work for much longer at all.*

A 35 years old pregnant woman also expressed that;

> *I am a teacher and had originally planned to work up until week 36 so that I could have longer time after the birth before I have to go back to work (after 3 months maternity leave). However, I got to week 20 and decided that I was not going to be able to cope working up to week 36 on my feet al day.*

An indication from the interviews and quantitative data results showcase that individual woman has their different opinion about when to stop going to work when it is close to the delivery date. It all depends on their coping strategies.

Table 4.3.16: Distribution of Respondents' Opinion on Effectiveness of the State Government's Role in the Distribution of Healthcare facilities in Urban Ekiti.

Ekiti State Government Has Influenced The Quality Of Maternal Health Service In The State	**Frequency**	**Percentage %**
Yes	1353	85.6
No	227	14.4
Total	**1580**	**100.0**
Effectiveness of Health Care Service Provided		
Very effective	326	20.6
Less effective	423	26.8
Not effective	768	48.6
Don't know	63	4.0
Total	**1580**	**100.0**
Health Workers Are Accessible to Pregnant Women		
Yes	1401	88.7
No	179	11.3
Total	**1580**	**100.0**

Source: Fieldwork, (2017)

Data collected showed that higher percentage (85.6%) of the respondents agreed that Ekiti State government has influenced the quality of maternal health service in the state. On the effectiveness of health care service provided at the health facilities across the state, about five out 10 of the respondents indicated that the services provided in the health facilities are not effective. This ineffectiveness might precipitate the utilisation of TBAs with health centres. 20.6% of the women sampled were of the view that the services provided

in the health facilities are very effective. These are the category of people that have money to utilise the facilities.

Investigation on the accessibility of health workers to pregnant women and nursing mothers, 88.7% of the respondents agreed that pregnant women have access to the health workers. This is very encouraging.

Table 4.3.17: Distribution of Respondents' Opinion on Short Falls of Ekiti State Government's Contributions to Healthcare facilities

Areas of The Short Falls of Ekiti State Government's Contributions To Healthcare facilities	**Frequency**	**Percentage %**
Supply more drugs	189	12.0
Employment of qualified personnel	339	21.5
Provide adequate equipment	568	35.9
Electricity Supply	304	19.2
Water Supply	84	5.3
Construct good roads	62	3.9
Others	34	2.2
Total	**1580**	**100.0**
What To Be Done To Improve The Health Quality In Ekiti State		
Employment of qualified health Personnel	324	20.5
Adequate supply of free drugs	425	26.9
Free Health Care Service	745	47.2
Provision of infrastructural facilities	86	5.5
Total	**1580**	**100.0**

Source: Fieldwork, (2017)

The analyzed data on the areas of the short falls of Ekiti State government's contributions to healthcare facilities revealed that majority (35.9%) of the respondents asserted that provision of adequate equipment in the health facilities across the state is the major shot falls of the state government. This if not attend to, would definitely have negative impact on the health of the women in the state, which may culminate in high rate of maternal mortality. 339/1580 (21.5%) of the respondents reported that employment of qualified health personnel is at a very devastating level in the state. This is a very vehement challenge in the health sector of Nigeria at large. There is high level of brain drain.

Power supply is an endemic problem in Nigeria. This has been a major cloak in the chain of economic growth in Nigeria.

Generally, the facility buildings were described as insufficient, with a few bed spaces and there were no security personnel to man the gates. In one of the Specialist Hospitals, the discussants complained about the walls which they said needed to be plastered and painted.

A young mother of two had this to say:

> *Accommodation for women who delivered is poor in this facility. When I delivered my first baby, I was not supposed to be discharged but because we were four, and since there were only three beds, the matron pleaded with me to go home, which is not fair enough for a whole Specialist Hospitals in this LGA.*

According to a 25-year-old nursery school teacher;

> *You know the time for labour is not planned, if a woman comes in labour at night, there would be no security man to open the gate for her.*

Most of the discussants said that personnel, equipment and supplies were fairly adequate. They mentioned equipment such as weighing scales, thermometers and added that the services of at least three doctors and 2 laboratory technologists are needed per health facility sections.

A 34-year-old pregnant woman and mother of two said:

> *Imagine that we pay for laboratory tests but these tests are done outside this health centre. Even if it is an emergency, you still have to wait until the results are brought back and only God knows for how long. At times it takes several days.*

The healthcare providers were of the opinion that the facilities were in fair condition. They said;

> *The walls have cracks, were in need of renovation and that the facilities need boreholes or an extension of the public pipe-borne water supply since they buy water from vendors.*

A Matron in one of the selected facilities mentioned that;

> *There is no residential accommodation for workers, and that toilet facility was inadequate and as such they share toilets with the clients, which is very bad.*

The interviewed health officers complained about the insufficiency of personnel and equipment. Such equipment as weighing scales, sphygmomanometer were mentioned.

One head of facility said:

> *For the past 5 years that I have been heading this facility, they have never changed our sphygmomanometers and stethoscopes. We are just patching, using them as they are. Sometimes, they do not give us accurate results.*

One of the health officers described the level of quality as fair, within the conditions they are made to operate.

> *Irrespective of our limitations, our patients still come in good number, this shows they appreciate what is available and how we attend to them.*

Another health officer however, said that there are areas of service delivery that needed to be improved on. She mentioned such areas as lack of pharmacy technicians, record personnel, power supply, and lack of at least three ambulances for a referral for the facilities in the LGA.

Suggestions offered on ways for improving the quality of maternal health services in the health facilities include: education of women on their health, eradication of some cultural beliefs impeding adequate health services, employment of more health personnel-doctors, midwives, nurses, record clerks, laboratory personnel and pharmacy technicians, procurement of basic equipment and supplies; procurement of a vehicle for use for referral by the health facilities in the LGAs; involvement of the community in the running of the health facilities.

4.4 Implications of Socio-cultural Factor on Maternal Mortality

The last objective of this study is to examine the implications of socio-cultural factor on maternal mortality in urban Ekiti. In the main, the objective explored on whether the utilisation of healthcare facilities as a result of socio-cultural factor, has influence maternal mortality in the study area

The study revealed that about 8 of 10 (78.7%) of the respondents affirmed that women died in pregnancy, during childbirth or shortly after delivery while 21.3% of the respondents were of the view that women had never died in pregnancy during childbirth or shortly after delivery in their communities. (See table 4.4.1)

Table 4.4.1: Frequency Distribution of Respondents by Whether Any Woman Has Ever Died In Pregnancy, During Childbirth or Shortly After Birth

Variable	Frequency	Percentage %
Yes	1243	78.7
No	337	21.3
Total	**1580**	**100.0**

Source: Fieldwork, 2017

In table 4.11, it is illustrated that about respondents affirmed that women died in pregnancy, during childbirth or shortly after delivery while few of the respondents were of the view that women had never died in pregnancy, during childbirth or shortly after

delivery. This finding might be connected with the years of experience of the sampled respondents for the study.

This was supported by the interview of a 49 years old mother, who utilised the health facility of Federal Teaching Hospital;

> *I gave birth to all my children at general hospitals. I have been using it for over 22 years. Though, I initially preferred going to TBAs to government hospitals for antenatal care and delivery because of spiritual reasons. But since when I had witnessed the death of many pregnant women from complications, I have stopped going to the TBAs.* (IDI/Female/Ado-Ekiti)

To corroborate the above findings, previous studies indicated that many women die of pregnancy and delivery related complications. According to the World Health Organization (2007), every minute of every day, somewhere in the world, a woman dies as a result of complications arising during pregnancy and childbirth. Out of one hundred and thirty million (130 million) babies born each year, approximately four million (4 million) die in the first four weeks of life (WHO, 2007). Women are dying much more frequently in the developing world, approximately half a million women die each year from complications of pregnancy or childbirth and yet the vast majority of these deaths are preventable.

The level of maternal mortality is disproportionately high in Africa, with a stateal maternal mortality ratio of 1000 per 100000 live births (World Health Organization, 2015). Most maternal deaths occur during childbirth, and the presence of trained medical staff could substantially reduce the number (Campbell et al, 2015). Scientific evidence has clearly established the inverse relationship between skilled attendants at birth and the occurrence of maternal deaths. Thus, the considerable variation in the maternal mortality estimates between different locations within the same state can be attributed, to a large degree, to the differences in the availability of and access to modern maternal health services (FMOH 2005). The use of maternal health services also contributes to neonatal

health outcomes as the health of the mother and the newborn is closely linked. Maternal complications in labor, for example, carry a high risk of neonatal death (Khalid et al, 2016; Lawn Cousens, Zupan and Lancet, 2016). Three-quarters of neonatal deaths occur in the first week, and the highest risk of death is on the first day of life.

Approximately 536,000 maternal deaths occur annually, of which over 95% occur in sub-Saharan Africa and Asia (WHO, 2015). Africa has the highest burden of maternal mortality in the world and sub-Saharan Africa is largely responsible for the dismal maternal death figure for that state, contributing approximately 98% of the maternal deaths for the state (WHO 2015). The lifetime risk of maternal death in sub-Saharan Africa is 1 in 22 mothers compared to 1 in 210 in Northern Africa, 1 in 62 for Oceania, 1 in 120 for Asia, and 1 in 290 for Latin America and the Caribbean (WHO, 2015). Nigeria is a leading contributor to the maternal death figure in sub-Saharan Africa not only because of the hugeness of her population but also because of her high maternal mortality ratio. Nigeria's maternal mortality ratio of 1,100 is higher than the stateal average (Ibrahim, 2015). With an estimated 59,000 maternal deaths, Nigeria which has approximately two percent of the world's population contributes almost 10% of the world's maternal deaths (FMOH, 2005).

In Nigeria, several studies (Ogunniyi et al, 2010; Adetoro, 2011) have shown that maternal mortality is more common among women in the lower socioeconomic class, when indices such as education, income level, and type of housing are used. Indeed, Harrison (2005) showed in his study of 22,774 consecutive births in Zaria that education was a strong determinant of maternal mortality in Nigeria. He found that among a group of pregnant women who had at least a secondary education, maternal mortality was as low as that in more developed parts of the world. Studies have also demonstrated an increased risk of maternal mortality among young mothers, grand multiparous women, and unmarried mothers, due in part to their lower socioeconomic status (Hartfield and Woodland, 2010).

Maternal mortality, while a rare event, has a clear definition and can be measured. Maternal morbidity is complex, with multiple causes, duration ranging from acute to chronic, severity ranging from transient to permanent and with a range of diagnosis and treatment options.

4.4.2 Healthcare facilities Where the Death of Pregnant Woman Occurred

The percentage distribution of respondents with respect to where the death of pregnant woman had occurred showed that bout Two (2) of Ten (10) of the respondents reported that the death of the pregnant women does happened on the way to hospital. Majority (33.5%) of the respondents affirmed that the death occurred at the TBAs' centres; 182 (14.6%) of them were of the view that the death of the pregnant women does happened at the hospital; while 273 (22.1%) of the respondents affirmed that the death of the pregnant women does occur at home. (See table 4.4.2)

Table 4.4.2: Frequency Distribution of Respondents by Where the Death Occurred

Where the Death Occurred	Frequency	Percentage %
Hospital	182	14.6
On the way to Hospital	321	25.8
TBAs Home	417	33.5
At Home	273	22.1.
Other	50	04.0
Total	**1243**	**100.0**

Source: Fieldwork, 2017

The data presentation on the table 4.4.2 indicated that 14.6% of the respondents said that the death of the pregnant women witnessed occurred at the hospital. This experience might be as a result of many latent factors such as the attitude of the health care providers, late referral, lack of money and many others. Conversely, majority (33.5%) of the respondents affirmed that the death occurred at the TBAs' centres. This finding is against the finding from the study of Owoseni & Owumi (2013), which reported that 13.6% of pregnant women's death occurred at the TBAs centres. This shows that the

TBAs referred to in this current study might be the unregistered and untrained TBAs across the state.

4.4.3 The Age range of the Deceased

An examination of the percentage of respondents on the age range of the deceased, finding indicated that the age range is closely related in which 33.1% of the respondents indicated that women within age 15 – 29 years died during pregnancy or at the delivery while 32.7% of them responded that women within the age 30 – 39 years usually died during pregnancy or at the delivery. Majority of the respondents (34.2%) were of the view that they had witnessed many women within the age 40 years and above, who had died during pregnancy or at the delivery as a result of complication.. (See table 4.4.3)

Table 4.4.3: Frequency Distribution of Respondents by The Age Range of the Deceased

The Age range of the Deceased	Frequency	Percentage %
15 – 29	412	33.1
30 – 39	406	32.7
40 and above	425	34.2
Total	**1243**	**100.0**

Source: Fieldwork, 2017

The study revealed as evident in table 4.4.3 that the age range is keenly nebulous in which 3 out 10 of the respondents indicated that women within age 15 – 29 years died during pregnancy or at the delivery while 33.1% of them responded that women within the age 30 – 39 years usually died during pregnancy or at the delivery. Majority of the respondents were of the view that they had witnessed many women within the age 40 years and above, who had died during pregnancy or at the delivery as a result of complication.

This finding affirmed that generally notional perception that if a woman is 40 years and above, she is vulnerable to fall victim of serious complication during pregnancy or at the delivery. This might be as a result of body weakness or closeness to menopause, which naturally cause menorrhea (menstrual bleeding). Albeit, women within the age 40 years

and above should understand what should be done during pregnancy due to their marital experience.

In corroboration of the above, previous studies indicated that the age at which a woman first gets married influences the length of time she is exposed to the risk of pregnancy during her childbearing age (NDHS 2013). Maternal age has been found to be positively associated with awareness and utilisation of healthcare service in many societies. Even though, it has been documented that awareness and utilisation of healthcare vary in sub-Saharan Africa and Latin America with age between the young and the old, it is well recognized that women's current age plays an important role in the utilisation of medical services (Fosu, 1994).

Women's age may sometimes serve as a proxy for the women's accumulated knowledge of healthcare services, which may have a positive influence on the use of health services. On the other hand, because of development of modern medicine and improvement in educational opportunities for women in recent years, younger women might have an enhanced knowledge of modern healthcare services and place more value upon modern medicine. Whereas some previous Nigerian studies had reported a significant relationship between age and maternal services utilisation (Ikeako *et al*, 2006; Adeoye *et al*, 2005),

4.4.4 Factors Responsible for the Death of Pregnant Woman

The percentage of respondents showed that about 5 of 10 (48.6%) of the women died as a result of lack of money. 26.2% of them were of the opinion that women died in pregnancy as a result of lacking of someone to take them to hospital for either antenatal or at the point delivery while 12.1% of the respondents that believed that delay in referral cause maternal death and 8.1% of the respondents were of the view that lack transport facility cause death during delivery. 2.3% of the respondents said poor road network resulted to the death of pregnant woman. (See table 4.4.4)

Table 4.4.4: Frequency Distribution of Respondents by Factors Responsible for the Death of Pregnant Woman

Factors Responsible for the Death of Pregnant Wor	Frequency	Percentage %
No money	603	48.6
Lack of someone to take her to hospital	326	26.2
Delay in referral	151	12.1
No transport facility	101	8.1
Poor road network	28	2.3
I don't know	34	2.7
Total	**1243**	**100.0**

Source: Fieldwork, 2017

An examination on the factors responsible for the death of women in pregnancy or during delivery, the table 4.4.4 showed that majority of the respondents declared that almost 5 of 10 (48.6%) of the women died as a result of financial incapacitation. 26.2% of them were of the opinion that women died in pregnancy as a result of lacking of someone to take them to hospital for either antenatal or at the point delivery while some of the respondents believed that delay in referral and lack of transport facility to convey them to the hospitals if there is complication during delivery especially for those that utilise the TBAs home certainly culminates in death of women in the study area.

This result validates the theoretical stance on healthcare service utilisation by Andersen. Andersen's (1968) health behavioural model submitted that certain resources need to be available to an individual in order to actualize health services utilisation even in the presence of predisposing factors. These resources are defined as enabling as they make health services available to the individual and are found both at the family and community levels. Family resources include income (economic status), health insurance coverage and location of residence (Anderson and Newman, 2005). Family income is an important enabling factor as it determines the amount of funds available to an individual to cover healthcare and related costs, e.g. physician consultation, drugs, transportation costs, etc.

This was supported by the interview of a 36 years old mother on factors responsible for the death of women in pregnancy of labour;

> *The money charged in the hospitals especially at the teaching hospital is too high. These hospitals don't consider that majority of Ekiti women are either civil servants with no regular salaries or petty traders, who could not afford to pay high hospital bill. This definitely makes us result in patronizing others means of health care delivery system. Many ignorant women end up in TBAs, which may lead to their untimely death. I am pleading to both Ekiti State and federal governments to help the poor women out.* (**IDI/Female/Ado-Ekiti).**

4.4.5 Cause(s) Women's Death During Delivery in Urban Areas of Ekiti State

Investigating the causes of death among women in labour, finding revealed that above 30 of 100 (34.5%) of the respondents ascertained that retained placental caused the majority of death that occurred in the urban areas among women during delivery. 12.7% and 16.3% of the women died as a result of Spontaneous abortion and induced abortion respectively. 8 of 10 (78.7%) of the respondents affirmed that women died in pregnancy, during childbirth or shortly after delivery while 21.3% of the respondents were of the view that women had never died in pregnancy during childbirth or shortly after delivery in their communities. Understanding the time it took the women to undergo delivery complication before their death, it is highly pivotal to unearth the causes of such death. The figure below reveals the major causes of pregnant women's death in the study areas. (See table 4.4.5)

Table 4.4.5: Frequency Distribution of Respondents by the Cause(s) of Death During Delivery in Urban Areas of Ekiti State

Main Cause(s) of Death	Frequency	Percentage %
Spontaneous abortion	200	12.7
Induced abortion	258	16.3
Hemorrhage after delivery	123	7.8
Retained placenta	545	34.5
Ruptured uterus	68	4.3
Infection	129	8.2
Tetanus	128	8.1
Yellow eyes (hepatitis)	129	8.2
Total	**1580**	**100.0**

Source: Fieldwork, (2017)

Investigating the causes of death among women in labour, finding revealed that above 30 of 100 (34.5%) of the respondents ascertained that retained placental caused the majority of death that occurred in the urban areas among women during delivery. Furthermore, 12.7% and 16.3% of the women died as a result of Spontaneous abortion and induced abortion respectively. This is very common among the women that had previously engaged in the termination of unintended pregnancy.

4.5: Test of Research Hypotheses

This section deals with the test of four main hypotheses, which were earlier formulated in the second chapter of this work. Generally, in line with the theoretical framework of this study, these hypotheses were drawn, which include:

i. There is a significant relationship between the women's socio-demographic characteristics and utilisation of healthcare facilities in the study setting
ii. Socio-cultural beliefs and practices during pregnancy significantly influence delivery complication

iii. Women's working conditions are likely to influence health care facilities utilization.

iv. There is a significant relationship between Decision-Making and utilisation of healthcare facilities

Hypothesis One:

The main Hypothesis

H_0: There is no significant relationship between the women's socio-demographic characteristics and utilisation of healthcare facilities in the study setting.

H_1: There is a significant relationship between the women's socio-demographic characteristics and utilisation of healthcare facilities in the study setting.

This section sets out to test the major hypothesis formulated for the onset of this study on the relationship between socio-economic and demographic characteristics of the respondents and utilisation of healthcare facilities. In order to do this, an attempt would be made to single out some variables on the questionnaire namely; Age, Marital Status, Religion, Education and income. These variables were cross tabulate with utilisation of healthcare facilities. Hence, five sub-hypotheses were formulated and tested in order to affirm or reject the main hypothesis. The next section sets out the first sub-hypothesis

4.5.1: Test of sub-hypothesis on Age and Utilisation of Healthcare facilities

In order to affirm as to whether or not there is relationship in the main hypothesis which states that there is no relationship between the socio-demographic characteristics and utilisation of healthcare facilities, the first sub-hypothesis is with regard to age and utilisation of healthcare facilities. To examine the relationship between the two variables, the following were subjected to some statistical tests and the results are as presented in Table 4.30

H_0: There is no significant relationship between age and utilisation of healthcare facilities in the study setting.

H_1: There is a significant relationship between age and utilisation of healthcare facilities in the study setting.

Table 4.5.1: Age and Utilisation of Healthcare facilities

Age	Healthcare facilities Utilised												Total	
	Government hospital		Private hospital/clinic		Traditional Birth Assistant house		Faith/Spiritual Home		Others		Not Applicable			
Less than 20	30	4.5%	11	4.8%	12	5.8%	6	3.8%	0	0.0%	12	3.9%	71	4.5%
20-24	39	5.8%	9	3.9%	10	4.9%	7	4.4%	0	0.0%	12	3.9%	77	4.9%
25-29	146	21.7%	50	21.7%	37	18.0%	38	23.9%	0	0.0%	62	19.9%	333	21.1%
30-34	191	28.4%	68	29.6%	64	31.1%	38	23.9%	0	0.0%	94	30.2%	455	28.8%
35-39	149	22.1%	58	25.2%	55	26.7%	46	28.9%	1	100.0%	80	25.7%	389	24.6%
40-44	71	10.5%	18	7.8%	15	7.3%	12	7.5%	0	0.0%	28	9.0%	144	9.1%
45-49	47	7.0%	16	7.0%	13	6.3%	12	7.5%	0	0.0%	23	7.4%	111	7.0%
Total	**673**	**00.0%**	**230**	**100.0%**	**206**	**100.0%**	**159**	**100.0%**	**1**	**100.0%**	**311**	**100.0%**	**1580**	**100.0%**

$\varkappa^2$ = 17.471; df = 30; Asymp. Sig. 2-sided = 0. 9663; P < 0.05; R = 0.023; Asymp. Sig = 0.25

Source: SPSS Output

Decision Rule

The table above shows the cross tabulation of respondents' age and preference for healthcare facilities utilised. It also shows a significant association between the age of the respondents and the utilisation of healthcare facilities. ($\varkappa^2$ = 17.471; P < 0.05). The important of the alternative hypothesis of respondents that utilise healthcare facilities and the age affiliation had been statistically established. The calculated chi-square from the table is $\varkappa^2$c = 17.471 with the degree of freedom of 1 at 0.05 level of significance and table value $\varkappa^2$t = 0.966.

Moreover, the correlation result R = 0.023 (0.25) points out that there is not significant relationship of 0.023, which shows that there is not relationship between age of the respondents preference of utilisation of healthcare facilities for antenatal care. In the main, this explains that age may not really influence pregnant women and nursing mothers to visit or utilise preferred healthcare facilities.

Since the chi-square value is greater than the critical table value, the alternative hypothesis (H_1) which states that there is a significant relationship between age and utilisation of healthcare facilities in the study setting is at this moment accepted. Hence, there is a significant relationship between age and preference for healthcare facilities utilization.

4.5.2 Test of Sub-hypothesis on Marital Status and Utilisation of Healthcare facilities

The next sub-hypothesis is on marital status and utilisation of healthcare facilities.

The hypothesis is formulated as below;

H_0: There is no significant relationship between marital status and utilisation of healthcare facilities.

H_1: There is a significant relationship between marital status and utilisation of healthcare facilities.

Table 4.5.2: Marital Status and Utilisation of Healthcare facilities

Marital Status	Healthcare facilities Utilised						Total
	Government hospital	Private hospital/clinic	Traditional Birth Assistant house	Faith/Spiritual home	Others	Not Applicable	
Single	84	30	20	36	0	40	210
	12.5%	13.0%	9.7%	22.6%	0.0%	12.9%	13.3%
Married	429	156	134	89	1	210	1019
	63.7%	67.8%	65.0%	56.0%	100.0%	67.5%	64.5%
Separated	46	16	16	11	0	24	113
	6.8%	7.0%	7.8%	6.9%	0.0%	7.7%	7.2%
Divorced	45	12	16	15	0	20	108
	6.7%	5.2%	7.8%	9.4%	0.0%	6.4%	6.8%
Widowed	41	9	12	4	0	13	79
	6.1%	3.9%	5.8%	2.5%	0.0%	4.2%	5.0%
Co-habiting	28	7	8	4	0	4	51
	4.2%	3.0%	3.9%	2.5%	0.0%	1.3%	3.2%
Total	673	230	206	159	1	311	1580
	100.0%	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

$\varkappa^2$ = 30.062; df = 25; Asymp. Sig. 2-sided = 0. .222; P < 0.05; R = -0.059; Asymp. Sig = 0.024

Source: SPSS Output

Decision Rule

The table above shows the cross tabulation of respondents' marital status and preference for healthcare facilities utilised. It also shows a significant association between the age of the respondents and the utilisation of healthcare facilities. ($\varkappa^2$ = 30.062; P < 0.05). The important of the alternative hypothesis of respondents that utilise healthcare facilities and the marital status affiliation had been statistically established. The calculated chi-square from the table is $\varkappa^2$c = 17.471 with the degree of freedom of 1 at 0.05 level of significance and table value $\varkappa^2$t = 0. .222.

Moreover, the correlation result R = -0.059 (0.024) points out that there is a negative significant relationship of 0.023, which shows that there is a negative relationship between marital status of the respondents preference of utilisation of healthcare facilities for antenatal care. In the main, this explains that marital status negatively influences pregnant women and nursing mothers to visit or utilise preferred healthcare facilities.

Since the chi-square value is greater than the critical table value, the alternative hypothesis (H_1) which states that there is a significant relationship between marital status and utilisation of healthcare facilities in the study setting is at this moment accepted. Hence, there is a significant relationship between marital status and preference for healthcare facilities utilization.

4.5.3Test of Sub-hypothesis on Religion and Utilisation of Healthcare facilities

The next sub-hypothesis is on religion and utilisation of healthcare facilities.
The hypothesis is stated thus;

H_0: There is no significant relationship between religion and utilisation of healthcare facilities.

H_1: There is a significant relationship between religion and utilisation of healthcare facilities.

Table 4.5.3: Religion and Utilisation of Healthcare facilities

Religion	Healthcare facilities Utilised					Total
	Government hospital	Private hospital/clinic	Traditional Birth Assistant house	Faith/Spiritual home	Others	
Christianity	432 27.3%	151 9.6%	136 8.6%	98 6.2%	193 12.3%	1010 63.9%
Islam	216 13.7%	74 4.7%	67 4.2%	56 3.5%	111 7.0%	524 33.2%
Traditional belief	23 1.5%	5 0.3%	3 0.2%	5 0.3%	7 0.4%	43 2.7%
Others	2 0.1%	0 0.0%	0 0.0%	0 0.0%	1 0.1%	3 0.2%
Total	**673** **42.6%**	**230** **14.6%**	**206** **13.0%**	**159** **10.1%**	**312** **19.7%**	**1580** **100.0%**

$\varkappa^2$ = 7.153; df = 15; Asymp. Sig. 2-sided = 0.953; P < 0.05; R = 0.082; Asymp. Sig = 0.774

Source: SPSS Output

Decision Rule

The table above shows the cross tabulation of respondents' religion and preference for healthcare facilities utilised. It also shows a significant association between the religion of the respondents and the utilisation of healthcare facilities. ($\varkappa^2$ = 7.153; P < 0.05). The important of the alternative hypothesis of respondents that utilise healthcare facilities and the religion affiliation had been statistically established. The calculated chi-square from the table is $\varkappa^2$c = 7.153 with the degree of freedom of 1 at 0.05 level of significance and table value $\varkappa^2$t = 0.953.

Moreover, the correlation result R = 0.082 (0.774) also points out that there is a significant relationship of 0. 082, which shows that there is a relationship between religion of the respondents preference of utilisation of healthcare facilities for antenatal care. In the main, this explains that religion really influences pregnant women and nursing mothers to visit or utilise preferred healthcare facilities.

Since the chi-square value is greater than the critical table value, the alternative hypothesis (H_1) which states that there is a significant relationship between religion and utilisation of healthcare facilities in the study setting is at this moment accepted. Hence,

there is a significant relationship between religion and preference for healthcare facilities utilization.

4.5.4 Test of Sub-hypothesis on Educational Status and Utilisation of Maternal Healthcare Facilities

The next sub-hypothesis is on educational status and utilisation of healthcare facilities. The hypothesis is stated thus;

H_0: There is no significant relationship between educational status and utilisation of healthcare facilities.

H_1: There is a significant relationship between educational status and utilisation of healthcare facilities.

Table 4.5.4: Educational Status and Utilisation of Healthcare facilities

Educational Status	Healthcare facilities Utilised					Total
	Government Hospital	Private Hospital/Clinic	Traditional Birth Assistant house	Faith/Spiritual Home	Others	
No Formal Education	15 0.9%	9 0.6%	2 0.1%	2 0.1%	8 0.5%	36 2.3%
Some Primary	25 1.6%	7 0.4%	4 0.3%	4 0.3%	11 0.7%	51 3.2%
Completed Primary	61 3.9%	19 1.2%	18 1.1%	23 1.5%	32 2.0%	153 9.7%
Completed Secondary	97 6.1%	35 2.2%	37 2.3%	25 1.6%	45 2.9%	239 15.1%
OND/NCE/Grade II	170 10.8%	54 3.4%	45 2.8%	30 1.9%	80 5.1%	379 24.0%
HND/BSC/Postgraduate	137 8.7%	55 3.5%	45 2.8%	44 2.8%	56 3.5%	337 21.3%
Others	168 10.6%	51 3.2%	55 3.5%	31 2.0%	80 5.1%	385 24.4%
Total	**673 42.6%**	**230 14.6%**	**206 13.0%**	**159 10.1%**	**312 19.8%**	**1580 100.0%**

χ^2 = 30.438; df = 30; Asymp. Sig. 2-sided = 0.443; P < 0.05; R = 0.118; Asymp. Sig = 0.731

Source: SPSS Output

Decision Rule

The table above shows the cross tabulation of respondents' Educational Status and preference for healthcare facilities utilised. It also shows a significant relationship between the Educational Status of the respondents and the utilisation of healthcare facilities.

The chi-square result (R = 0.118 (0.0731)) shows that there was an association between the educational qualification and the preference for the utilisation of healthcare facilities. This explains that education has a positive influence on the choice that the pregnant women and nursing mothers make about their preferred facilities consumption. Furthermore, the correlation findings $\varkappa^2$ = 30.438 (0.443) illustrated that there is a relationship between educational qualification and the healthcare facilities preference.

On the whole, since the chi-square value is greater than the critical table value, the alternative hypothesis (H_1) which states that there is a significant relationship between educational status and utilisation of healthcare facilities in the study setting is at this moment accepted. Hence, there is a significant relationship between educational status and preference for healthcare facilities utilization.

4.5.5 Test of Sub-hypothesis on Income and Utilisation of Healthcare facilities

The next sub-hypothesis is on income and utilisation of healthcare facilities.
The hypothesis is stated thus;

H_0: There is no significant relationship between income and utilisation of healthcare facilities.

H_1: There is a significant relationship between income and utilisation of healthcare facilities.

Table 4.5.5: Income and Utilisation of Healthcare facilities

Monthly Income	Healthcare facilities Utilised					Total
	Government hospital	Private hospital/clinic	Traditional Birth Assistant house	Faith/Spiritual home	Others	
Less N10,000	81 5.1%	26 1.6%	24 1.5%	18 1.1%	37 2.3%	186 11.8%
N10,000 - N30,000	142 9.0%	46 2.9%	41 2.6%	32 2.0%	65 4.1%	326 20.6%
N31,000 - N50,000	174 11.0%	63 4.0%	54 3.4%	45 2.8%	83 5.3%	419 26.5%
N51,000 - N80,000	159 10.1%	56 3.5%	48 3.0%	34 2.2%	73 4.6%	370 23.4%
N80,000 and above	117 7.4%	39 2.5%	39 2.5%	30 1.9%	54 3.4%	279 17.7%
Total	**673** **42.6%**	**230** **14.6%**	**206** **13.0%**	**159** **10.1%**	**312** **19.8%**	**1580** **100.0%**

$\varkappa^2$ = 4.275; df = 20; Asymp. Sig. 2-sided = 1.000; P < 0.05; R = 0. 022; Asymp. Sig = 0.882

Source: SPSS Output

Decision Rule

The table above shows the cross tabulation of respondents' Income and preference for healthcare facilities utilised. It also shows a significant relationship between the Income of the respondents and the utilisation of healthcare facilities.

In the main, the chi-square result ($\varkappa^2$ = 4.275 (1.000)) with the degree of freedom of 1 at 0.05 level of significance depicts that there is an association between monthly income and the preference for the utilisation of healthcare facilities for taking care of maternal and child health challenges. Also, the correlation result R = 0.022 (0.0880) points out that there is no relationship between monthly income and the preference for the utilisation of healthcare facilities in taking care of their health status. Although, this explains that monthly income cannot really influence pregnant women and mothers to visit or use healthcare facilities.

Furthermore, from the findings, respondents who earn lesser income tend to have utilised or visited Faith-Based Clinic or TBAs as regards to their health and that of their children for economic reason. Conversely, some pregnant women and nursing mothers with higher income had also utilised Faith-Based Clinic or TBAs facilities despite the fact that they can still afford to go to modern health centres no matter the distance to their environment or communities.

Since the chi-square value is less than the critical table value, the alternative hypothesis (H_1) which states that there is a significant relationship between the women's demographic characteristics (Income) and utilisation of healthcare facilities in the study setting is at this moment rejected. Hence, there is no significant relationship between the women's socio-demographic characteristics (Income) and preference for healthcare facilities utilization.

4.5.6 Regression Analysis on Socio-Economic and Demographic Characteristics and Utilisation of Healthcare facilities

In order to affirm statistically as to whether or not socio-economic and demographic characteristics influence utilisation of healthcare facilities, an attempt is made to examine the association between independent variables and the dependent variable with application of regression analysis. (See table 4.5.6)

Table 4.5.6: Regression Analysis of the Effect of Age, Educational Status, Religion and Income on Utilisation of Healthcare facilities.

Selected Variables	B	S.E.	Wald	df	Sig.	Exp(B)
Age						
15-19	**RC**	-	-	-	-	
20-24	-.461	.242	3.637	1	.057	.631
25-29	-.476	.234	4.155	1	.042	.621
30-34	-.280	.261	1.150	1	.284	.756
35-39	.054	.725	.006	1	.941	1.056
40-49	.388	.147	.000	1	.999	.000
Educational Qualification						
No formal Education	**RC**	-	-	-	-	
Primary Education	.507	.293	3.000	1	.083	.602
Secondary Education	.167	.247	.460	1	.498	.846
Tertiary Education	.027	.186	.020	1	.886	.974
Occupation						
Petty Trading	**RC**	-	-	-	-	
Farming	1.839	1.043	3.112	1	.078	6.290
Civil servant	-.306	.162	3.577	1	.059	.736
House wife	-.823	.227	13.139	1	.000	.439
Unemployed	-.655	.264	6.172	1	.013	.519
Others	-.718	.184	15.153	1	.000	.488
Income per Month						
<₦10,000	**RC**	-	-	1	-	-
₦ N10,000 - N30,000	.317	.187	2.858		.091	1.373
₦ N31,000 - N50,000	-.023	.185	.015	1	.903	.978
₦51,000-N80,000	.186	.229	.660	1	.417	1.204
₦80,001 and Above	.104	.272	.146	1	.702	1.110
	-.276	.272	1.026	1	.311	.759
Religion						
Christian	**RC**	-	-	-	-	
Islamic	.509	.134	14.444	1	.000	1.664
Traditional	1.790	1.049	2.911	1	.088	5.992
Free thinker	.409	.683	.357	1	.550	1.505
Marital Status	**RC**	-	-	-	-	
Married	.151	.379	.158	1	.691	.860
Single	.490	.504	.944	1	.331	.613
Widowed	1.827	.622	8.642	1	.003	.161
Divorced	.587	.602	.951	1	.329	1.799
Cohabiting	1.765	.506	12.147	1	0.000	5.840

Source: Fieldwork, (2017)

Dependent variable: Utilisation of Maternal Health Services

The relationship between some selected socio-demographic variables and utilisation of healthcare facilities were computed in this model to identify socio-demographic correlates of healthcare facilities utilization. In terms of measurement, the dependent variable in this model (healthcare facilities utilization) were measured by means of a checklist containing healthcare facilities utilised, some of which include Health clinic, Traditional Birth Attendants. Spiritual home, Chemist/medicine store, Home /self-medication and Both Health clinic and TBA/Spiritual Home. Respondents were classified according to whether (at the time of the survey) they had ever utilised at least one of these facilities. All variables were dichotomized into 0 and 1. Where 0 means the absence of healthcare facilities utilisation and 1 denotes utilisation of one or more of healthcare facilities utilisation. This makes the dependent variable to satisfy the condition for logistic regression.

In this model, the predictors are age of the respondents, educational attainment, occupation, income, religion, marital status.

The Beta values are equivalent to the B values obtained in a multiple regression analysis, which is use to calculate the probability of a case falling into a specific category.

The contributions of various factors to maternal health are presented here. Age groups 20-24, 25-29, and 30-34 below 34 years are negatively associated with utilisation of healthcare facilities, indicating that those who are below 34 years are 0.631, 0.621 and 0.756 less likely to have utilised healthcare facilities before, during and after pregnancy compared to those in age group 15-19 (i.e. the reference category) in the study area. This result conformed to other findings, specifically, those within these age groups had been found to carry the lowest risk of dying during pregnancy and child birth (Olusanya, 2008).

Meanwhile, those in age group 35-49 are positively related to utilisation of healthcare facilities indicating increase in the likelihood of utilisation of healthcare facilities as age increases. However, the proportion of the unit change in the utilisation of healthcare facilities is explained by Exp (B) value 1.056. The findings imply an increased level of healthcare facilities utilisation among older women.

Same observations go for the result for educational attainment, where primary school qualification, secondary school qualification and tertiary qualification show positive association with the predicted variable and are 0.631, 0.621 and 0.756 more likely to utilise healthcare facilities compare to RC. This implies that the higher the level of education, the more likely the utilisation of healthcare facilities in the study area.

Furthermore, the same observation goes for income which shows a weak association with utilisation of healthcare facilities as indicated by the Wald values. The implication of this finding is that other factors rather than just education and income might be significantly militating against utilisation of healthcare facilities that need to be considered in order to ensure utilisation of healthcare facilities and prevent mortality. These findings on education and income had been raised in Olusanya (2008), which stated that women's education and wealth status have no association with the likelihood of utilising healthcare facilities.

However, all occupational categories are statistically significant to utilisation of healthcare facilities. This could be as a result of the nature of working condition in the study setting. The problems associated with utilisation of healthcare facilities are closely linked to inadequate working conditions (Olusanya, 2008). Specific result indicated that farming in the study location is positively associated with utilisation of healthcare facilities (Beta value 1.839). Pregnant women and nursing mothers in this group would be 6.290 times more likely to utilise healthcare facilities. This could be true because farming involves more exertion of energy and with low income to utilise of healthcare

facilities. All other categories of occupation show negative association with utilisation of healthcare facilities with strong Wald value.

Furthermore, from the analysis, religion shows positive relation with utilisation of healthcare facilities. The result indicated that Christians are 1.664, which is the reference category times more likely to have utilised healthcare facilities compare to other category (Islam). While traditional religion believers and others are 5.992 and 1.505 times less likely to have utilisation of healthcare facilities to the reference category. However, this study has demonstrated that, marital status also has positive association with the utilisation of healthcare facilities. Divorced women had 0.003 level of significance, while cohabiting is 1.799 times more likely to less concern for utilisation of healthcare facilities.

4.5.7 Test of Hypothesis on Cultural Belief and Practices and Complication(s) Experienced during Pregnancy

This section set out to examine whether or not there is relationship between cultural belief and practices and complication(s) experienced during pregnancy

Hypothesis Two

Null hypothesis H_0:

There is no significant relationship between cultural belief and practices and complication(s) experienced during pregnancy

Alternative hypothesis H_1:

There is a significant relationship between cultural belief and practices and complication(s) experienced during pregnancy

Table 4.5.7: Cultural Beliefs And Practices and Complication(s) Experienced In pregnancy

Cultural Beliefs and Practices	Complication(S) Experienced						Total
	Excessive Bleeding	Swollen Legs	Abdominal Pain	Fainting	Dizziness	Others	
Food/Drinks prohibition	313	133	118	179	19	28	790
	19.8%	8.4%	7.5%	11.3%	1.2%	1.8%	50.0%
Activities Prohibition	59	34	18	35	5	9	160
	3.7%	2.2%	1.1%	2.2%	0.3%	0.6%	10.1%
Medicines Prohibition	68	30	19	35	6	6	164
	4.3%	1.9%	1.2%	2.2%	0.4%	0.4%	10.4%
Other beliefs	196	83	66	98	12	11	466
	12.4%	5.3%	4.2%	6.2%	0.8%	0.7%	29.5%
Total	**636**	**280**	**221**	**347**	**42**	**54**	**1580**
	40.3%	**17.7%**	**14.0%**	**22.0%**	**2.7%**	**3.4%**	**100.0%**

Decision Rule

The table above shows the cross tabulation of the relationship between cultural belief and practices and complication(s) experienced during pregnancy.

Basically, the chi-square result ($\varkappa^2$ = 9.738 (0.836)) with the degree of freedom of 1 at 0.05 level of significance depicts that there is an association between Socio-cultural belief and practices and the complication(s) experienced during pregnancy and delivery period. Also, the correlation result R = 1.844 (0.174) depicts that there is relationship between Socio-cultural beliefs and practices and the complication(s) experienced during pregnancy and delivery period. This explains that Socio-cultural beliefs and practices really influence the complication(s) experienced during pregnancy and delivery period.

Since the chi-square value is greater than the critical table value, the alternative hypothesis (H_1) which states that there is a significant relationship between cultural belief and practices and complication(s) experienced during pregnancy is at this moment accepted. Hence, there is significant relationship between cultural belief and practices during pregnancy and the Complication(s) Experienced

4.5.8 Test of Hypothesis on Women's working conditions and utilisation of maternal health care facilities

This section set out to examine whether or not there is relationship between Women's working conditions and utilisation of maternal health care facilities

Hypothesis Three

Null hypothesis H_0:

Women's working conditions may not likely influence the maternal health care facilities utilisation

Alternative hypothesis H_1:

Women's working conditions are likely to influence the maternal health care facilities utilization.

Table 4.5.8: The Nature Work and the Frequence of Maternal Health Service Utilization

The Nature Work	Frequence of Maternal Health Service Utilization						Total
	As much as Required	2-3 Times in a Week	Weekly	Every two weeks	Every Month	Others	
Full-Housewife	70	41	67	28	96	25	327
	4.4%	2.6%	4.3%	1.8%	6.1%	1.6%	20.7%
Employer	17	6	18	6	32	2	81
	1.1%	0.4%	1.1%	0.4%	2.0%	0.1%	5.1%
Small Private Business	66	33	110	36	135	42	422
	4.2%	2.1%	6.9%	2.3%	8.5%	2.7%	26.7%
Public servants	60	33	117	50	131	33	424
	3.8%	2.1%	7.4%	3.2%	8.3%	2.1%	26.8%
Artisan	9	4	15	9	15	3	55
	0.6%	0.3%	0.9%	0.6%	0.9%	0.2%	3.5%
Unemployed	50	22	73	22	81	23	271
	3.2%	1.4%	4.6%	1.4%	5.1%	1.5%	17.2%
Total	**272**	**139**	**400**	**151**	**490**	**128**	**1580**
	17.2%	**8.8%**	**25.3%**	**9.6%**	**31.0%**	**8.1%**	**100.0%**

χ^2 50.873; df = 30; Asymp. Sig. 2-sided = 0.010; P < 0.05; R = 1.783; Asymp. Sig = 0.182

Source: SPSS Output

Decision Rule

The table above shows the cross tabulation of the relationship between women's work condition and the frequence of maternal health service utilization.

On the whole, the chi-square result ($\varkappa^{2}$ = 50.873 (0.010)) with the degree of freedom of 1 at 0.05 level of significance showcases that there is no association between women's work condition and the frequence of maternal health service utilization. Albeit, the correlation result R = 1.783 (0.182) depicts that there is relationship between women's work condition and the frequence of maternal health service utilization. Furthermore, this explains that women's working conditions are likely to influence the maternal health care facilities utilization.

Since the chi-square value is less than the critical table value, the alternative hypothesis (H_1) which states that women's working conditions are likely to influence the maternal health care facilities utilisation is at this moment rejected. Hence, there is no significant relationship between women's work condition and the frequence of maternal health service utilization.

4.5.9 Test of Hypothesis on Stereotypes and utilisation of maternal health care facilities

This section set out to examine whether or not there is relationship between stereotypes (decision-making) and utilisation of maternal health care facilities

Hypothesis Four

Null hypothesis H_0:

There is no significant relationship between stereotypes and healthcare facilities utilised

Alternative hypothesis H_1:

There is a significant relationship between stereotypes and healthcare facilities utilised.

Table 4.5.9: Stereotypes and Healthcare Facilities Utilised.

Healthcare facilities Utilised	Decision Maker(s)	Total

	Husband	Me (Wife)	Joint Decision	Friends or Family Members	
Government hospital	370	54	95	100	619
	23.4%	3.4%	6.0%	6.3%	39.2%
Private hospital/clinic	162	28	45	36	271
	10.3%	1.8%	2.8%	2.3%	17.2%
Traditional Birth Assistant house	288	31	72	80	471
	18.2%	2.0%	4.6%	5.1%	29.8%
Faith/Spiritual home	94	16	30	25	165
	5.9%	1.0%	1.9%	1.6%	10.4%
Others	30	4	9	11	54
	1.9%	0.3%	0.6%	0.7%	3.4%
Total	**944**	**133**	**251**	**252**	**1580**
	59.7%	**8.4%**	**15.9%**	**15.9%**	**100.0%**

$\varkappa^2$ 7.191; df = `12; Asymp. Sig. 2-sided = 0.845; P < 0.05; R = 0.233; Asymp. Sig = 0.629

Source: SPSS Output

Decision Rule

The table above shows the cross tabulation of the relationship between stereotypes and healthcare facilities utilised in the study area.

In the main, the chi-square result ($\varkappa^2$ = 7.191 (0.845)) with the degree of freedom of 1 at 0.05 level of significance showcases that there is an association between stereotypes in the family and healthcare facilities utilised. However, the correlation result R = 0.233 (0.629) shows that there is a relationship between decision-making and healthcare facilities utilised. Furthermore, this explains that the healthcare facilities utilised by pregnant women and nursing mothers in the study area are determined by who make decisions in the family.

In the main, so far the chi-square value is greater than the critical table value, the alternative hypothesis (H_1) which states that is a significant relationship between stereotypes and healthcare facilities utilised is at this moment accepted. Hence, there is a significant relationship between stereotypes and healthcare facilities utilised

Regression Estimating The Influence of Socio-Cultural Factors on The Utilisation of Healthcare Facilities

This model was computed to identify socio-cultural factors correlates of utilisation of healthcare facilities. Socio-cultural factors were; religious belief; cost of service; efficacy of the service; women's working conditions; stereotypes and family customs

The classification table (Table 4.3.9) shows the accuracy of the model in predicting the influence of socio-cultural factors on healthcare facilities utilization.

Table 4.3.9: Logistic Regression Estimating The Influence of Socio-Cultural Factors on The Utilisation of Healthcare Facilities

Selected Variables	B	S.E.	Wald	df	Sig.	Exp(B)
socio-cultural factors	**RC**	-	-	-	-	
Religious Belief	0.628	.536	.290	2	.289	1.335
Cost of Service	0.821	.637	.637	2	.508	.602
Efficacy of the Service	0.726	1.061	.678	2	.873	.418
Women's Working Conditions	0.604	1.065	.269	2	.552	.576
Stereotype	0.600	.492	.275	2	.258	1.294
family customs	0.878	.569	.024	2	.088	.916
2 Log likelihood = 1743.612(a) Cox & Snell R Square =.062 Nagelkerke R Square = .074 Overall Percentage = 68.9						

Source: Field Survey 2017 RC =Reference Category

The model shows an accuracy level of 68.9%. The variables were dichotomized to satisfy the condition for logistic regression. However, in terms of socio-cultural factors, the result of the analysis shows that observance of religious belief is significantly associated

with utilisation of healthcare facilities at p-value of 0.628. Cost of service probably still prevents many pregnant and nursing mothers from Utilising healthcare facilities. Denial or avoidance of utilisation of healthcare facilities as a result of cost of service can adversely affect the health of pregnant women.

The finding also shows a positive association with Efficacy of the Service (0.726) more likely to influence utilisation of healthcare facilities in the study area. Women's Working Conditions is 0.182 statistically significant with ratio 0.552) more likely to affect utilisation of healthcare facilities. This is not surprising, as it has been discovered by ILO (2015) that in Sub-Saharan Africa, where the highest rates of maternal mortality are reported, more than 80 percent of pregnant women, who are working in private organisations usually find it difficult to utilise healthcare facilities during pregnancies. The same observation goes for the Stereotypes and family customs practiced in the study area, which pregnant women usually observe are statistically significant at p-value = 0.845 and 0.814 more likely to great influence on the utilisation of healthcare facilities among the pregnant women in urban areas of Ekiti State.

Discussion of Findings:

Basically, there is a growing recognition of the maternal health challenges, diagnostic and intervention strategies as predominantly related to medical condition of pregnant women, whereas, there are socio-cultural conditions that need to be monitored in order to reduce the risk of maternal health complications mortality. This study examined some of these socio-cultural factors and their implications on healthcare facilities utilization. This section highlights findings from this study.

Finding depicts that 37.5% of the sampled pregnant women and nursing mothers indicated that lack of financial capability has been the major reason for their antenatal care service utilisation preference preferring. This might be true due to the economic recession the country is being faced. 14.4% of them were of the side that the

Inaccessibility of health centres close to them has instigated their preference in antenatal care service.

The study also revealed that 37.5% of the respondents lack financial capability, which has been the major reason for their antenatal care service utilisation preference. This might be true due to the economic recession the country is being faced. 14.4% of them were of the side that the Inaccessibility of health centres close to them has instigated their preference in antenatal care service. Though, the health facilities are available but not accessible to the health consumer, which might be as a result of lack of money.

Furthermore, 19.9% of the respondents said that inadequate care given at the health centres dictates their preference for other source of antenatal care over modern health centres. The minima number of the respondents (13.2%) was of the opinion that they preferred using the facilities they patronized for antenatal care service. This particular preference might be for those who mainly patronize TBAs or utilise both TBAs and modern health centres simultaneously purposely for spiritual reason while 15% of them chose others.

The finding was corroborated by the in-depth interview conducted with a community health committee leader in a selected LGA. Community health committee members are generally older people who "care" about younger members of the community. They also take care of those women that are not able to pay for delivery and are therefore also seen as benevolent members of the community. Below is a claim about attending to spiritual issues that may occur;

> "*It is good for pregnant women to patronize both hospital and church. To my own knowledge, hospital does not handle any spiritual issue. As for me, I advise pregnant women to make use of church for prayer and hospital for immunization and medical check-up.*

In support of the above, (Joesoef, Baughman and Utomo, 1988) observed that the role of TBAs on maternal and child health care cannot be undermined. Exiting literatures have shown that when the TBAs are cooperative and supportive in child health care, it has good impact on the mother and child health of the urban dwellers.

Despite the high level of awareness about maternal and child high mortality rate, the number of the respondents that still do not make use of hospitals facilities for antenatal care was still high. The reason for this is not farfetched; public health care facilities that are supposed to provide basic prevention and health promotion services that include immunization, health education, promotion of adequate nutrition and management of malaria, diarrhoea, acute respiratory infection and other common illness are not available, which make the urban dwellers make use of the available health facilities such as TBAs (Simpson 2004). This is corroborated by the interview of a healthcare provider;

> *People prefer home delivery or TBAs for antenatal care or delivery instead of going to teaching or general hospitals for proper care. This may be as a result of high cost of services at the health centres. If any woman wants to deliver in the teaching or general hospital now, she must prepare up to ₦30,000 if not more without complication but if it by caesarean, it would cost nothing less than ₦150,000*

In relation to above, one of the pregnant women attending antenatal care at both health clinic and TBA/Spiritual Home said that as long as they know that both the federal and State teaching hospitals are not affordable during delivery, they are comfortable with attending both hospitals and TBAs for antennal care.

> *It is very expensive to deliver at the teaching hospitals. At the same time, the health centres are very far from my place. I have been attending TBA for long time and it is good for me. The TBAs are really taking care of us.)*

To ascertain the level of utilisation of antenatal care services, a woman interviewed was of the opinion that:

> *It is better to utilise both hospitals and mission house for antenatal care and deliver at the mission house or Ile-Agbebi than in hospitals. I also go to health centre for my child immunization but for delivery, I prefer mission house to hospitals. In fact, all my four children were delivered at mission house and home*

The supposition which states that is a significant relationship between the women's socio-demographic characteristics and utilisation of healthcare facilities in the study setting was accepted at $P < 0.05$. The contingency coefficient result shows that the relationship between religion of the respondents and the utilisation of healthcare facilities was very strong (0.953). This shows that about 80 percent of the utilisation of healthcare facilities preference is a function of the religion of the women.

This finding corroborates various studies that have shown that the use of modern health services is often influenced by individual perceptions of the efficacy of modern health services and the religious beliefs of the individual woman (Adetunji, 1991). According to Baley (1997) and Mekonnon (2002) there is a significant variation in the utilisation of healthcare by religion. Furthermore, Addai, (1998) and Mekonnon (1998) in their study in Ethiopia revealed that religion has emerged as an important predictor of maternal care utilisation in urban Ethiopia.

In Borno state it is common among the Muslim ethnic groups for religious rituals to be performed in order to assist a woman in labour. Mallams and their grown up students *(Almarjirais*) would come and read the Holy Quran to the woman for protection against all evils relating to pregnancy and childbirth. And after that, a drink of Quranic verses particularly *Aya-tul Kursiyu* are written on plate and washed and given to her to drink for safe delivery (Waziri 2004, El-Nafaty, 1998). Adamu (2001) also revealed similar rituals among the Hausa people of Kano state in Northern Nigeria. Consequently, women tend to remain in the house instead of going to the health facilities for delivery because of the psychological satisfaction and assurance of nothing wrong would happened derived from the rituals.

Furthermore, the hypothesis tested on the relationship between education of respondents and preference for healthcare facilities utilised at $P < 0.05$. Thus, the correlation findings $\varkappa^2 = 30.438$ illustrated that there is a relationship between educational qualification and the healthcare facilities preference. The contingency coefficient of the two variables is 0.443. This means that about 55 per cent of the utilisation of healthcare facilities preference is determined by the level of education of the women.

In the main, there is no significant relationship between the women's socio-demographic characteristics (Income) and preference for healthcare facilities utilization. This finding is aligned with many studies, which have indicated the role of some socio-demographic factors in the utilisation of health services; factors such as maternal age (Adersen et al. 1963; Morris 1967; Reide 2002), ethnicity (Zborowski, 1952), Education (Erinosho 1977), Gender factors (The Prevention of Maternal Mortality Network 1992; Erinosho 1998) and socio-economic status (Mckinley, 1972). All of these factors influence the patterns of utilisation of health services in most human societies.

The finding shows the frequencies and percentages of respondents that had utilised healthcare facilities for antenatal care when pregnant in urban areas of Ekiti State. 97.3% of the respondents agreed that they had utilised healthcare facilities while 2.7% of the respondents had never utilised healthcare facilities for antenatal care when pregnant in their locality. This percentage shows that they also make use health facilities for antenatal care.

The highest percentage of the respondents that had had utilised healthcare facilities patronized Both Health clinic and TBA/Spiritual Home (52.2%) while 28.3% of the respondents visited Health clinics, those that utilised Traditional Birth Attendants were 14.6% and 4.7% of them visited others (Spiritual home, Chemist/medicine store and Home /self)

It can be concluded that women attend antenatal but not early into their pregnancy and therefore, most women miss out of intended benefits of early antenatal care. Earlier findings indicated that attendance of antenatal care is a determinant factor in maternal health. These conditions include complications during pregnancy and prompt attention in case of medical challenges and monitoring of fetus. Antenatal care is generally acknowledged as an effective method of preventing adverse outcomes in pregnant women and their babies. The present pattern of routine antenatal care in Nigeria consists of a first antenatal or "booking' visit at around 12 weeks gestation, followed by monthly visits up to 28 weeks, fortnight visits up to 36 weeks and weekly visits thereafter. Observational studies suggest an association between gestational age at initiation of antenatal care and outcomes for mothers and babies (Gortmaker 1979, Ryan, Sweeney, Solala, 1980 and Quick, Greenlick and Roghmann, 1981). Many antenatal screening tests, including ultrasonography for the detection of fetal anomalies and biochemical screening for neural tube defects and Down's syndrome, take place during the first trimester or early in the second trimester. Women who initiate antenatal care after this time may be denied the opportunity to benefit from these screening tests.

Education appears as an important factor that precipitates the medical proximate and maternal health. Women without formal education appear to ignore antenatal and as level of education increases the probability of attending antenatal equally increases. Although, attendance of antenatal is high generally among women, low income was associated with delayed antenatal. The findings of the present study are in agreement with earlier studies. Oxaal and Baden, (2016) reported that educated women have more understanding of the physiology of reproduction and are less disposed to accept the complications and risks of pregnancy as inevitable, than illiterate or uneducated women. Graczyk (2007) opined that lack of education affects health because it limits young women's knowledge about nutrition, birth spacing, and contraception. These results highlight variation in the association of socioeconomic status with attendance of antenatal. Most of the respondents with low level of education seem to have positive disposition to maternal health care

utilisation in terms of attending ante natal care. Education is a key determinant of maternal health. Not only does education lead to higher income and greater awareness of important maternal health indicators (Fadeyi, 2007), it also enhances the value for a healthy life style. Studies have shown that educated women are more likely to take measures to protect themselves, accept change and be more receptive to prevention messages

A study in Paraguay has reported that maternal health knowledge would be improved with wide application of community-based antenatal care program to meet the needs of those who are functionally illiterate (Ohnishi, Nakamura, Takano, 2005).

The state of maternal health is worsened by economic situation. The unprecedented harsh economic climate is increasingly influencing maternal health outcome. Majority of the respondents earn below 20,000 naira as income per month and engage in economic activities that are tedious even during pregnancy. They live on daily income and this makes it mandatory for them to keep working in order to meet the daily needs and support the home front. The socioeconomic pressures brought about by lack of opportunities and high levels of unemployment push pregnant women into risky activities just to generate income. When asked what she does and the activities involved in the business, one respondent said the following:

> *My business is seasonal. I sell whatever is in season for that period. For instance, this period we have fruits, I would have to wake up as early as 5.30am to go to a very far village to buy fruits and come to sell here in Ado-Ekiti*

The apparent low standard of living during pregnancy due to economic crunch might actually be an indication for irregular pattern of food intake necessary to sustain the body during pregnancy. This is a major risk factor for the trend of maternal health complication that was observed during the course of this study. The quantity and quality of food intake among expectant mothers is vital for their overall wellbeing. From the key informant interview with the medical practitioners the issue of anemia emerged as major

risk factor in pregnancy that was re-emphasized, a pregnant woman needs to eat the right kind of food regularly as anemia in pregnancy remains a major threat to maternal health.

One of the health care providers was of the view that;

> *Most pregnant women and nursing mothers don't eat right nutrition that can sustain them and the fetus during pregnancy and lactation respectively largely due to lack of money.*

In pregnancy, women require an extra 300 calories above their normal daily intake to meet the needs of their growing baby; so also, the nursing mothers. When a pregnant woman or a nursing mother is not eating balanced meals, the body may lack the required level of iron and at this stage the body requires iron in double of the normal requirement in pregnancy and in lactation. Another critical nutrient in pregnancy is folic acid. Pregnant women and those planning a pregnancy in particular should get 400 micrograms of folic acid in food daily or supplement form (Ford-martin & Aron, 2013).

The finding also revealed that most pregnant women are so engrossed in economic activities that they overlook early signs of complications and resort to traditional medicine in emergency, especially because it is cheaper.

Below is an excerpt from a participant in Ikole Ekiti;

> *Normally, I used to attend my antenatal when it is my appointment day. But since my father in-law help me and many others in the community prepare 'Agbo' (herbal medicine), no need of wasting money to go and complain for dizziness in the hospital I always complain to him and he would give me the remedy.*

In corroboration of the above, Owoseni & Owumi (2012) in his study revealed that 79.2% of the pregnant women Ekiti State believed in the efficacy of the medicine given by the Traditional Birth Attendants. The result signifies that majority of the pregnant women and nursing mothers believed in the efficacy of the medicine given at the TBAs centres. Among those respondents that utilised the TBAs, there were some who still patronized other health facilities such as modern health care service (Owoseni and Owumi, 2012)

Although the role of traditional medicine and its potentials have been receiving attention in the past decade, the danger here is that most herbal medicine practices have been "commercialized" in Ekiti State that most herbal medicine sellers sells to make a living from it even without adequate knowledge.

The major fear here is what is being dispensed is on trial and error basis and without accurate measures since large quantity and variety of herbs are often prescribed for a single ailment (Owoseni and Owumi, 2012).

The above was further established by one of the health care providers interviewed at Ido-Ekiti was of the assertion that;

> *Most pregnant women report to the maternity center late and by the time they come is either they have still birth or liver problem that they have to be referred for dialysis.*

On the whole, various studies in the past did not yield a consistent pattern of relationships between healthcare facilities utilisation and individual and household predictors. Elo (1992) showed that women with primary level education were more likely to utilise maternal health services compared to those without any formal education. Raghupathy (2006) did not record any significant difference between the two educational groups. Whereas, many studies found positive correlations between age and the use of skilled attendants at child birth (Celik and, Hotchkiss, 2000, Navaneetham and Dharmalingam, 2002).

The interaction effect of the socio-cultural variables on maternal health in Ekiti State was further explored by examining the cultural beliefs and stereotypes associated with pregnancy. The finding revealed a significant influence of cultural beliefs and practices on healthcare facilities utilization. Cultural beliefs, attitudes and practices have been found to be one of the main factors affecting maternal health in Africa. These factors

along with poverty and the inaccessibility of existing health facilities have resulted in low use of antenatal services, delivery and postnatal care as revealed by findings of studies conducted in Africa. Food restrictions and taboos constitute a major area of cultural impact that creates problems for pregnant women. In some urban societies women eat food after men. Depending on the quantity and quality of food available, a pregnant woman who eats left-overs may also lack sufficient nutrition (Chukuezi, 2010).

The result of this study agrees with Ogbu's finding. Snails are rich in calcium, to avoid babies drooling. Denial or avoidance of such foods can adversely affect the health of pregnant women by increasing their chances of suffering from anemia. Some people believe that while the fetus resides in the womb, it absorbs information which develops its personality and physical appearance. The expectant mother may fear that if she does not consume the item that she craves, for her baby would take on (physical) characteristics of that food.

Cultural beliefs, practices and taboos organized according to mainstream societal values dominated by patriarchal values of male superiority and preference exacerbate difficulties of pregnancy and childbirth often leading to maternal mortality or morbidity. Many of these traditions may be harmless and some may be beneficial, but others can be damaging to both mother and infant. Many conflicts and misunderstandings in patient care are a direct result of the division between the values of the health care culture and those of the patient. This implies that acknowledging patient cultural differences and Utilising them to individualize health care would positively affect the patient's experience and response to pregnancy and childbirth.

Another major risk from cultural beliefs and stereotype was from the misconception that certain feelings and experiences were „normal' in pregnancy. But these stereotypes invariably had influence on pregnant women's health. In the main, majority of the women believed that swollen legs, vomiting, dizziness and others are usual occurrences during pregnancy. However, a few respondents with higher level of education and better

income report to their health care provider on noticing such abnormalities while pregnant. Lamentably, among the highly educated women, some still belief that these signs are normal to pregnancy. Maternal health complications can therefore be understood from this perspective.

Although these feelings can be said to be signs of pregnancy, a deeper look at this attitude reveals that most women are at risk. Swollen legs may be associated with preeclampsia/toxemia. Also, excessive vomiting can be Hyperemesis gravidarum, while dizziness is often a sign of ectopic pregnancy. Pregnant women who believe that these signs are normal tend to get themselves into complications that could have been controlled earlier (Ford-martin & Aron, 2013). This supported the findings by Chiwuzi, Braimoh, Unuigbe and Olumeko (1995), which emphasized the inability of women to recognize early warning signs even when clear evidence of danger existed.

This study also revealed that working conditions appear to affect healthcare facilities utilization. An examination on the nature of work, about nine (88.5%) out of ten of the pregnant women sampled work on full-time basis. Finding from data on the level of the relationship that existed between the co-workers and the pregnant women questioned showcased that 20.8% of them enjoy good relationship with their co-workers while the majority 79.2% viewed the relationship existing with their co-workers to be fair.

Housewives who were preoccupied with only house chores, for example, reported good maternal health (10.9%) and entrepreneurs or owners of establishment equally reported good maternal health (44.9%). Women in employment of private or government establishments who combined house chores with official assignments reported poorer maternal health (34.1%) when compared with other categories mentioned earlier. There are categories of jobs that posed more danger to pregnant women, for example marketers reported highest poor maternal health when compared to women that owned their businesses. Bankers, hawkers and casual workers reported poor maternal health. This may be attributable to the nature of their jobs and rigors involved in carrying out their

activities. The relationship with boss as a measure of role conflict is also a determinant of maternal health. Women who cited good relationship with their bosses reported good maternal health.

Furthermore, the finding from hypothesis revealed a significant influence of women's working conditions on maternal health. On the whole, the chi-square result ($\varkappa^2$ = 50.873 (0.010)) with the degree of freedom of 1 at 0.05 level of significance showcases that there is no association between women's work condition and the frequence of maternal health service utilization. Albeit, the correlation result R = 1.783 (0.182) depicted that there is relationship between women's work condition and the frequence of maternal health service utilization.

In the main, working has many health benefits especially for pregnant and nursing mothers, hazardous working conditions, particularly for those in manual or unskilled jobs, or less secure and low paid jobs can have adverse effects on maternal health. These can be direct hazards that arise from the physical environment or indirect hazards associated with job insecurity, low pay or limited access to pensions or career progression. Discrimination against pregnant women was reported to be prevalent in earlier studies and this represented a large portion of claims brought against employers by women. One of the major factors influencing women's labour force participation is economic necessity (Fadayomi, 1991). With their peculiar role in the family the tendency for them to be prone to maternal health challenges increases. This is largely due to a combination of factors such as lack of rest, excessive work and other forms of stress.

The combination of poorly planned cities, poor state of roads amidst rapidly increasing transportation and ineffective law enforcement contribute to the increasing burden of pregnant women's working conditions in Ekiti State. Working policies require early resumption to work. With the poor transport situation, a pregnant woman wakes up as early to avoid getting to the office late due to the unavailability of taxi or 'Okada'.

This research finding is corroborated by Mordi and Ojo (2011) finding on work life balance. The work suggested flexible working arrangement for workers. The emerging evidence underscores the need to pay more attention to pregnant women's working hours. Most women continue to go to work until the day of delivery. The respondents continue to work due to various reasons indicated on the table. Some enjoyed half salary during the period of maternity leave which they would like to avoid. To some, starting leave early means resuming early too after delivery. Although women expressed dissatisfaction with the working conditions in Ekiti State, they were less likely to report any intentions to stop working because they need the work for economic buoyancy and independence.

Working during pregnancy is not in and of itself a risk. But women around the world continue to face considerable maternity-related threats to their health and economic security. Women continue to face dismissal and discrimination in hiring on the basis of maternity. Workplace environments can pose hazards (e.g. exposure to pesticides, solvents and other chemicals); requirements of physically demanding work (e.g. heavy lifting); and irregular or long working hours: all can have potentially negative effects for the health of pregnant women and their fetuses, including greater risks of preeclampsia and hypertension, complications during pregnancy, miscarriage and stillbirth, fetal growth retardation, premature birth and other problems.

As stated by Salihu, Myers and August (2012), the importance of paid work in the lives of so many makes the quality of working conditions paramount to the reproductive health of women as well as men. Indeed, 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.

In addition, discrimination based on gender often passed on from generations by cultural stereotypes and economic, social and political norms has also multiple adverse consequences on access to maternal health. Gender discrimination at work, constraining

women's earning capacity, is particularly prejudicial. In general, standard working conditions presented little hazard to infant health; however, pregnancy could significantly impact a mother's psychosocial well-being in the workplace (Salihu, Myers and August, 2012).

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This study sought to examine implications of socio–cultural factors and utilisation of healthcare facilities on maternal mortality in urban areas of Ekiti-State, Nigeria. This chapter focuses on the summary of the whole work, conclusion and recommendations.

The study was designed to generate knowledge on the implication of socio-cultural factors on maternal health facility utilization. Both quantitative and qualitative research approaches were independently and complimentarily employed. These involved the use of structured questionnaire, key informant interviews and focus group discussions for data collection. The study population comprises women ages 15-49 years.

Descriptive and inferential statistical methods were used to analyze the quantitative data. The copies of the questionnaires retrieved were processed, and the data were analyzed for theme and relationship using the Statistical Package for Social Sciences (SPSS 22) software. First, the characteristics of the study sample were described using univariate analyses (frequency distributions and simple percentages) and the patterns of relationships were determined using cross tabulation.

The tapes and notes from the key informant interviews and case studies were analyzed and common responses were identified for each topic included in the interview guide. Responses to each topic were summarized and important quotations were reported verbatim to highlight individual's views

.

5.2 Summary of Findings

This study was carried out in all the 16 Local Government Areas of Ekiti State. The age characteristic revealed mean age of the women surveyed was 31 years. The youngest woman in the sample was 15 years while the oldest was 47 years old. The age distribution revealed that women continue childbearing until their late 40s. The distribution of the respondents by marital status shows that 32.3 % of the sampled women were without husband. 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, separated or divorcees. Education appeared as an important factor that precipitates the utilisation of healthcare facilities. Women without formal education appeared to attach cultural beliefs to healthcare usage, ignore or delayed antenatal while as level increases the probability of attending antenatal equally improved. While, ample of women engaged in petty trading, low income was associated with the utilisation of healthcare facilities.

The findings show a fair utilisation of healthcare facilities. However, women delay antenatal till the forth and above month of pregnancy or later. Other intervening factors, rather than just education and income might be significantly militating against maternal wellbeing that needs to be considered to ensure maternal health and prevent maternal death. There is ample evidence that the critical economic situation of women is a factor that has prevented a significant proportion of women from paying prompt and adequate attention to their health care during pregnancy. Most women rely on petty trading as their main source of income and would not attend to their health because of economic activities. On the other hand, low level of education affects the rationality and sensitivities of the women to the demand of pregnancy, thereby resulting in ineffective health decision. Therefore, women often face many socio-cultural hazards such as prohibition of some activities in pregnancy, taboos which sometimes induce morbidity or even death.

This research finding is in corroboration with what is in the literature that the precarious conditions and unsatisfied needs regarding the health of women are at the root of maternal health (Camarena and Lerner, 2005). There are some women, who live in social, cultural and institutional condition, where they have many opportunities to access education and have experienced gender and power equity relations but still experienced serious socio-cultural challenges. These women live in circumstances of weak reproductive health policy, where programmes are implemented with political and medical rationale, without taking into account the specific economic, social and cultural conditions and needs of the various populations or groups.

The association of cultural beliefs and stereotypes with maternal health utilisation was examined. The findings show that cultural beliefs and stereotypes affect healthcare service utilization. The beliefs and stereotypes of pregnancy significantly account for delay in healthcare service utilisation and frequency of hospital visits for self-reporting cases.

This study also investigates the influence of women working conditions on maternal health services usage. In the main, some of the working conditions were found to be negatively related to maternal health complications. This may be attributable to the nature of their jobs and rigours involved in carrying out their activities.

5.3 Conclusion

The study has been able to provide a strong relationship between socio-cultural factors and utilisation of healthcare facilities. From clear and meaningful understanding of the subject matter, the synthesis of Political Economic Theory and Healthcare Utilisation Model was employed in presenting the relationship between the dependent and independent variables.

Socio-economic and cultural beliefs of women have been identified as the most important predicators in the utilisation of healthcare facilities, which invariably dictate place of delivery. The study shows that respondents of low socio-economic status patronized TBAs and faith based organisations more frequently than government hospital. This indicates that more funds should be allocated to the health sector in order to improve the facilities and facility rendered.

The importance of patriarchal natures of virtually every developing country in which Nigeria is not an exception has also been reiterated by this study. The men initiate and control decision making in the household, the type of health facilities to be utilised, when and where to seek such facility is solely determined by the husband as the head of the family.

In all, the study has been able to reveal the importance of socio-cultural factors, socio-economic status of the women and community as well as how availability and accessibility affect the utilisation of healthcare facilities and has equally reinforced the need for the intensification of awareness that is geared toward attitudinal change for better health of the people and mothers at large.

This study has also revealed that socio-cultural factors of maternal health cluster together and are mutually reinforcing. Hence it has become problematic to attempt to develop a single description of the situation of women. It is imperative to also consider the two-way nature of many of the possible relations observed. For instance, despite the relatively massive emphasis and expansion of maternal health care services, maternal health challenges prevail. The complexity of the nature of maternal health means that solutions need to be equally complex. Maternal health complication does not just have one model of causes, so government's effort to reduce maternal mortality and morbidity must focus on the various dimensions of socio-cultural causes of maternal health complications. Understanding the influences is crucial to improving maternal health.

While urban environments provide many economic opportunities, they are also complex and intimidating social and physical environments. Because of the disruptive social circumstances, current medical interventions are not effective enough to reduce maternal mortality and morbidity. This is why the social, economic and cultural factors should be seen as an important source of complications requiring means/ways of intervention.

The study revealed the need for practical and sustainable development which could help push this country out of its plague of high maternal mortality rate as it is done in developed countries and the emerging middle-income countries around the globe. It was evident from the study that, the achievement of vision 20-20-20 would be a mirage if the current poor planning, poor infrastructure and basic amenities, growing poverty and deteriorating health outcomes are not forcefully and sustainably addressed.

The study successfully identified some of the critical aspects of maternal health complications in Ekiti State. The risk factors were identified and they include age, educational level, economic situation/status, cultural belief and stereotypes, working conditions and social supports. All these variables are significantly related to the well being of mothers during pregnancy. Furthermore, economic status of mothers, which is also, a function of education, was found to be one of the predictors of utilisation of healthcare facilities. This means that a woman who is highly educated does not face economic pressure and is better able to be on top of these social factors than a woman who is under economic pressure. The lesson that can therefore be drawn from this point is that if maternal health is to improve, operational intervention must be design for education, economic situation and other social circumstances of women. In this regard therefore, proper education, poverty reduction social infrastructural developments are germane to maternal health.

5.4 Recommendations

In light of the literature review and study evidence, in order to increase the level of healthcare utilisation facilities among pregnant women; reduce the rate of health mortality and achieve considerable improvement in the health and well being of Ekiti women, the following recommendations were made:

1. There should be adequate public enlightenment with the involvement of religious institution on the utilisation of healthcare facilities by the pregnant women. It is believe that this awareness would have long lasting effects on the attitude of people as a result of socio-cultural factors towards utilisation of healthcare facilities which invariably would reduce both maternal health morbidity and mortality.
2. The health system must be strengthened, equipped with adequate facilities so that they are able to offer a continuum care from conception, through pregnancy and delivery.
3. There should be general improvement in the socio-economic status of the population at large including availability of free and compulsory education up to at least secondary level.
4. There is need to provide a solid infrastructure for the provision of facility which is comprehensive, culturally sensitive and which respond to the needs of child bearing women and their family. Element of this infrastructure should include empowerment, training and development.
5. There is need for more training of traditional birth attendants (TBAs) to refer women with complication promptly. Attention must also be paid to the antenatal care facility with facilities for early detection of complication
6. Female education was associated with the utilisation of healthcare facilities. Educational levels of women need to be improved. In the sample studied, some of the women had either none or just primary education. Education affects healthcare facility utilisation by changing ideas about health and attitudes toward risk prevention by using the healthcare facility.

7. The fact that working conditions affect the level of healthcare facilities utilization, called for urgent policy intervention. Employers must realize that they have a social responsibility to address the issue of healthcare facilities utilisation by pregnant women. In particular, there should be targeted health policies toward maternal wellbeing during pregnancy in the working place. This could be developed in the light of urban poor infrastructure and the double pressure which the body experiences during pregnancy. Policies establishing flexible working hour for pregnant women, such as closing earlier than others to avoid the pressure on the road for them to have enough time to prepare and rest for the next day activities can be established.
8. Entrenchment of social security for pregnant women is quite essential for the improvement in maternal health. Apparent low standard of living during pregnancy due to economic crunch appeared to be an indication for engagement in tedious economic activities during pregnancy. This can result into irregular pattern of food intake necessary to sustain the body during pregnancy. Therefore, every effort must be in place to reduce effect of poverty. Improving living conditions in such areas as good road net work, provision of other infrastructure, income, housing, transportation, education, social support, and health services, would greatly impact on the wellbeing of pregnant women, thereby reducing the level of stress in raising the family economic status. Any attempt at establishing health sector reforms without first addressing the important issue of improving the state of the enabling factors for better health in a country is likely to be an unsuccessful attempt. Also, public assistance programmes, though not always sufficient, must be available for the pregnant women to augment their resource and encourage them to pay more attention to their health.
9. Many commonly held attitudes and behaviours, like husband's supportive role and other cultural beliefs that are inimical to healthcare utilisation should be addressed, which can be achieved through community-based programmes. Health promotion and education as a primary prevention approach would create opportunity for easier

communication, dealing with the dynamics of knowledge, power and decision making process in the family, as part of the effort to ensuring good health during pregnancy.

10. Since pregnant women believe in the efficacy of the services of the TBAs, the TBAs should be given more autonomy and assistance by the local, state, federal governments and even International health organization. All TBAs, regardless of status should be assisted by government in the provision of health equipment. The TBAs that have not been trained should be urged to participate in training programmes or activities, while they should continue to have government links. Funding the TBAs is important as they should be aware that they are not "illegal," and so that their work does not go underground and becomes dangerous.
11. Finally, there must be strong political would on the part of government at all levels that would help in reducing maternal mortality in Nigeria. Government at all levels should endeavour to provide antenatal care services for the pregnant women as stipulated by the World Health Organisation (WHO).

5.5: Contribution of the Study to Body of Knowledge

This study is an attempt to extend our knowledge and understanding of the socio-cultural factors that precipitate the utilisation of healthcare facilities as determinants for maternal mortality in Nigeria. The value of this research is anchored on its seeming simplicity, and it focuses on those factors that biomedical researchers have overlooked and which medical sociologists have discussed in a cursory fashion. The underlying premise of undertaking this study is the conviction that the overall effect of these "little foxes" is overwhelming and they significantly impact on maternal morbidity and mortality.

While this study acknowledges the importance of biological factors and health care utilisation in the reduction of maternal mortality and morbidity, the focus of the research

would help to chart a new understanding of maternal health within a socio-cultural framework.

This study adds to the body of knowledge, particularly in its application to pregnant women in the poor urban neighbourhoods.

1. The study has generated some pertinent questions regarding maternal health, which registered a new insight and direction to the body of literature. Such as;

a. What social factors precipitate medical risk factors that affect maternal health?

b. How does stereotype and working conditions influence maternal health complications?

2. The study revealed the maternal health circumstances in urban centre, and this enlightened the reader contrary to the expectation that all is rosy in urban health.

3. The study presented prospects for fundamental social, institutional and emotional support benefits for pregnant women. It revealed those unseen difficulties that women experience during pregnancy.

4. The study has also brought to the fore the connection between health and level of development and challenge the government on development issues.

5. The influences of biomedical model of health in bridging the gap in maternal health have been identified. Quick Emergency Obstetrics Care service intervention is very important to reduction in maternal mortality rate.

6. Finally, the study has provided data on socio–cultural factors and utilisation of healthcare facilities on maternal mortality in urban areas in Ekiti State and in Nigeria as a whole. This brought to the fore the intrigue influence of neglected seemingly trivial

factors that affect the health of the pregnant women which could be used for programme intervention.

References:

Abdul'Aziz, I. (2008) "Health-Nigeria: Little Progress on Maternal Mortality". Source:http://www.ipsnew.net/G:/health2/HEALth-NIGERIA.Retrieved August 9th, 2008.

Adamu, Y. M (2015) 'Causes and Determinants of Maternal Mortality in Kano State'. Ph. D Progress seminar paper presented to the Department of Geography, Bayero University Kano.

Addai, G.O. (2000) Spatial Aspects of Utilisation of Healthcare facilities in Lagos state, Nigeria. *International Journal of Academic Research*, 3(3): 222-227.

Addai, I. (2000) Determinant of Maternal-child health service in urban Ghana. In Journal of Biosocial Science 32: (1) 1-15

Adetoro, O.O. 2011. "Maternal mortality: A twelve year review at the University of Ilorin, Nigeria." International Journal of Gynaecology and Obstetrics 25: 93-99.

Adeyemi, E.O, Waziri, B.A, Atere, A.A and Amoo E. (2009) Economic Reforms, Living Conditions and Urban Violence: A Situation Analysis of Metropolitan Lagos. Ethiopian *Journal of Environmental Studies and Management* (EJESM); 2 (2): 1998-0507.

Afolabi J. F.. (2012). *Surveying the Social World: Principle and Practice in Survey Research.* Buckingham: Open University Press.

Ahmed, K.T., Ijadunola, M.Y., Esimai, O.A and Abiona, T.C. (2005). New paradigm old thinking: the case for emergency obstetric care in the prevention of maternal mortality in Nigeria. *BMC Women's Health* 2010, 10:6 http://www.biomedcentral.com/1472-6874/10/6

Aina, O.I. (2012) *Two Halves Make a Whole: Gender at the Crossroads of the Nigerian Development Agenda*. Inaugural Lecture Series 250. Ile-Ife: Obafemi Awolowo University.

Akande, T.M and Owoyemi, J. O. (2009) Healthcare Seeking Behaviour in Anyigba, North-Central, Nigeria. *Research Journal of Medical Sciences*, 3(2): 47-51.

Akintunde, D.O. (2006) Women as Healer: The Nigerian (Yoruba) Example. In Phiri, I.A. and Nadar, S. (Ed) *African Women, Religion, and Health: Essays in Honour of Mercy Amba EwudZiwa Uduyoye*. New York: Orbis Books Pg 157- 169.

Aladejana, E.O. (2009) The Impact of Urbanization on Housing Development: The Lagos Experience Nigeria. *Ethiopian Journal of environmental Studies and Management* 3(3): 64-74.

Amoo, E., and Adeyemi, E. (2010) Scanty Dressing Habit and Sexual Comportment among Adolescent Girls in Metropolitan Lagos: Implication for HIV/AIDS Incidence. *Gender and Behaviours* 18 (1): 1596-9231.

Andersen, R., Newman T (2005). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior, 36*, 1-10

Anderson, M.L and Taylor, H.F. 2002. Sociology: Understanding a Diverse Society. Belune may, Vao day coi co con nho nay ngon lan http: // gaigoibaucat. Xlphp.net.

Asakitikpi, A.E. (2007) An Interrogation of Diarrhoea Concept among Yoruba Women in Ibadan Metropolis, Nigeria. *Nordic Journal of African Studies*. 16 (1):64-74.

Asakitikpi, A.E. (2013) Risk Factors Influencing the Incidence of childhood Diarrhoea in Ibadan metropolis, Oyo State, Nigeria. Unpublish Ph.D Work. Ibadan: University of Ibadan.

Azimi, C and loffi, M. (2011) Association of Socioeconomic status with Health and Birth Outcomes: Maternal Variables. *International Journal of medicine and Medical Science* 3; 346-352. Source: http;//www.academicjournals.or/ijmms.

Babalola, S.O. (2013). Socio-Economic Factors, Conjugal Relations and Contraceptive use in Urban Ekiti State Nigeria. African Population Studies. UEPA, No. 8 pg 78-100.

Badru, F. I. (2003) Sociology of Health and Illness Relations. In Olurode, L and Soyombo, O (eds) *Sociology for Beginners.* Lagos: John West Publications, pp. 327-348.

Bankole S., Aziz-un, N. and Begun, I (2013). Analysis of Maternal Mortality in a Tertiary care Hospital to Determine Causes and Preventable Factors. Pakistan: *Ayuba medical College Abbottabad*, 15(2).

Bankole, A., Sedgh, G., Okonofua, F., Imarhiagbe, C., Hussain, R., and Wulf, D. 2013. Barriers to Safe Motherhood in Nigeria, New York: Guttmacher Institute

Basu, A.M. (2002) Women/Poverty and Demographic Change: Some Possible Interrelationship Over Time Space. In Brigida, G. (Ed) *Women, Poverty, and Demographic Change.* United State: Oxford University Press.

Baulch, B., Truong, C., Haugton, D., & Haughton, J. (2008). Ethnic minority development in Nigeria . *Journal of Development Studies, 43*, 1151-1176

Becker, S., Peters, D. H., Gray, R. H., Gultiano, C. and Blake, R. E. (2013) The determinants of use of maternal and child health services in Metro Cebu, the Philippines. Health Transition Review, 3, 77–89

Benerji, D. 1984. "The Political Economy of Western Medicine in Third World Countries", Issues in Political Economy of Healthcare John B, Mckinlay (ed) Tavistock Publications New York.

Ben-Joseph, E.P. (2013) "Medical Care During Pregnancy". *The Nemours Foundation.* From http://kidshealth.org/parent/pregnancy_newborn/index.html Retrieved August, 2008.

Berkman, L.F and Syme, S.L. (1979) Social Network, Host Resistance, and Mortality: A

Berkman, L.F and Syme, S.L. (2009) Social Network, Host Resistance, and Mortality: A nine-Year Follow-up of Alaned Country Residents. America Journal of Epidemiology, 109:186-204

Brigida, G. (2002) *Women, Poverty, and Demographic Change*. United State: Oxford University Press.

Campbell O, Gipson R, Issa A H. (2015). National maternal mortality ratio in Egypt halved between 1992-93 and 2000, Bull World Health Organ. 83: 462-471.

Carolan, M. (2010). Pregnancy health status of sub-saharan refugee women who have resettled in developed countries: A review of the literature. *Midwifery, 27*, 407-414

Chan, H. (2011) Addressing Maternal Mental Health Needs in Singapore. Psychiatric Services, 62(1).

Choté, A. A., Koopmans, G. T., Redekop, W. K., Groot, C. J., Hoefman, R. J., Jaddoe, V. W., & Foets, M. (2011). Explaining ethnic disparities in late antenatal care entry by predisposing, enabling and need factors in the Netherlands. The generation R study. *Maternal & Child Health, 15*, 689-699.

Diallo, H.E (1991) Menopause is The Good Old Women's Thoughts about Reproductive Aging. *Journal of Gender and Society*. 19, (3): 22-30.

Elo, I. T. (2012) Utilisation of Maternal Health-care Services in Peru: the Role of Women's Education. *Health Transition Review*, 2: 49-69.

Encyclopedia (2011) Pregnancy, Complication of Complete Human Diseases and Conditions. Source: http://www.encyclopedia.com/doc/. Retrieved September, 2010.

Encyclopedia of Mental Disorder (2009) Gender Issues in Mental Health. Source:www.minddisorders.com. Retrieved, October, 2011.

Erinosho, O. A. (1998) *Sociology for Medical, Nursing, and Allied Professions in Nigeria*. Nigeria: Bulwark Consult.

Fadayomi, T O. (1991) Women in the Nigerian Labour Force. *International Journal of Sociology of the Family*. 21:87- 98.

Fadeyi A. O. (2007) Determinants of Healthcare in Lagos, Nigeria. *Ife Social Sciences Review*. 22(1): 38-48.

Falkingham, J. (2003) Inequality and Changes in Women's Use of Maternal Health-Care Services. *Studies in Family Planning*, 34(1):32-43 http://www.jstor.org/stable/3181150. Retrieved May, 2008. Family Care International. (1991) The Challenge of Survival Safe Motherhood in the SADCC state, Family Care International and the World bank, New York.

Fatusi AO, Ijadunola KT. (2016). National Study on Essential Obstetric Care Facilities in Nigeria. Abuja, Federal Ministry of Health & United Nations Population Fund (UNFPA).

Fatusi, M. F. (2003) Impact of Family Planning on Health. In Senanayake, P and Kleinman, R (eds). *Family Planning: Meeting Challenges, Promoting Choices*. The Proceedings of The Internation Planned Parenthood Federation Family Planning Congress. New York: The Parthenon Publishing.

Federal Ministry of Health (2004) Revised National Health Policy, Nigeria. Ford-Martin, P and Aron, E.A. (2003) *The Every Thing Pregnancy Book* (2nd Edition). USA: F+W Publication. fields/2091.html

Federal Ministry of Health (FMOH) (2015).Road map for accelerating the attainment of the millennium development goals related to maternal and newborn health in Nigeria. Abuja, FMOH.

Feyisetan BJ and Bankole A, .2002. Fertility transition in Nigeria: trends and prospect, paper presented at the Expert Group Meeting on Completing the Fertility Transition, United Nations, New York, Mar. 11–14, 2002,

Fosu, G. B. (2014) Childhood morbidity and health services utilization: cross-national comparisons of user-related factors from DHS data. Social Science and Medicine, 38, 1209–1220.

Gabriel, M., Sohel, N., Do, T. T., Eriksson, L., & Persson, L.-A. (2010). Distance decay in delivery care utilisation associated with neonatal mortality: A case referent study in Northern Nigeria . *BMC Public Health, 10*, 762-771

Galadanci, J., Ejembi, M. and Umar, A. M. (2004) *Key Concepts in Medical Sociology*. London: Sage Publication.

Gavin, M.L. (2005) "Staying healthy during pregnancy". *Nemours Foundation Journal of Kids Health.* From http://kidshealth.org/parent Retrieved August, 2008.

George M., Igboanugo p, Caroline H. Martin D. (2011). What are Pregnant Women in a Urban Niger Delta Community's Perceptions of Conventional Maternity Service Provision? An Exploratory Qualitative Study. African Journal of Reproductive Health.

Goodburn E, Campbell O (2011). Reducing maternal mortality in the developing world: sector- wide approaches may be the key. BMJ322: 917-920.

Graczyk, K. (2013) "Adolescents Maternal Mortality: An Overlooked Crisis".From Advocates for youth. Source: http://www.advocatesfor youth.org/publication/

Hammersley, D. (2006). Safe motherhood programs: Options and Issues. New York: Columbia University, Centre for Population and Family Health

Harrison, K. 2005. "Survey of 22,774 consecutive hospital births in Zaria, Northern Nigeria." British Journal of Obstetrics and Gynaecology 5 (supplement): 3-118.

Hartfield, V.J. and M. Woodland. 2010. "Prevention of maternal mor- tality in a Nigerian village." International Journal of Gynaecology and Obstetrics 18: 150-152.

Henry, S. (2007) Diet for Healthy Pregnancy. Retrieved from: Blue Cross Blue Shield of Massachusetts site. www.healyme.com/topic/pregnancycenter. Retrieved August, 2008.

Houweling KA and John CT. .(2007). Maternal mortality in developing countries. *Lancet* 1996; 347(8998): 400

Ibrahim A. (2015). Health Nigeria: little progress on maternal mortality: net/news.asp?idnews=43379.

ICM (2012) The Safe Motherhood Initiative. Source: www.internationalmidwives.org/whatwedo/programmes/.Retrieved, November, 2011.

Idowu, A.E and Asakitikpi, A.E. (2008) Religion and the Quality of Maternal Health in Badagry, Lagos State. *Nigeria Sociological Review* 4(1&2): 129-140.

Idowu, A.E, Osinaike, M.O, and Ajayi, M.P. (2011) Maternal Health Challenges and Prospects for National Development: A Study of Badagry Lacal Government, Lagos State. *Gender and Behaviour*, 9(20: 4224-4246.

Idris, J. (2010) Lagos State Commissioner for Health. In The punch, „Maternal and Child Health Status in Nigeria is poor' Wednesday, May 26, 2010.

Igun, U. (1989) *Medical Sociology: An Introduction*. Ibadan: Shaneson.

IHME (2012) Institute for Health Metrics and Evaluation at University of Washinton. Source: http://www.who.int/entity/pmch/media. Retrieved, January, 2012.

Ijadunola, K.T. (2003) Support to the strengthening of EOC centersin Ekiti State. A report submitted to the Partnership for Transforming Health Systems (PATHS)/ DFID in Ekiti State and the Ekiti State Ministry of Health 2003

Ijadunola, K.T. (2004) Support to the strengthening of HEALTHCARE SERVICES centersin Ekiti State. A report submitted to the Partnership for Transforming Health Systems (PATHS)/ DFID in Ekiti State and the Ekiti State Ministry of Health 2004.

Ijadunola, K.T., Ijadunola, M.Y., Esimai, O.A and Abiona, T.C. (2010). New paradigm old thinking: the case for healthcare in the prevention of maternal mortality in Nigeria. BMC Women's Health 2010, 10:6 http://www.biomedcentral.com/1472-6874/10/6

ILO. (2010) Maternity Protection at Work: A key Human Right to Prevent Maternal Mortality and Morbidity. Source: www.ohchr.org/english/issues/women/docs/responses/ilo.

Isiugo-Abanihe, U. C. (2003) *Male Role and Responsibility in Fertility and Reproductive Health in Nigeria*. Ibadan: Center for Population Activities and Education for Development (CEPAED).

Iyaniwura C,Yussuf Q. (2011) Utilisation of antenatal care and delivery services in Sagamu,south western Nigeria.African journal of reproductive health, 13(3):111-122

Izugbara, C. O. and Ukwayi, J. K. (2004) An Intercept Study of Persons Attending Traditional Birth Homes in Urban Southeastern Nigeria. *Culture, Health & Sexuality*. 6 (2): 101-114. http://www.jstor.org/stable/4005334. Retrieved May, 2008.

Jegede, A. S. (2010) *African Culture and health*. Ibadan: BookWright Publishers.

Jegede, A.S. (1998) *African Culture and Health*. Ibadan: Stirling-Horden Publishers.

Jibo, U. (2004): The Beijing Challenge. News Watch Nigeria. www.newswatchngr.com. Retrieved, December 2010.

Khalid Y.T, (2016) 'Prevalence and associated factors for non utilisation of maternity care services in urban Kano State'. In Highland Medical Research Journal Vol.2 No.2: 29-36

Khama O.R. Oucho J. and Mwalali P. (2006) Maternal Mortality. In Jamison D.T, Feachim R.G, Makgoba M.W, Bos, E.R, Baingana F.K. Hofman K. J. and Rogo K. O. (Eds). *Disease and Mortality in Sub-saharan Africa*. The International Bank for Reconstruction and Development/ The World Bank: 223-236.

Kitts, J. and Roberts, J. H. (2016) The Health Gap: Beyond Pregnancy and Reproduction. Canada: The International Development Research Centre. United Nations Population Fund (2000) *State of the World Population: Lives Together, World Apart: men and Women in a Time of Change.* San Francisco: UN

Lanre-Abass, B. A. (2008) Poverty and maternal mortality in Nigeria: Towards a more viable Ethics of Modern Medical Practice. *International Journal for Equity in Health. Vol. 7* http://www.equityhealthj.com/content/7/1/11 . Retrieved August, 2008.

Lawan , T Sohel, N. C Eriksson, M & Persson., U, (2011). Ethnic inequity in neonatal survival: A case-referent study in Northern Nigeria . *Acta Pædoatric, 100*, 340-346

Lawn J.E, Cousens S, Zupan J. Lancet T.(2016). Neonatal Survival Steering Team. 4 million neonatal deaths: when? Where? Why? Lancet. 365:891–900.

Lawoyin, T.O., Lawoyin, O.O.C and Adewole, A.D. 2007. "Men's perception of Maternal Mortality in Nigeria." Journal of Public Health Policy. Vol. 28, 299-318.

Lawrence T. M. (2015). Determinants of antenatal care utilisation in three urban areas of Nigeria . *Public Health Nursing, 24*, 300-310

Lubbock L. A. and Stephenson R. B. (2008) Utilisation of Healthcare Services in the Department of Matagalpa, Nicaragua: *Rev Panam Salud Publica*. 24(2):75-84.

Lule, E., Ramana, G.N.V., Epp, J., Huntington, D. and Rosen, J. E. (2005) Achieving the Millennium Development Goal of Improving Maternal Health: Determinants, Interventions and Challenges. The International bank for Reconstruction and Development/ The World Bank: Health, Nutrition and Population (HNP) Discussion Paper.

M. (1994) *Counseling in Obstetrics and Gynaecology*. Leicester, UK: British Psychology Society.

Magadi, M. A., Madise, N. J., & Roddrigues, R. N. (2000). Frequency and timing of antenatal care in Kenya: Explaining the variations between women of different communities. *Social Sciences & Medicines, 51*, 551-561

Malin, M., & Gissler, M. (2009). Maternal care and birth outcomes among ethnic minority women in Findland. *BMC Public Health, 9*, 84-98

Mensah, F.A (2013) The Spiritual Basis of Health and Illness in Africa. In Falola, T and Heaton, M.M (Ed). *Health Knowledge and Belief Systems in Africa.* USA: Carolina Academic Press. pp 171-180.

Ministary of Economic Planning and Budget, Ekiti State, Nigeria. (2004) State of Ekiti Megacity and Other Nigeria Cities.

Mordi, c. and Ojo, S. (2011) Work-Life Balance Practices in The Banking Sector: Insights from Nigeria. *Ife PsychologiA*, 19(2): 285-295.

Mullany A, Becker D. B and Hindin R, (2007). Poverty, inequality and ethnic minorities in Nigeria . *International Review of Applied Economics, 25*, 249-282

Murray, C.J.L. and Lopez, A.D., 2016. The global burden of disease. Boston: Harvard School of Public Health.

National Bureau of Statistics, (2013) Nigeria and ICF Macro. Nigeria *Demographic and Health Survey, Abuja,*

National Mirror, March 23, 2012: 10. National Population Commission (2009) 2006 Population and Housing Census of the Federal Republic of Nigeria: Priority Tables.

National Population Commission [Nigeria] and ICF Macro 2009. Nigeria Demographic and Health Survey 2008. Abuja, Nigeria: National Population Commission and ICF Micro.

National Population Commission [Nigeria] and ICF Macro 2013. Nigeria Demographic and Health Survey 2008, South South Stateal Fact Sheet. Abuja, Nigeria: National Population Commission and ICF Micro.

National Population Commission and ORC Macro 2014.

Nigeria Ministry of Health. (2013). National standards and guideline for reproductive healthcare services. Abuja, Nigeria : Nigeria Ministry of Health

Nigeria Demographic and Health Survey 2013. Calverton, Maryland: National Population Commission and ORC Micro.

Nigeria. 2007. Multi-Indicator Cluster Survey. National Bureau of Statistics, Abuja Nigeria Demographic and Health Survey- NDHS (2013). National Population Commission, Abuja

NISER (2008) *Mid-Point Assessmnet of Millennium Development Goals in Nigeria*. Ibadan: Nigeria Institute of Social and Economic Research.

Nwabueze, N. (2003) Social Institution: Health. In Olurode, L and Soyombo, O (eds) (2003) *Sociology for Beginners.* Lagos: John West Publications, 192-196.

Obono, (2003) Culture, Healthcare and Women's Status: a Comparison of Morocco and Tunisia. Studies in Family Planning, 24: 354-365.

Odebiyi T. O. (1989) Decent Work and the Millennium Development Goals. Source: http://www.ilo.org/public/english/bureau/pardev/mdg. Retrieved, January, 2012.

Ogbonnaya, R. and Olawale, T. (2008) Nigeria: Maternal Mortality - Saving Urban Women. This Day (Lagos) http://allafrica.com/stories/. Retrieved August 9th, 2008.

Ogbu, M. and Agu (2009). Utilisation of skilled birth attendants in public and private sectors in Nigeria. *Bio Social Sciences, 20*, 289-309

Ogbuagu, S. C. (2004) *Gender, Population and Environment Issues.* Owerri: Ark Publisher

Ogunbameru, O.A. (2008) Sociological Theory. Ibadan: Penthouse Publications.

Ogunniyi, S.O. and B.L. Faleyimu. 2010. "Trends in maternal deaths in Ilesha, Nigeria, 1977-1988." West African Journal of Medicine 10: 100- 104.

Okafor, U. V., Efetie, E. R., and Ekumankama, O. (2009) Eclampsia and Variation in the Tropics: A study in Nigeria. *The Pan African Medical Journal*, 2 (7).

Okemgbo, C. N., Kutey, D. and Odimegwu, C. (2005) Gender Role Ideology and Prevalence of Violence Against Women in Imo State, Nigeria. Journal of Sociology, 2(1): 24-54.

Okonofua, F. Bankole, Sedgh, Imarhiagbe, Hussain, and Wulf, (2013) *Maternal and Child Health in Nigeria.* A paper Presented at Nigerian Medical Research (NIMR)

Okonofua, F.E. (2010) Reducing Maternal Mortality in Nigeria: An Approach through Policy Research and Capacity Building. African Journal of Reproductive Health, 14(3): 9-13.

Oluwadare C T. (2014). "Socio-cultural and Norms Factors Influencing Family Planning among Couples in Ibadan Metropolis, Nigeria." *European Journal of Scientific Research* Vol.23 No.2 (2008), pp.212-218

Omideyi, A. K. (1990) Women's position, conjugal relationships and fertility behaviour among the Yoruba. *African Population Studies.* UEPA, 4: 21-28.

Omideyi, A. K. (2016) Women's position, conjugal relationships and fertility behaviour among the Yoruba. African Population Studies. UEPA, 4: 21-28.

Orobuloye, I.O and Oni, J.B. (1996) Health Transition Research in Nigeria in the Era of the Structural Adjustment Programme. *Health Transition Review,* 6; 301-324.

Orubuloye, O. I. and Ajakaye, D. O. (2002) *Health Seeking Behaviour in Nigeria*. Ibadan: Nigerian Institute of Social and Economic Research (NISER).

Osungbade, K. O and Ige, O. K. (2011) Public Healrth Perspectives of Preeclampsia in Developing countries: Implication for health system Strengthening. *Journal of Pregnancy,* 2011, Article ID 481095, 6b pages.

Osungbade, K.O and Olusimbo,K. I. (2013). Public Health Perspectives of Preeclampsia in Developing Countries:Implication for Health System Strengthening. *Journal of pregnancy,*:.2011, acticle ID 481095. Source: http://hindaw.com/journal/jp/2011. Retrived December, 2014.

Otite, O. and Ogionwo, W. (2006) *An Introduction to Sociological Studies*. Ibadan: Heinemann Educational Books.

Owoseni, J.S, & Owumi B.E, (2012) Factors Influencing Utilisation Of Traditional Birth Attendants' Services By Pregnant Women And Nursing Mothers In Ikole LGA of Ekiti State, Nigeria. Journal of Health and Social Issues 5(1). 2012 52-70 Ado Ekiti

Owumi, B.E. 2002. "The Political Economy of Maternal and Child Health in Africa", In: Currents and perspectives in Sociology, edited by Isiugo-Abanihe, U.C. Isamah, A.N and Adesina, J.O. Malthouse Press Limited, P.O. Box 500, Ikeja, Lagos State, Nigeria.

Population Reference Bureau (2002). World Population Data Sheets. Washington: Population Reference Bureau.

Population Reference Bureau (2010). World Population Data Sheets. Washington: Population Reference Bureau.

Population Reference Bureau, (2013). Field-Friendly Guide to Integrate Emergency Obstetric Care in Humanitarian Programs. Women's Commission for Refugee Women and Children on behalf of the Reproductive Health Research Conflict Consortium

Population Reference Bureau. (2010) *World Population Data Sheets*.Washington: United Nation Economic Commission for Africa

Quick, J, Greenlick, M., and Roghmann K. (1981) Prenatal Care and Pregnancy Outcome in HMO and General Population: A Multivariate Cohort Analysis. *Am J Publ Hlth*, 71: 381-390.

Radio Lagos (2009) HealthCare: Lagos State would curb Maternal Mortality. Source: http://www.radiolagosekofm.net/ retrieved October 2010.

Raghupathy, S.E. (1996) Education and the Use of Healthcare in Thailand. *Social Science Medical*, 43: 459-471.

Raju, H. (2000) *From their Own Perspective: Perceptions of Women about Modern and Natural/Traditional Methods of Contraception in Koforiduape and Asokore in the Eastern State of Ghana*. A Research Paper in University of Science and Technology, Troudheim.

Ribeiro E. RO, Guimaraes A. M. DN, Bettiol H., Lima D. DF, Almeida M. L. D, Souza L., Augusto A., Silva M., & Gurgel R. (2015). Risk factors for inadequate prenatal care used in the metropolitan area of Aracaju, Northeast Brazil. *BMC Pregnancy and Childbirth, 9*, 9-31

Ritzer, G. (2008) *Modern Sociological Theory*. New York: Mcgraw-Hill. Rosenfield, S. (1999) Gender and Mental Health: Do Women Have More Psychopathology, Men More, or Both the Same (and Why)? In *A Handbook for the Study of Mental Health,* edited by Allan V. Horwitz and Teresa L. Scheid. New York: Cambridge University Press.

Rosenstock, 1974. "The Health Belief Model and Preventive Health Model", In: The Health Belief Model and Personal Health Behaviour. Marshal Backer, Charles. R. Stalker in New Jersey. Digest of Current Information

Routledge. Mulder, E.J.H., Robles de Madina, P.G., Huizink, H.C., Van den Bergh, B.R.H., Buitelar, J. K. and Visser, G.H.A. (2010) Prenatal Maternal Stress: Effect on Pregnancy and the (Unborn) Child. *ELSEVIER, Early Human Development*; 70:3-14. National Mirror (2012) High Maternal, Infant Mortality Worry Nigerian Government.

Rutenberg, T.S and Watkins M. (1997) Safe Motherhood Initiatives Critical Issues. Preventing Maternal Mortality: Evidence, Resources, Leadership, Action. London: Black Well Science.

Say, L., & Raine, R. (2007). A systematic review of inequalities in the use of healthcare in developing countries: Examining the scale of the problem and the importance of context. *Bullentin of the World Health Orgnization, 85*, 812- 830

Schetter, D. and Tanner, L. (2012) Anxiety, Depression and Stress in Pregnancy: Implications for Mothers, Children, Research, and Practice. *Co.psychiatry*; 25(2) 141-172.

Schieman, S., McBrier, D. B. and Gundy, K. V. (2003) Home-to-Work Conflict, Work Qualities, and Emotional Distress. Sociological Forum, 18 (1): 137-164.

Sepehri, A., Sarma, S., Simpson, W., & Moshiri, S. (2008). How important are individual, household and commune characteristics in explaining utilisation of healthcare facilities in Vietnam. *Social Sciences & Medicine, 67*, 1009-1017

Seye T. Y &. abimo 1966. *Health Orientation and Medical Care.* Am J Public Health 56:97-105, January 1966.

Seye T. Y. & Abimbola, E.U. (2012) Reducing the Pressure on Lagos State. PM News June 20, 2011. Source: http://pmnewsnigeria.com/2011/06/20. Retrieved August 2011.

Simkhada, B., Teijlingen, R. v., Porter, M., & Simkhada, P. (2007). Factors affecting the utilisation of antenatal care in developing countries: Systematic review of the literature. *Journal of Advanced Nursing, 61*, 244-260

Simon, S. (2014) Social Support and Social Cohesion', in Marmot, M. and Wilkinson, R (eds), Social Determinants of Health. Oxford: Oxford University Press.

Stanton, C., Blanch, A., Croft, T., & Choi, Y. (2014). Skilled care at birth in the developing world: Progress to date and strategies for expanding coverage. *Bio Social Sciences, 39*, 109-120

Stephenson, R., Koenig, M.A, Acharya, R. and Roy, T.K. (2008) Domestic Violence, Contraceptive Use, and Unwanted pregnancy in Urban India. *Studies in Family Planning*, 39(3) 177-186.

Stephenson, R., Koenig, M.A, Acharya, R. and Roy, T.K. (2008) Domestic Violence, Contraceptive Use, and Unwanted pregnancy in Urban India. Studies in Family Planning, 39(3) 177-186.

Stock R: Distance and utilisation of health facilities in urban Nigeria. Social Science and Medicine 1983;17(9):563-70.

Stock, R. and Anyinam, C. 1992. "National Government and Health Service Policies In Africa." The Political Economy of Health in Africa, Falola, T and Ityavyar, D. (eds) Ohio University Centre for International Studies.

Stroebe, W. (2000) Social Psychology and Health (Second Edition). Buckingham: Open University

Ufford, J. and Menkiti, M. (2001) Delivery Care Is Key for Maternal Survival: a Story of Two States in Nigeria Source: Population Reference Bureau. http:prb.org/Articles/2001/. Retrieved August, 2008.

Ugabi, I.A.O. and Awa, I.S. (2010) *Postpartum Hemorrhage and Maternal mortality in Nigeria.* Sapiens Publishing Source: www.sapienspublishing.com/pph

Ukoro, C. (2011) Alimosho Model City plan Anticipates Increased Investment. Business Day: News paper. Source: http://businessdayonline.com. Retrieved, March 2012.

UNFPA (1995) Programme of Action; Adopted at the International Conference on Population and Development. 5-13 September 1994. Source: http://www.unfpa.org/poblic/pulications/rid/. Retrieved, January, 2012.

UNFPA (2000) *State of World population 2000: Lives Together, World Apart, Men and Women in a Time of Change*. San Francisco: UN.

UNFPA (2005) *State of World Population 2005: The Promise of Equality.* San Francisco: UN.

UNFPA (2005) Women and HIV/AIDS: Confronting the crisis. A Joint Report by UNAIDS/UNFPA/UNIFEM. Source: http://www.unfpa.org/hiv/women/report

UNFPA (2013) The Role of Traditional/Religious Leaders on Reduction of Maternal Mortality and survival of women. UNFPA: Nigeria. Source: www.nigeria.unfpa.org.

UNFPA, WHO, UNFPA (2014). Nigeria: 52, 000 Women Die Yearly, 145 Daily. Retrieved January 6, 2009 from http://allafrica.com/stories/ 200812120244.

UNICEF (2008) Monitoring the Situation of Children and Women. Source: http://www.childinfo.org/maternal_mortality. Retrieved August, 2010.

UNICEF (2009) The State of the World's Children 2009: Maternal and New born Health. Source: www.unicef.org/protection/sowco9.

UNICEF (2010) At a Glance: Nigeria. Source: http://www.unicef.org/info/country/nigeria.

UNICEF (2011) At a glance: Singapore. Source: www.unicef.org/infobycountr/singapore.

UNICEF (2013). Nigeria: 52, 000 Women Die Yearly, 145 Daily. Retrieved January 6, 2009 from http://allafrica.com/stories/ 200812120244.

UNIFEM (2000) *Gender and Development: An Information Kit*. United Nations Development Fund for Women. Source: www.siyanda.org.

United Nation Children's Fund, World Health Organization, World Bank, United Nation DESA/Population Division. (2011). *Levels and trends in child mortality report: Estimates developed by UN inter-agency group for child mortality estimation. Report 2011*. United Nation Children's Fund

United Nation Children's Fund, World Health Organization, World Bank, United Nation DESA/Population Division. (2010). *Levels and trends in child mortality report: Estimates developed by UN inter-agency group for child mortality estimation. Report 2010*. United Nation Children's Fund

United Nations (1991) The World's Women: The Trends and Statistics 1970-1990.

United Nations (1994) Report of the International Conference on Population and Development, Cairo.

United Nations (2016) *Reproductive Rights and Reproductive Health: A concise Report*. New York: Department for Economic and Social Information and policy Analysis.

United Nations Economic Commission for Africa (2005). The Mellennium Development Goals in Africa: Progress and Challenges. Source: www.uneca.org/mdgs/mdgsin africa. Retrieved, January, 2012.

United Nations Population Fund (2012). State of Nigerian Population.

United Nations Population Information Network (POPIN) (2004) Report of the International Conference on Population and Development, Cairo. Source: http://www.un.org/popin/icpd/conference.

USAID (2006) USAID's Family Planning Service. *Family Planning*. http://www.usaid.gov/our_work/global_health/pop/news/issue_briefs/fpservices.html Retrieved September, 2008.

USAID (2009) MNPI- Maternal and Neonatal Program Effort Index. A Tool for Maternal Health Advocates. Source: http://www.usaid.gov/our-work/global-health/.

Walle, D., & Gunewardena, D. (2001). Souces of ethnic inequality in Vietnam. *Journal of Development Economics, 65*, 177-207.

Warner R. (2008). Applied Statistics: *From bivariate to multivariate techniques*. California, United States of America: Sage Publications

Webster (2011) Common Expressions: Obstetrics Hemorrhage. Source: http://websters-online-dictionary.org/. Retrieved, October, 2011.

WHO (2006) Reproductive Health Indicator: Guidelines for their Generation, Interpretation and Analysis for Global monitoring. Source: www.searo.who.int/linkfiles/publication

WHO (2007) Maternal Mortality in 2005; Estimates Developed by WHO, UNICEF, UNFPA and The World Bank.

WHO (2008) Closing the Gap in a Generation: Health Equity through Action and the Social Determinants of Health. Geneva: http://whqlibdoc.who.int/publications /9789241563703. Retrieved, March 2012.

WHO (2011) Maternal Health Source: www.who.int/topics/maternal_health/en/. Retrieved March, 2011.

WHO (2012) Reproductive Health Indicator: Guidelines for their Generation, Interpretation and Analysis for Global monitoring.

WHO (World Health Organization), (2010). Monitoring of emergency obstetric care: a Handbook

WHO and ICM. (2008) *Education Material for Teachers of Midwifery: Managing Puerperal Sepsis*. World Health Organization and International Conference of Midwifes.

WHO, (2015). Legal status traditional medicine and complementary/Alternative medicine: A world review, Geneva: WHO

WHO, UNFPA, UNICEF and the World Bank (2015). Maternal Mortality in 2005: Estimates Developed By, Geneva

Wikipedia, (2010) Maternal Death. http://en.wikipedia.org/wiki/maternal_death. Retrieved August, 2010

Wouldiams, J. (2006) Learning from Mothers: How Myths, Policies and Practices Affect the Detection of Subtle Developmental Problems in Children. *Child: Care, Health And Development.*33 (3): 282-290.

World Bank (2011) *World Development Indicators*. USA: Washington, D.C. World Health Organization (2009) *Managing Puerperal Sepsis*. Geneva Switzerland: WHO press.

World Bank (2014), Health Systems Development Project II, Washington, DC: World Bank

World Health Organization (2001). WHO antenatal care randomized trial for the evaluation of a new model of routine antenatal care. *The Lancet, 357*, 1551-1564

World Health Organization (2006). Neonatal and perinatal mortality: Country, stateal, and global estimates. *World Health Organization,* 1-59

World Health Organization (2013). World Statistics Quarterly Report Trimestriel, vol.44(3) Geneva, WHO

World Health Organization (WHO) (2007). Standards for maternal and neonatal care. Geneva: WHO; 2007.World Health Organization. (2014). Method of delivery and pregnancy outcomes in Asia: the Who global survey on maternal and perinatal health 2010-2012. *The Lancet, 12*, 1-10

World Health Organization, (2008) Making Pregnancy Safer: Maternal Mortality and Morbidity Case Review. Retrieved from; http//www.euro.who.int/infopages. August, 2008.

World Health Organization, (2011). *World health statistics – world health statistics indicators*. World Health Organization

World Health Organization, (2015). *World health statistics – world health statistics indicators*. World Health Organization

World Health Organization. (2003). Antenatal care in developing countries. Promises, achievements and missed opportunities: An analysis of trends, levels, and differentials. *World Health Orgnization*, 1-30.

World Health Statistics (2006) http://www.who.int/whosis/en/ Country Health System Fact Sheet Nigeria Retrieved May, 2008.

Appendix I

Questionnaire

My name is OWOSENI, Joseph Sina, a student of the Department of Sociology, University of Ilorin. As part of the requirements for the award of a PhD degree, I am conducting a study on '**Implications of Socio–Cultural Factors and Utilisation of Healthcare Facilities on Maternal Mortality in Urban areas of Ekiti-State, Nigeria'**. Your consent and cooperation are highly solicited. Your responses would be used for academic purposes only and treated with the utmost confidentiality. Thank you.

SECTION ONE: SOCIO-DEMOGRAPHIC CHARACTERISTICS
INSTRUCTION: Tick corresponding codes to your choice of answer, provide answers to the open ended questions and where necessary, tick or provide multiple answers.

S/N	Question	Responses	Codes
1.	How old are you now?	……. In Years	
2.	What local government do you belong?		
3.	How long have you staying in the town?	Length in Years…….	
4.	Where were you born?	Place of birth…….	
5.	What ethnic group do you belong?	Yoruba Hausa/Fulani Igbo Other (specify)……	1 2 3 4 5
6.	What religion do you practice?	Christianity Muslim Traditional belief Other (specify)…….	1 2 3 4
7.	What is your marital status?	Single Married Separated Divorced Widowed Co-habiting	1 2 3 4 5 6
8.	What is your highest level of education completed?	No formal education Some primary Completed primary Some secondary Completed secondary OND/NCE HND/BSC Other (specify)……....	1 2 3 4 5 6 7 8
9.	Which one of these describes your occupational status?	Full-Housewife Employer	1 2

		Small private business Professional (Teacher, nurse) Government Employee Unemployed Large private business (banks, others) Manufacturing firm Student Other (specify)	3 4 5 6 7 8 9 10
10.	What is your total monthly income from your occupation?		
11.	Do you have other source(s) of income?	Yes (If Yes specify……. No	1 2

SECTION TWO: REPRODUCTIVE AND DELIVERY HISTORY

INSTRUCTION: Tick corresponding codes to your choice of answer, provide answers to the open ended questions and where necessary, tick or provide multiple answers.

S/N	**Questions**	**Responses**	**Codes**
12.	For how long have you been married?		.
13.	How old were you when you married?		
14.	Apart from you, does your husband have another wife?	Yes. No	1 2
15.	What is your position among your husband's wife?	First wife Second Third Other (specify)…….	1 2 3 4
16.	What is your husband's occupation?		
17.	Have you ever had a child?	Yes No (If No, skip Question 18-22)	1 2
18.	How many children do you have?	How many males…….. How many females……	
19.	Are they all alive today?	Yes No	1 2
20.	How was the last child delivered?	Normal delivery Caesarean section/operation Others (specify)…….	1 2 3

21.	Where did you deliver the child?	Federal Teaching hospital State Teaching hospital Government General hospital Government Health Care Centre Private hospital Traditional Birth Attendants house Faith Based Clinic At home Others (specify)	1 2 3 4 5 6 7 8 9
22.	What is the reason(s) for your preferred place of delivery?	Low cost Good service Convenience Suggested by others Others (specify ……	1 2 3 4 5

SECTION THREE: LEVEL OF HEALTHCARE FACILITIES UTILISATION AND MATERNAL MORTALITY AMONG PREGNANT WOMEN IN URBAN AREAS

INSTRUCTION: Tick corresponding codes to your choice of answer, provide answers to the open ended questions and where necessary, tick or provide multiple answers.

S/N	**Questions**	**Responses**	**Codes**
23.	Did you go for antenatal care when you were pregnant?	Yes No	1 2
24.	If yes, where did you have your antenatal care? (tick as many as applicable)	Health clinic Traditional Birth Attendants Spiritual home Chemist/medicine store Home /self	1 2 3 4 5
25.	And if No to question **24**, why?	No money Non availability of health centre Inadequate care in health centres There is no need for it Other, please specify…….	1 2 3 4 5
26.	Do you know of any women in the community who died in pregnancy, during childbirth or shortly after birth?	Yes No	1 2
27.	If yes, How old was she?	15 – 29 30 – 39 40 and above	1 2 3

28.	If death occurred at home why was she not taken to hospital/health centre?	No money Lack of someone to take her to hospital Delay in referral No transport facility Poor road network I don't know	1 2 3 4 5 6
29.	Who attended to the woman at home?	TBA Relations Other (specify)…….	1 2 3
30.	If death occurred in hospital/maternity, how long was the woman in labour before being taken there?	Minutes Hours Days	1 2 3
31.	What do you think was the main cause(s) of the death?	(i) Spontaneous abortion (ii) Induced abortion (iii) Ante-partum hemorrhage (iv) Hemorrhage after delivery (v) Retained placenta (vi) Ruptured uterus (vii) Infection (viii) Tetanus (ix) Yellow eyes (hepatitis) (x) Witchcraft	1 2 3 4 5 6 7 8 9 10

SECTION FOUR: SOCIO-CULTURAL FACTORS THAT INFLUENCE UTILISATION OF PROXIMATE HEALTHCARE FACILITIES

Instruction: tick corresponding codes to your choice of answer, provide answers to the open ended questions and where necessary, tick or provide multiple answers.

S/N	Questions	Responses	Codes
32.	When you fall sick, where do you usually go for treatment?	General hospital/health center Traditional birth attendants/clinic Private hospital Church Self medication Other (specify)……	1 2 3 4 5 6
33.	Who decide where you go to seek treatment?	Husband Me Joint decision Friends or family members	1 2 3 4

34.	Who provides the finance for your treatment?	Husband Me Both	1 2 3
35.	Why do you prefer your place of treatment?	Close proximity Quality of service Affordable cost Other (specify)…….	1 2 3 4
36.	How frequently do you use this service?	Daily or as much as required Once a week Twice a week Thrice a week Weekly Every two weeks Every month	1 2 3 4 5 6 7
37.	What are the supportive roles your husband could have performed during the period?	……. …….	
38.	Did you at any point in time single handedly take a decision about place and type of treatment when sick?	Yes No	1 2
39.	Have you ever experienced any complication since you have been Utilising the facility?	Yes……. No……..	1 2
40.	How can you describe the attitude of the health workers in managing complication?	Bad…… Fair……. Good……. No comment……	1 2 3 4
41.	What can you say about the quality of services rendered by the health clinic?	Bad…… Fair……. Good……. No comment……	
42.	Where did you deliver your first child if any?	At home…… At the TBA centre……. At Maternity centre……. At a Mission house…… At an Herbalist home……. At an Alfa home…….. Others Specify……..	1 2 3 4 5 6 7
43.	Why do you prefer visiting the health facility?	Services are affordable…….. Spiritual reasons…… Saves time…… Cultural reasons…… Other Specify…….	1 2 3 4 5
44.	Do you attend TBAs apart from healthcare centres?	Yes…… No…….	1 2

45.	If Yes, Why do you attend TBAs?	Services are affordable…….. Spiritual reasons…… Saves time…… Cultural reasons…… Other Specify…….	1 2 3 4 5

46. In your community, are there any of the following traditional prohibition(s) or prescription(s) or restriction(s) practice(s) for women when they are pregnant?

Nature of Traditional practice(s)	**Type**	**Advice Given**	**Reasons for Prohibition**
Food/Drinks prohibited/prescribed	…… …… ……	…… …… ……	…… …… ……
Activities Prohibited/prescribed	…… …… ……	…… …… ……	…… …… ……
Medicines Prohibited/prescribed	…… …… ……	…… …… ……	…… …… ……
Festivals Prohibited/prescribed	…… …… ……	…… …… ……	…… …… ……
Other beliefs	…… …… ……	…… …… ……	…… …… ……

47.	When women are in labour or develop complication(s), can they violate the prohibition relating festival(s) to seek treatment?	Yes No	1 2
48.	What is/are the consequence(s) of violating such prohibition?	…… …… …… ……	

SECTION FIVE: STEREOTYPES ASSOCIATED WITH MATERNAL HEALTH SERVICE UTILISATION ON MATERNAL MORTALITY IN URBAN EKITI

Instruction: Tick corresponding codes to your choice of answer, provide answers to the open ended Questions and where necessary, tick or provide multiple answers.

49.	Do you share the same room with your husband during pregnancy?	Yes No	1 2
50.	Does your husband normally help you with the house chores when you are pregnant?	Yes No	1 2

51.	Before you became pregnant, what agreement did you have with your husband?	My partner and I agreed that I should be pregnant. We never discussed having children together	1 2
52.	During your last pregnancy, did your husband, mother in-law/relative come to give you support?	Yes No	1 2
53.	During your last pregnancy, did you have someone you could turn to if you needed someone to comfort or listen to you?	Yes No	1 2
54.	What are those feelings/conditions that you think are normal to experience during pregnancy? Tick as many as applicable	1) Swollen leg 2) Dizziness 3) Fatigue 4) Other, please specify ……	1 2 3 4

SECTION SIX: WOMEN'S WORKING CONDITIONS

Instruction: tick corresponding codes to your choice of answer, provide answers to the open ended questions and where necessary, tick or provide multiple answers.

55.	What is the nature of your work		
56.	What is your position in your place of work?	....	
57.	How is your relationship with your co-workers?	Good Fair Not good Not Applicable	1 2 3
58.	How far is your place of work from where you live, in k/m?		1
59.	How long does it take on the average, to get to your place of work?	Less 10 minutes 10-20 minutes 21 -30 minutes More than 30 minutes Not Applicable	1 2 3 4
60.	What is your means of transportation to your place of work?	Official/private car Public transport Okada Trekking Other …… Not Applicable	1 2 3 4 5

61.	At what stage of pregnancy do you apply/stop going to work for maternity leave?	1-2 weeks to delivery A month Delivered and sent application letter Other ……	1 2 3 4
62.	How long does your maternity leave last?	1 month 2 months 3 months Other (please specify) ……	1 2 3 4

SECTION SEVEN: EFFECTIVENESS OF THE STATE GOVERNMENT'S ROLE IN THE DISTRIBUTION OF HEALTHCARE FACILITIES IN URBAN EKITI.

Instruction: tick corresponding codes to your choice of answer, provide answers to the open ended
questions and where necessary, tick or provide multiple answers.

63.	Do you think Ekiti state government has influenced the quality of maternal health service in this community?	Yes No	1 2
64.	Is the Health Care Service Effective to the Community	Very effective Effective Less effective Not effective Don't know	1 2 3 4 5
65.	Means of transportation to health centre	Trekking Okada Taxi Others, Pls Specify ……..	1 2 3 4
66.	Are health workers accessible?	Yes No	1 2
67.	How has been the role of the state government in the distribution of healthcare facilities in your LGA?	Good Fair Not good	1 2 3
68.	In what area(s) do you think there have been short falls from the Ekiti state government's contributions to healthcare facilities?	....	
69.	Does the state government make drugs available at affordable rate?	Yes No	1 2

70.	What do you think should be done to improve the health quality?	Employment of qualified health Personnel Adequate supply of drugs Free Health Care Service Provision of infrastructural facilities	1 2 3 4 5
71.	In general, how is your health	Excellent Good Average Poor	1 2 3 4

Appendix II

KEY INFORMANT INTERVIEW GUIDE (For Medical Practitioners)

My name is OWOSENI, Joseph Sina, a student of the Department of Sociology, University of Ilorin. As part of the requirements for the award of a PhD degree, I am conducting a study on '**Implications of Socio–Cultural Factors and Utilisation of Healthcare Facilities on Maternal Mortality in Urban areas of Ekiti-State, Nigeria'**. Your consent and cooperation are highly solicited. Your responses would be used for academic purposes only and treated with the utmost confidentiality.

Thank you.

1. What is your specialization?
2. What common pregnancy related complications do you handle?
3. Which of these problems that you mentioned would you say is commonly reported in this clinic/hospital?
4. What are the causes of these complications?
5. Why are women susceptible to these complications?
6. How would you describe the characteristics of those who are suffering from these complications?
7. How can we reduce women susceptibility to these complications?

Appendix III

KEY INFORMANT INTERVIEW GUIDE (For Women Ages 15-49)

- **Introduction** , explanation of the purpose of the study
- Explain that the tape recorder would be needed but, that the information would be kept confidential and used only for the study.
- There are no right and wrong answers.
- Drop the unit about incentives for the participants.
- Thank the respondent for her time.

Pregnancy Experience

- At what age did you get married?
- Can you please tell me what life is like as a pregnant woman?
- How many children do you have?
- Have you had any miscarriage?
- Why?
- Did you go for antenatal?
- Where did you go to? And why?
- Where did you give birth?
- What type of health challenge do you normally have during pregnancy?
- And what do you do to treat yourself?

Working Experience

- In your working place, are you permitted to go for ante natal clinic?
- Do you still resume and close the same time?
- Is there any other policy that is gear toward save pregnancy in your organization?

Social-cultural Support

- Did your husband/partner support you?
- How?

- Can you tell your husband/partner how you are feeling or what you need when you are pregnant?
- How does your belief influence what you do when you are pregnant?
- What are the cultural/ traditional practices you are to observe during pregnancy?
- What are the foods you are to or not to eat when you are pregnant?
- What role do extended family members play in your home (when you are pregnant)?
- Do your in-laws influence what happen in your home concerning your health?

Stereotypes

- ✓ When you are not pregnant, what is your typical daily routine like?
- ✓ When you are pregnant, what is your typical daily routine like? (follow up questions of why, how, when etc)
- ✓ When you are not pregnant, what is your typical regular food menu?
- ✓ When you are pregnant, what is your typical regular food menu?

Appendix IV

UNIVERSITY OF ILORIN, ILORIN, NIGERIA.

UNVERSITY ETHICAL REVIEW COMMITTEE

Vice-Chancellor: Prof. A.G. Ambali
DVM (ABU), M.V. Sc., Ph.D (Liverpool, UK),
MVCN, MCVSN, MNVMA,FCVSN
Registrar: Mr. E.D.Obafemi
B.A. (Hons), Cert. Public Information (Kaduna),
MNIPR

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Website: ethicalreview.unilorin.edu.ng
www.unilorin.edu.ng

Our Ref: UIL/UERC/14/68MR001

Date: 13TH April, 2017

Protocol Identification Code: UERC/SSC/012
UERC Approval Number: UERC/ASN/2017/814

IM PLICATION OF SOCIO-CULTURAL FACTORS AND ULTLIZATION OF HEALTHCARE FACILITIES ON MATERNAL MORTALITY IN URBANIZED AREAS OF EKITI-STATE, NIGERIA

Name of applicant/Principal Investigator: **OWOSENI,** Joseph Sina
Address of Applicant: Department of Sociology
Faculty of Social Sciences
University of Ilorin, Ilorin.

Type of Review: Full Committee Review
Date of Approval: 13/4/2017

Notice of Full Committee Approval

I am pleased to inform you that the research described in the submitted proposal has been reviewed by the University Ethical Review Committee (UERC) and given full Committee approval.

This approval dates from 13/4/2017 to 12/04/2020, and there should be no participant accrual or any activity related to this research to be conducted outside these dates.

You are requested to inform the committee at the commencement of the research to enable it appoints its representative who will ensure compliance with the approved protocol. If there is any delay in starting the research, please inform the UERC so that the dates of approval can be adjusted accordingly.

The UERC requires you to comply with all institutional guidelines and regulations and ensure that all adverse events are reported promptly to the UERC. No charges are allowed in the research without prior approval by the UERC. Please note that the UERC reserves the right to conduct monitoring/oversight visit to your research site without prior notification.

Thank You.

Ismaila Isah
For: University Ethical Review Committee

UNIVERSITY ETHICAL REVIEW COMMITTEE
University of Ilorin, Ilorin, Nigeria

"....if it's not ethical, it's not scientific, if it's not scientific, it's not ethical"

Appendix V

INFORMEDCONSENT FORM

I, Mr/Mrs/Alhaji/Alhjah/Chief …… whose address is ……do hereby give consent for my participation as a subject in the research titled "Implications of Socio–Cultural Factors and Utilisation of Healthcare Facilities on Maternal Mortality in Urban areas of Ekiti-State, Nigeria"

I am aware of the requirements of the study and my right to withdraw from the study at any time.

At the terms of the consent including the potential risks and what it takes to participate have been fully explained to me in a language I understand. I am also aware that strict confidentiality would be maintained in the study.

Sign …… Sign …….....

Participant Interviewer / Researcher

Date …….. Sign ……

Time …….. Witness……...

Appendix VI

Budget

The total estimated budget for this research protocol is **N2,004,800.00** the money would be used to cover the expenses associated with the programme, including school fees, stationeries (realm of papers, staple machine, cenotaph, biros, pencils, toner for printing machine, etc), questionnaire production and distribution, provision of internet and personal-research assistants, administrative support and travelling.

S/N	CATEGORY	ITEMS	SUB TOTAL	JUSTIFICATION
1.	Direct **ERROR! NOT A VALID LINK.**			This would cover direct expenses which includes: materials and supplies, questionnaire production and administration, etc
2.	School fees and others		N350,000.00	
	Materials and Supplies			
3.	Paper	20 realms of A4 paper	N30,000.00	
4.	Envelops	10 Packets	N3,000.00	
5.	Questionnaire production	Typing and Printing	N150,000	
6.	Biro and Pencil	1 Packet each	N1000.00	
	SUB TOTAL		**N534,800.00**	
	Personnel **Cost of Recruitment**			
7.	Remuneration Coordinator Research Assistants Administrative Support Statistical Analyst	 6@N20,000 4@N15,000 1 Person	 Volunteer N120,000.00 N60,000.00 N150,000.00	
	Travelling			
8.	*Coordinator Trip (10) *Domestic Movement and vouchers (credit cards) of research assistants and administrative assistance *meal per day	N800*10*90	N200,000.00 N170,000.00 N720,000.00	
	SUB TOTAL		**N1,090,000.00**	
9.	Laptop	1	N150,000.00	
10.	Cost of seminar papers production and presentations		N80,000.00	
11.	Cost of final Thesis production	5 Copies	N150,000.00	
12.	**SUB TOTAL**		**N380,000.00**	
13.	**GRAND TOTAL**		**N2,004,800.00**	

Appendix VII

TIME CHART

		2014			2015											2016												2017					
Item	**Activity**	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6
1.	PhD Proposal Development																																	
1.1	Literature Review																																	
1.2	analysis of Literature Review and Proposal Report																																	
2	Research Development																																	
2.1	Determination of scope of study																																	
2.2	Instrument Development																																	
2.3	Pilot Study																																	
2.4	Instrument Modification																																	
3	Transfer of Knowledge																																	
3.1	Preparation of papers																																	
3.2	Participation in seminar/ conferences																																	
3.3	Participation in Internal PhD activities																																	
3.4	Final Report																																	
3.5	PhD Defence																																	

Appendix VIII

Frequency Table

Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Less than 20	71	4.5	4.5	4.5
	20-24	77	4.9	4.9	9.4
	25-29	333	21.1	21.1	30.4
	30-34	455	28.8	28.8	59.2
	35-39	389	24.6	24.6	83.9
	40-44	144	9.1	9.1	93.0
	45-49	111	7.0	7.0	100.0
	Total	1580	100.0	100.0	

Local government

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Efon Alaaye	85	5.4	5.4	5.4
	Ijero	104	6.6	6.6	12.0
	Emure	67	4.2	4.2	16.2
	Ikere	23	1.5	1.5	17.7
	Ido/Osi	277	17.5	17.5	35.2
	Ikole	296	18.7	18.7	53.9
	Ado Ekiti	574	36.3	36.3	90.3
	Ekiti South/West	154	9.7	9.7	100.0
	Total	1580	100.0	100.0	

How long have you been staying in this community?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Less than 5years	104	6.6	6.6	6.6
	5-9years	195	12.3	12.3	18.9
	10-14years	299	18.9	18.9	37.8
	15-19years	198	12.5	12.5	50.4
	20-24years	246	15.6	15.6	65.9
	25 and above	538	34.1	34.1	100.0
	Total	1580	100.0	100.0	

State of Birth

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Ekiti	962	60.9	60.9	60.9
	Others	617	39.1	39.1	100.0
	Total	1579	99.9	100.0	
Missing	System	1	.1		
Total		1580	100.0		

Ethnic group

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yoruba	1014	64.2	64.2	64.2
	Hausa/Fulani	125	7.9	7.9	72.1
	Igbo	209	13.2	13.2	85.3
	Others	232	14.7	14.7	100.0
	Total	1580	100.0	100.0	

Religion

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Christianity	1010	63.9	63.9	63.9
	Islam	524	33.2	33.2	97.1
	Traditional belief	43	2.7	2.7	99.8
	Others	3	.2	.2	100.0
	Total	1580	100.0	100.0	

Marital status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Single	210	13.3	13.3	13.3
	Married	1019	64.5	64.5	77.8
	Separated	113	7.2	7.2	84.9
	Divorced	108	6.8	6.8	91.8
	Widowed	79	5.0	5.0	96.8
	Co-habiting	51	3.2	3.2	100.0
	Total	1580	100.0	100.0	

Highest level of education

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No formal Education	36	2.3	2.3	2.3
	Some primary	51	3.2	3.2	5.5
	Completed primary	153	9.7	9.7	15.2
	Completed secondary	239	15.1	15.1	30.3
	OND/NCE/Grade II	379	24.0	24.0	54.3
	HND/BSC/Postgraduate	337	21.3	21.3	75.6
	Others	385	24.4	24.4	100.0
	Total	1580	100.0	100.0	

Are you currently employed?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	1078	68.2	68.2	68.2
	No	502	31.8	31.8	100.0
	Total	1580	100.0	100.0	

Occupational status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Full-Housewife	143	9.1	9.1	9.1
	Employer	66	4.2	4.2	13.2
	Small Private Business	462	29.2	29.2	42.5
	Public servants	631	39.9	39.9	82.4
	Artisan	166	10.5	10.5	92.9
	Unemployed	112	7.1	7.1	100.0
	Total	1580	100.0	100.0	

Monthly Income

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Less N10,000	186	11.8	11.8	11.8
	N10,000 - N30,000	326	20.6	20.6	32.4
	N31,000 - N50,000	419	26.5	26.5	58.9
	N51,000 - N80,000	370	23.4	23.4	82.3
	N80,000 and above	279	17.7	17.7	100.0
	Total	1580	100.0	100.0	

Do you have other sources of income?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	978	61.9	61.9	61.9
	No	602	38.1	38.1	100.0
	Total	1580	100.0	100.0	

Years in marriage

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Less than1 year	150	9.5	9.5	9.5
	1 - 4 years	482	30.5	30.5	40.0
	5 - 9 years	222	14.1	14.1	54.1
	10 and above	726	45.9	45.9	100.0
	Total	1580	100.0	100.0	

How old were you when you got married

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Less 15 years	163	10.3	10.3	10.3
	15 - 20 years	389	24.6	24.6	34.9
	21 - 30 years	800	50.6	50.6	85.6
	31 years above	228	14.4	14.4	100.0
	Total	1580	100.0	100.0	

Apart from you, does your husband have another wife?

	Frequency	Percent	Valid Percent	Cumulative Percent

Valid	Yes	511	32.3	32.3	32.3
	No	1069	67.7	67.7	100.0
	Total	1580	100.0	100.0	

What is your position among your husband's wife?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	First wife	1069	67.7	67.7	67.7
	Second Third	302	19.1	19.1	86.8
	Other	209	13.2	13.2	100.0
	Total	1580	100.0	100.0	

What is your husband's occupation?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Employer	216	13.7	13.7	13.7
	Small Private Business	432	27.3	27.3	41.0
	Public servants	500	31.6	31.6	72.7
	Artisan	353	22.3	22.3	95.0
	Unemployed	79	5.0	5.0	100.0
	Total	1580	100.0	100.0	

Have you ever had a child?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	1241	78.5	78.5	78.5
	No	339	21.5	21.5	100.0
	Total	1580	100.0	100.0	

How many children do you have?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	442	28.0	28.0	28.0
	2	414	26.2	26.2	54.2
	3	206	13.0	13.0	67.2
	4 and above	207	13.1	13.1	80.3
	Not Applicable	311	19.7	19.7	100.0
	Total	1580	100.0	100.0	

Are they all alive today?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	1138	72.0	73.2	73.2
	No	103	6.5	6.6	79.9
	Not Applicable	313	19.8	20.1	100.0
	Total	1554	98.4	100.0	
Missing	System	26	1.6		
Total		1580	100.0		

How was the child delivered?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Normal delivery	961	60.8	60.8	60.8
	Caesarean section/operation	308	19.5	19.5	80.3
	Not Applicable	311	19.7	19.7	100.0
	Total	1580	100.0	100.0	

Where did you deliver the child?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Government hospital	673	42.6	42.6	42.6
	Private hospital/clinic	230	14.6	14.6	57.2
	Traditional Birth Assistant house	206	13.0	13.0	70.2
	Faith/Spiritual home	159	10.1	10.1	80.3
	Others	1	.1	.1	80.3
	Not Applicable	311	19.7	19.7	100.0
	Total	1580	100.0	100.0	

Reasons for your preferred place of delivery

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Low cost	254	16.1	16.1	16.1
	Good service	1026	64.9	65.0	81.1
	Convenience(nearness)	194	12.3	12.3	93.4
	Suggested by others	35	2.2	2.2	95.6
	Religious reasons	70	4.4	4.4	100.0
	Total	1579	99.9	100.0	
Missing	System	1	.1		
Total		1580	100.0		

Did you go for antenatal care when you were pregnant?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	1537	97.3	97.3	97.3
	No	43	2.7	2.7	100.0
	Total	1580	100.0	100.0	

if yes, where did you have your antenatal care?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Health clinic	447	28.3	28.3	28.3
	Traditional Birth Attendants	230	14.6	14.6	42.8
	Spiritual home	44	2.8	2.8	45.6
	Chemist/medicine store	1	.1	.1	45.7
	Home /self	29	1.8	1.8	47.5
	Both Health clinic and TBA/Spiritual Home	829	52.5	52.5	100.0
	Total	1580	100.0	100.0	

If no, why?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No money	592	37.5	37.5	37.5
	Inavailability of health centre	227	14.4	14.4	51.9
	Inadequate care in health centres	315	19.9	20.0	71.9
	There is no need for it	209	13.2	13.2	85.1
	Others	235	14.9	14.9	100.0
	Total	1578	99.9	100.0	
Missing	System	2	.1		
Total		1580	100.0		

any women in the community who died in pregnancy, during childbirth or shortly after birth?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	1243	78.7	78.7	78.7
	No	337	21.3	21.3	100.0
	Total	1580	100.0	100.0	

If yes, How old was she?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	15 – 29	502	31.8	31.8	31.8
	30 – 39	526	33.3	33.3	65.1
	40 and above	552	34.9	34.9	100.0
	Total	1580	100.0	100.0	

If death occurred at home why was she not taken to hospital/health centre?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No money	903	57.2	57.2	57.2
	Lack of someone to take her to hospital	526	33.3	33.3	90.5
	Delay in referral	51	3.2	3.2	93.7
	No transport facility	51	3.2	3.2	97.0
	Poor road network	24	1.5	1.5	98.5
	I don't know	24	1.5	1.5	100.0
	Total	1579	99.9	100.0	
Missing	System	1	.1		
Total		1580	100.0		

Who attended to the woman at home?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	TBA	547	34.6	34.6	34.6
	Relations	838	53.0	53.0	87.7
	Others	195	12.3	12.3	100.0
	Total	1580	100.0	100.0	

If death occurred in hospital/maternity, how long was the woman in labour before being taken there?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Minutes	554	35.1	35.1	35.1
	Hours	833	52.7	52.7	87.8
	Days	193	12.2	12.2	100.0
	Total	1580	100.0	100.0	

What do you think was the main cause(s) of the death?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Spontaneous abortion	200	12.7	12.7	12.7
	Induced abortion	258	16.3	16.3	29.0
	Hemorrhage after delivery	123	7.8	7.8	36.8
	Retained placenta	545	34.5	34.5	71.3
	Ruptured uterus	68	4.3	4.3	75.6
	Infection	129	8.2	8.2	83.7
	Tetanus	128	8.1	8.1	91.8
	Yellow eyes (hepatitis)	129	8.2	8.2	100.0
	Total	1580	100.0	100.0	

When you fall sick, where do you usually go for treatment?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Government hospital	619	39.2	39.2	39.2
	Private hospital/clinic	271	17.2	17.2	56.3
	Traditional Birth Assistant house	471	29.8	29.8	86.1
	Faith/Spiritual home	165	10.4	10.4	96.6
	Others	54	3.4	3.4	100.0
	Total	1580	100.0	100.0	

Who decide where you go to seek treatment?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Husband	946	59.9	59.9	59.9
	Me	131	8.3	8.3	68.2
	Joint decision	251	15.9	15.9	84.1
	Friends or family members	252	15.9	15.9	100.0
	Total	1580	100.0	100.0	

Who provides the finance for your treatment?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Husband	832	52.7	52.7	52.7
	Me	205	13.0	13.0	65.6
	Both	543	34.4	34.4	100.0
	Total	1580	100.0	100.0	

Why do you prefer your place of treatment?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Close proximity	393	24.9	24.9	24.9
	Quality of service	869	55.0	55.0	79.9
	Affordable cost	269	17.0	17.0	96.9
	Other	47	3.0	3.0	99.9
	5	2	.1	.1	100.0
	Total	1580	100.0	100.0	

How frequently do you use this service?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Daily or as much as required	272	17.2	17.2	17.2
	Once a week	96	6.1	6.1	23.3
	2-3 times in a week	139	8.8	8.8	32.1
	Weekly	304	19.2	19.2	51.3
	Every two weeks	151	9.6	9.6	60.9
	Every month	490	31.0	31.0	91.9
	Others	128	8.1	8.1	100.0
	Total	1580	100.0	100.0	

What are the supportive roles your husband could have performed during the period?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Cook food	281	17.8	17.8	17.8
	Pay bills/Buy drugs	224	14.2	14.2	32.0
	Take her to the hospital	449	28.4	28.4	60.4
	Care for the wife and the children	321	20.3	20.3	80.7
	Pray	16	1.0	1.0	81.7
	Others	289	18.3	18.3	100.0
	Total	1580	100.0	100.0	

Did you at any point in time single handedly take a decision about place and type of treatment when sick?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	1467	92.8	92.8	92.8
	No	113	7.2	7.2	100.0
	Total	1580	100.0	100.0	

When pregnant, do you attend ante-natal services?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	1476	93.4	93.4	93.4
	No	104	6.6	6.6	100.0
	Total	1580	100.0	100.0	

During your last pregnancy, what were the source(s) of ante-natal care you used?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Government hospital	639	40.4	40.5	40.5
	Government Primary Health Centre	3	.2	.2	40.7
	Private hospital	269	17.0	17.0	57.7
	TBAs house	461	29.2	29.2	86.9
	Faith Home	151	9.6	9.6	96.5
	Others	56	3.5	3.5	100.0
	Total	1579	99.9	100.0	
Missing	System	1	.1		
Total		1580	100.0		

Who decided when and where to go for the services?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Husband	944	59.7	59.7	59.7
	Me	133	8.4	8.4	68.2
	Joint decision	251	15.9	15.9	84.1
	Friends or family members	252	15.9	15.9	100.0
	Total	1580	100.0	100.0	

Are you aware of complication(s) common to pregnant women and nursing mothers?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	1454	92.0	92.0	92.0
	No	126	8.0	8.0	100.0
	Total	1580	100.0	100.0	

What do you consider before Utilising your preferred health facility?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	The cost	924	58.5	58.5	58.5
	Efficacy	208	13.2	13.2	71.6
	Proximity	140	8.9	8.9	80.5
	Religious Belief	154	9.7	9.7	90.3
	Custom	109	6.9	6.9	97.2
	Experience	45	2.8	2.8	100.0
	Total	1580	100.0	100.0	

When do you normally start attending ante-natal service?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Month or less	125	7.9	7.9	7.9
	2 Months	159	10.1	10.1	18.0
	3 Months	521	33.0	33.0	50.9
	4 Months	534	33.8	33.8	84.7
	5 Months and above	241	15.3	15.3	100.0
	Total	1580	100.0	100.0	

Have you ever experienced any complication since you have been Utilising the facility?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	980	62.0	62.0	62.0
	No	600	38.0	38.0	100.0
	Total	1580	100.0	100.0	

what complication(s)?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Excessive Bleeding	636	40.3	40.3	40.3
	Swollen legs	280	17.7	17.7	58.0
	Abdominal pain	221	14.0	14.0	72.0
	Fainting	347	22.0	22.0	93.9
	Dizziness	42	2.7	2.7	96.6
	Others	54	3.4	3.4	100.0
	Total	1580	100.0	100.0	

How can you describe the attitude of the health workers toward clients?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Bad	263	16.6	16.7	16.7
	Fair	255	16.1	16.1	32.8
	Good	602	38.1	38.1	70.9
	No comment	457	28.9	28.9	99.9
	5	2	.1	.1	100.0
	Total	1579	99.9	100.0	
Missing	System	1	.1		
Total		1580	100.0		

What can you say about the quality of services rendered by the health clinic?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Bad	611	38.7	40.1	40.1
	Fair	300	19.0	19.7	59.8
	Good	583	36.9	38.3	98.1
	No comment	26	1.6	1.7	99.8
	33	3	.2	.2	100.0
	Total	1523	96.4	100.0	
Missing	System	57	3.6		
Total		1580	100.0		

Where did you deliver your first child if any?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	At home	552	34.9	35.0	35.0
	At the TBA centre	309	19.6	19.6	54.6
	At Maternity centre	512	32.4	32.4	87.0
	At a Mission house	61	3.9	3.9	90.9

	At an Herbalist home	58	3.7	3.7	94.6
	At an Alfa home	66	4.2	4.2	98.7
	Others	20	1.3	1.3	100.0
	Total	1578	99.9	100.0	
Missing	System	2	.1		
Total		1580	100.0		

Why do you prefer visiting the health facility?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Services are affordable	559	35.4	35.4	35.4
	Spiritual reasons	294	18.6	18.6	54.0
	Saves time	520	32.9	32.9	86.9
	Cultural reasons	131	8.3	8.3	95.2
	Other	76	4.8	4.8	100.0
	Total	1580	100.0	100.0	

Do you attend TBAs apart from healthcare centres?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	1111	70.3	70.7	70.7
	No	461	29.2	29.3	100.0
	Total	1572	99.5	100.0	
Missing	System	8	.5		
Total		1580	100.0		

Why do you attend TBAs?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Services are affordable	552	34.9	34.9	34.9
	Spiritual reasons	294	18.6	18.6	53.5
	Saves time	516	32.7	32.7	86.2
	Cultural reasons	142	9.0	9.0	95.2
	Other	76	4.8	4.8	100.0
	Total	1580	100.0	100.0	

Traditional practice(s) during pregnancy

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Food/Drinks prohibition	790	50.0	50.0	50.0
	Activities Prohibition	160	10.1	10.1	60.1
	Medicines Prohibition	164	10.4	10.4	70.5
	Other beliefs	466	29.5	29.5	100.0
	Total	1580	100.0	100.0	

When women are in labour or develop complication(s), can they violate the prohibition relating festival(s) to seek treatment?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	1353	85.6	85.6	85.6
	No	227	14.4	14.4	100.0
	Total	1580	100.0	100.0	

What is/are the consequence(s) of violating such prohibition?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Complication during delivery	488	30.9	30.9	30.9
	Disease	461	29.2	29.2	60.1
	Delay in Delivery	267	16.9	16.9	77.0
	Death	176	11.1	11.1	88.1
	Others	188	11.9	11.9	100.0
	Total	1580	100.0	100.0	

Do you share the same room with your husband during pregnancy?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	1453	92.0	92.0	92.0
	No	127	8.0	8.0	100.0
	Total	1580	100.0	100.0	

Does your husband get irritated with during pregnancy

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	1411	89.3	89.3	89.3
	No	169	10.7	10.7	100.0
	Total	1580	100.0	100.0	

Before you became pregnant, what agreement did you have with your husband?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	My partner and I agreed that I should be pregnant.	1361	86.1	86.1	86.1
	We never discussed having children together	219	13.9	13.9	100.0
	Total	1580	100.0	100.0	

During your last pregnancy, did your husband, mother in-law/relative come to give you support?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	1438	91.0	91.0	91.0
	No	142	9.0	9.0	100.0
	Total	1580	100.0	100.0	

During your last pregnancy, did you have someone you could turn to if you needed someone to comfort or listen to you?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	1398	88.5	88.5	88.5
	No	182	11.5	11.5	100.0
	Total	1580	100.0	100.0	

What are those feelings/conditions that you think are normal to experience during pregnancy? Tick as many as applicable

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Swollen leg	1070	67.7	67.7	67.7
	Dizziness	257	16.3	16.3	84.0
	Fatigue	201	12.7	12.7	96.7
	Others	52	3.3	3.3	100.0
	Total	1580	100.0	100.0	

While you were experiencing those condition(s) did you seek medical attention?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	1438	91.0	91.0	91.0
	No	142	9.0	9.0	100.0
	Total	1580	100.0	100.0	

What is the nature of your work

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Full-Housewife	327	20.7	20.7	20.7
	Employer	81	5.1	5.1	25.8
	Small Private Business	422	26.7	26.7	52.5
	Public servants	424	26.8	26.8	79.4
	Artisan	55	3.5	3.5	82.8
	Unemployed	271	17.2	17.2	100.0
	Total	1580	100.0	100.0	

How is your relationship with your co-workers?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Good	328	20.8	20.8	20.8
	Fair	1252	79.2	79.2	100.0
	Total	1580	100.0	100.0	

How far is your place of work from where you live, in k/m?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very Far	164	10.4	10.4	10.4
	Far	436	27.6	27.6	38.0
	Not Far	437	27.7	27.7	65.6
	Not Applicable	543	34.4	34.4	100.0
	Total	1580	100.0	100.0	

How long does it take on the average, to get to your place of work?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Less 10 minutes	220	13.9	13.9	13.9
	10-20 minutes	490	31.0	31.0	44.9
	21 -30 minutes More than 30 minutes	162	10.3	10.3	55.2
	More than 30 minutes	165	10.4	10.4	65.6
	Not Applicable	543	34.4	34.4	100.0
	Total	1580	100.0	100.0	

What is your means of transportation to your place of work

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Official/private car	109	6.9	6.9	6.9
	Public transport	384	24.3	24.3	31.2
	Okada/Tricycle	326	20.6	20.6	51.8
	Trekking	218	13.8	13.8	65.6
	Other	109	6.9	6.9	72.5
	Not Applicable	434	27.5	27.5	100.0
	Total	1580	100.0	100.0	

At what stage of pregnancy do you apply/stop going to work for maternity leave?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-2 weeks to delivery	444	28.1	28.1	28.1
	A month to delivery	641	40.6	40.6	68.7
	After Delivered and sent application letter	416	26.3	26.3	95.0
	Other	79	5.0	5.0	100.0
	Total	1580	100.0	100.0	

How long does your maternity leave last?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 month	225	14.2	14.2	14.2
	2 months	367	23.2	23.2	37.5
	3 months	653	41.3	41.3	78.8
	Other	335	21.2	21.2	100.0
	Total	1580	100.0	100.0	

Do you think Ekiti state government has influenced the quality of maternal health service in this community?

	Frequency	Percent	Valid Percent	Cumulative Percent

Valid	Yes	1353	85.6	85.6	85.6
	No	227	14.4	14.4	100.0
	Total	1580	100.0	100.0	

Is the Health Care Service Effective to the Community

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very effective	326	20.6	20.6	20.6
	Less effective	423	26.8	26.8	47.4
	Not effective	768	48.6	48.6	96.0
	Don't know	63	4.0	4.0	100.0
	Total	1580	100.0	100.0	

Means of transportation to health centre

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Official/private car	125	7.9	7.9	7.9
	Public transport	532	33.7	33.7	41.6
	Okada/Tricycle	512	32.4	32.4	74.0
	Trekking	267	16.9	16.9	90.9
	Other	144	9.1	9.1	100.0
	Total	**1580**	**100.0**	**100.0**	

Are health workers accessible?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	1401	88.7	88.7	88.7
	No	179	11.3	11.3	100.0
	Total	**1580**	**100.0**	100.0	

How has been the role of the state government in the distribution of healthcare facilities in your LGA?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Good	544	34.4	34.4	34.4
	Fair	465	29.4	29.4	63.9
	Not good	571	36.1	36.1	100.0
	Total	1580	100.0	100.0	

In what area(s) do you think there have been short falls from the Ekiti state government's contributions to healthcare facilities?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Supply more drugs	189	12.0	12.0	12.0
	Employment of qualified personnel	339	21.5	21.5	33.4
	Provide adequate facilities	568	35.9	35.9	69.4

	Supply electricity	304	19.2	19.2	88.6

Did you go for antenatal care when you were pregnant? * Why do you prefer visiting the health facility? Crosstabulation

	Supply electricity	304	19.2	19.2	93.9 96.1 100.0

Does the state government make drugs available at affordable rate?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	520	32.9	32.9	32.9
	No	1060	67.1	67.1	100.0
	Total	1580	100.0	100.0	

What do you think should be done to improve the health quality?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Employment of qualified health Personnel	324	20.5	20.5	20.5
	Adequate supply of drugs	425	26.9	26.9	47.4
	Free Health Care Service	745	47.2	47.2	94.6
	Provision of infrastructural facilities	86	5.5	5.5	99.8
	Total	**1580**	**100.0**	100.0	100.0

In general, how is your health

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Excellent	298	18.9	21.0	21.0
	Good	390	24.7	27.4	48.4
	Average	646	40.9	45.5	93.9
	Poor	87	5.5	6.1	100.0
	Total	1421	89.9	100.0	
Missing	System	159	10.1		
Total		1580	100.0		

Did you go for antenatal care when you were pregnant?	Why do y---ou prefer visiting the health facility?					Total
	affordable Services	Spiritual reasons	Saves time	Cultural reasons	Other	
Yes	542	289	504	127	75	1537
	34.3%	18.3%	31.9%	8.0%	4.7%	97.3%
No	17	5	16	4	1	43
	15.2	8.0	14.2	3.6	2.1	43.0
Total	559	294	520	131	76	1580
	35.4%	18.6%	32.9%	8.3%	4.8%	100.0%

Hypothesis One: There is a significant relationship between the women's demographic characteristics and utilisation of healthcare facilities in the study setting

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Religion * Where did you deliver the child?	1580	100.0%	0	0.0%	1580	100.0%
Highest level of education * Where did you deliver the child?	1580	100.0%	0	0.0%	1580	100.0%
Monthly Income * Where did you deliver the child?	1580	100.0%	0	0.0%	1580	100.0%

Religion * Where did you deliver the child?

Religion	**Healthcare facilities Utilised**					Total
	Government hospital	Private hospital/clinic	Traditional Birth Assistant house	Faith/Spiritual home	Others	
Christianity	432	151	136	98	193	1010
	27.3%	9.6%	8.6%	6.2%	12.3%	63.9%
Islam	216	74	67	56	111	524
	13.7%	4.7%	4.2%	3.5%	7.0%	33.2%
Traditional belief	23	5	3	5	7	43
	1.5%	0.3%	0.2%	0.3%	0.4%	2.7%
Others	2	0	0	0	1	3
	0.1%	0.0%	0.0%	0.0%	0.1%	0.2%
Total	**673**	**230**	**206**	**159**	**312**	**1580**
	42.6%	**14.6%**	**13.0%**	**10.1%**	**19.7%**	**100.0%**

Crosstab

Chi-Square Tests

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	7.153[a]	15	.953
Likelihood Ratio	8.679	15	.894
Linear-by-Linear Association	.082	1	.774
N of Valid Cases	1580		

a. 10 cells (41.7%) have expected count less than 5. The minimum expected count is .00.

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Nominal by Nominal	Contingency Coefficient	.067			.953
Interval by Interval	Pearson's R	.007	.026	.287	.774[c]
Ordinal by Ordinal	Spearman Correlation	.012	.025	.480	.632[c]
N of Valid Cases		1580			

a. Not assuming the null hypothesis.
b. Using the asymptotic standard error assuming the null hypothesis.
c. Based on normal approximation.

Highest level of education * Where did you deliver the child?

Crosstab

Educational Status	**Healthcare facilities Utilised**					**Total**
	Government Hospital	**Private Hospital/Clinic**	**Traditional Birth Assistant house**	**Faith/Spiritual Home**	**Others**	
No Formal Education	15 0.9%	9 0.6%	2 0.1%	2 0.1%	8 0.5%	36 2.3%
Some Primary	25 1.6%	7 0.4%	4 0.3%	4 0.3%	11 0.7%	51 3.2%
Completed Primary	61 3.9%	19 1.2%	18 1.1%	23 1.5%	32 2.0%	153 9.7%
Completed Secondary	97 6.1%	35 2.2%	37 2.3%	25 1.6%	45 2.9%	239 15.1%
OND/NCE/Grade II	170 10.8%	54 3.4%	45 2.8%	30 1.9%	80 5.1%	379 24.0%
HND/BSC/Postgraduate	137 8.7%	55 3.5%	45 2.8%	44 2.8%	56 3.5%	337 21.3%
Others	168 10.6%	51 3.2%	55 3.5%	31 2.0%	80 5.1%	385 24.4%
Total	**673 42.6%**	**230 14.6%**	**206 13.0%**	**159 10.1%**	**312 19.8%**	**1580 100.0%**

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	30.438[a]	30	.443
Likelihood Ratio	28.396	30	.549
Linear-by-Linear Association	.118	1	.731
N of Valid Cases	1580		

a. 9 cells (21.4%) have expected count less than 5. The minimum expected count is .02.

Monthly Income * Where did you deliver the child?

Crosstab

Monthly Income	Where did you deliver the child?						Total
	Government hospital	Private hospital/clinic	Traditional Birth Assistant house	Faith/Spiritual home	Others	Not Applicable	
Less N10,000	81	26	24	18	0	37	186
	5.1%	1.6%	1.5%	1.1%	0.0%	2.3%	11.8%
N10,000 - N30,000	142	46	41	32	0	65	326
	9.0%	2.9%	2.6%	2.0%	0.0%	4.1%	20.6%
N31,000 - N50,000	174	63	54	45	1	82	419
	11.0%	4.0%	3.4%	2.8%	0.1%	5.2%	26.5%
N51,000 - N80,000	159	56	48	34	0	73	370
	10.1%	3.5%	3.0%	2.2%	0.0%	4.6%	23.4%
N80,000 and above	117	39	39	30	0	54	279
	7.4%	2.5%	2.5%	1.9%	0.0%	3.4%	17.7%
Total	673	230	206	159	1	311	1580
	42.6%	14.6%	13.0%	10.1%	0.1%	19.7%	100.0%

Chi-Square Tests

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	4.275[a]	20	1.000
Likelihood Ratio	4.157	20	1.000
Linear-by-Linear Association	.022	1	.882
N of Valid Cases	1580		

a. 5 cells (16.7%) have expected count less than 5. The minimum expected count is .12.

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Nominal by Nominal	Contingency Coefficient	.052			1.000
Interval by Interval	Pearson's R	.004	.025	.148	.883[c]
Ordinal by Ordinal	Spearman Correlation	.005	.025	.196	.845[c]
N of Valid Cases		1580			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

c. Based on normal approximation.

Regression

Variables Entered/Removed[a]

Model	Variables Entered	Variables Removed	Method
1	Monthly Income, Religion, Age, Marital status, Highest level of education[b]	.	Enter

a. Dependent Variable: Utilisation of Healthcare Facilities

b. All requested variables entered.

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.065[a]	.004	.001	2.306

a. Predictors: (Constant), Monthly Income, Religion, Age, Marital status, Highest level of education

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	35.235	5	7.047	1.325	.251[b]
	Residual	8369.446	1574	5.317		
	Total	8404.680	1579			

a. Dependent Variable: Utilisation of Healthcare Facilities

b. Predictors: (Constant), Monthly Income, Religion, Age, Marital status, Highest level of education

Coefficients[a]

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.	95.0% Confidence Interval for B	
	B	Std. Error	Beta			Lower Bound	Upper Bound
(Constant)	3.382	.346		9.765	.000	2.703	4.062
Age	.040	.041	.025	.989	.323	-.040	.121
Religion	.017	.105	.004	.162	.872	-.190	.224
Marital status	-.120	.051	-.060	-2.365	.018	-.219	-.070
Highest level of education	-.080	.038	-.077	-.275	.783	-.085	.064
Monthly Income	.089	.046	.085	.199	.842	-.081	.099

a. Dependent Variable: Where did you deliver the child?

Hypothesis Two: Socio-cultural beliefs and practices significantly affect utilisation of healthcare facilities

Case Processing Summary

C	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Pearson Chi-Square Likelihood Ratio Linear-by-Linear Association N of Valid Cases						
a. 2 cells (8.3%) have expected c is 4.25.						
Traditional practice(s) during pregnancy * complication(s) experienced	1580	100.0%	0	0.0%	1580	100.0%

Traditional practice(s) during pregnancy * complication(s) experienced Crosstabulation

Traditional practice(s) during pregnancy	complication(s) experienced						Total
	Excessive Bleeding	Swollen legs	Abdominal pain	Fainting	Dizziness	Others	
Food/Drinks prohibition	313	133	118	179	19	28	790
	19.8%	8.4%	7.5%	11.3%	1.2%	1.8%	50.0%
Activities Prohibition	59	34	18	35	5	9	160
	3.7%	2.2%	1.1%	2.2%	0.3%	0.6%	10.1%
Medicines Prohibition	68	30	19	35	6	6	164
	4.3%	1.9%	1.2%	2.2%	0.4%	0.4%	10.4%
Other beliefs	196	83	66	98	12	11	466
	12.4%	5.3%	4.2%	6.2%	0.8%	0.7%	29.5%
Total	636	280	221	347	42	54	1580
	40.3%	17.7%	14.0%	22.0%	2.7%	3.4%	100.0%

Symmetric Measures

		Value	Asymp. Std. Error[a]	Approx. T[b]	Approx. Sig.
Nominal by Nominal	Contingency Coefficient	.078			.836
Interval by Interval	Pearson's R	-.034	.025	-1.358	.175[c]
Ordinal by Ordinal	Spearman Correlation	-.028	.025	-1.100	.271[c]
N of Valid Cases		1580			

a. Not assuming the null hypothesis.
b. Using the asymptotic standard error assuming the null hypothesis.
c. Based on normal approximation.

Hypothesis Three: Women's working conditions are likely to influence antenatal care facilities utilization.

The Nature Work * How frequently do you use this service? Crosstabulation

The Nature Work	How frequently do you use this service?							Total
	As much as required	Once a week	2-3 times in a week	Weekly	Every two weeks	Every month	Others	
Full-Housewife	70	25	41	42	28	96	25	327
	4.4%	1.6%	2.6%	2.7%	1.8%	6.1%	1.6%	20.7%
Employer	17	7	6	11	6	32	2	81
	1.1%	0.4%	0.4%	0.7%	0.4%	2.0%	0.1%	5.1%
Small Private Business	66	21	33	89	36	135	42	422
	4.2%	1.3%	2.1%	5.6%	2.3%	8.5%	2.7%	26.7%
Public servants	60	19	33	98	50	131	33	424
	3.8%	1.2%	2.1%	6.2%	3.2%	8.3%	2.1%	26.8%
Artisan	9	7	4	8	9	15	3	55
	0.6%	0.4%	0.3%	0.5%	0.6%	0.9%	0.2%	3.5%
Unemployed	50	17	22	56	22	81	23	271
	3.2%	1.1%	1.4%	3.5%	1.4%	5.1%	1.5%	17.2%
Total	272	96	139	304	151	490	128	1580
	17.2%	6.1%	8.8%	19.2%	9.6%	31.0%	8.1%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	50.873[a]	30	.010
Likelihood Ratio	50.651	30	.011
Linear-by-Linear Association	1.783	1	.182
N of Valid Cases	1580		

a. 4 cells (9.5%) have expected count less than 5. The minimum expected count is 3.34.

Hypothesis Four: There is a significant relationship between stereotypes and utilisation of healthcare facilities.

where do you usually go for treatment? * Who decided when and where to go for the services? Crosstabulation

where do you usually go for treatment?	Who decided when and where to go for the services?				Total
	Husband	Me	Joint decision	Friends or family members	
Government hospital	370	54	95	100	619
	23.4%	3.4%	6.0%	6.3%	39.2%
Private hospital/clinic	162	28	45	36	271
	10.3%	1.8%	2.8%	2.3%	17.2%
Traditional Birth Assistant house	288	31	72	80	471
	18.2%	2.0%	4.6%	5.1%	29.8%
Faith/Spiritual home	94	16	30	25	165
	5.9%	1.0%	1.9%	1.6%	10.4%
Others	30	4	9	11	54
	1.9%	0.3%	0.6%	0.7%	3.4%
Total	944	133	251	252	1580
	59.7%	8.4%	15.9%	15.9%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	7.191[a]	12	.845
Likelihood Ratio	7.248	12	.841
Linear-by-Linear Association	.233	1	.629
N of Valid Cases	1580		

a. 1 cells (5.0%) have expected count less than 5. The minimum expected count is 4.55.