FACTORS AFFECTING MATERNAL HEALTH SEEKING BEHAVIOUR IN A YORUBA COMMUNITY OF NIGERIA: AN ANALYSIS OF SOCIO-CULTURAL BELIEFS AND PRACTICES

By

AYOOLA ADEKUNLE DADA

Supervisor: Professor Sultan Khan
Co-Supervisor: Dr. Lubna Nadvi

Thesis Submitted in Fulfillment of the Doctor of Philosophy in the School of Social Sciences, University of Kwa-Zulu-Natal, Howard College, Durban, South Africa

2019

DECLARATION

I, Ayoola Adekunle Dada declare that:

1. The research reported in this thesis, except where otherwise indicated is my original research.

2. This thesis has not been submitted for any degree or examination at any other university.

3. This thesis does not contain other persons' data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other persons.

4. This thesis does not contain other persons' writing unless specifically acknowledge as being sourced from other researchers. Where other written sources have been quoted, then:

(a) Their words have been re-written but the general information attributed to them has been referenced.

(b) Where their exact words have been used, then their writing has been placed in italics and inside quotation marks, and referenced.

5. This thesis does not contain text, graphics or tables copied and pasted from the internet, unless specifically acknowledged, and the source being detailed in the thesis and in the references sections.

Signed… ……..

DEDICATION

This thesis is dedicated to my children: Emmanuel, Grace and Paul.

ACKNOWLEDGEMENTS

Sincerely, words alone cannot express the depth of my gratitude to Professor Sultan Khan and Dr. Lubna Nadvi for indeed; they are supervisors par excellence. Their constructive criticisms, inspirational words of advice, commitment to ethics, diligence and impeccable research prowess sustained and lead to the realization of this work. The series of tutorial they gave me in the course of my studentship under them fill a lot of lacuna in my knowledge of research. Their doggedness, excellent feedback confirms their readiness and commitment towards human development. You are not only mentors but also a real blessing to the academic enterprise and humanity as a whole. It is my prayer that you will never have a better yesterday as you continue to soar in the journey of life. I say a very big thank you.

I will like to register my gratitude to the authority of Ido/Osi Local Government Council in Ekiti State, Nigeria for granting me permission to conduct this research in the LGA. I equally appreciate all the participants that supplied the needed data towards the actualization of this research. I am grateful indeed.

As a matter of fact, I don't know how to start appreciating Professor C. T. Oluwadare because, I will forever be grateful for being a father, a steadfast prop in times of distress. As a rose fill a room with its fragrance, so will God's love, grace and favour will continue to fill your life (Amen). Thank you very much sir.

I want to specially appreciate the love, support and concern of Dr. Kolawole and Dr. Babatunde Durowaiye. Thank you for the encouragement.

In addition, I want to extend my gratitude to the following friends for being there; Dr. George Dosunmu, Deji Ale, Dr. Ayoola Jegede, Dr. Lucky Asuelime, Akin Fasusi and other friends and colleagues too numerous to mention. I am grateful to the authority of The Federal Polytechnic, Ado Ekiti of Nigeria for the opportunity given to advance my study.

I want to say a big thank you to my children: Emmanuel, Grace and Paul for their tolerance and support especially while I was away for the study; also to their mum for her role in my life and other family members, alas, everything work for good.

While acknowledging all this support, I know surely, except God build the house, the builders build in vain, for He is I am that I am, greater than the greatest, mightier than the mightiest, higher than the highest, the fountain of wisdom, the final source of hope in a state of despondency. Even in the midst of seemingly overwhelming impediments, He still made this PhD a possibility, for saying another Yes! In my life despite all the crucibles of this world, God! You are too much. To Him alone the glory due while I remain responsible for the shortcomings of the work.

Ayoola Adekunle DADA

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

ANC: Antenatal Care

BHC: Basic Health Centre

CAC: Christ Apostolic Church

CHC: Comprehensive Health Centre

CRR: Centre for Reproductive Rights

EA: Enumerated Area

EOC: Emergency Obstetric Care

FGM/C: Female Genital Mutilation/Cutting

HBM: Health Belief Model

ICF: Inner City Fund

IDI: In-Depth Interview

LGA: Local Government Authority

MDG: Millenium Development Goal

NPC: National Population Commission

PHC: Primary Health Care

PNC: Post Natal Care

PPD: Postpartum Depression

RRs: Reproductive Rights

TBA: Traditional Birth Attendant

WHO: Wolrd Health Organization

ABSTRACT

The significance of mothers to the overall sustenance of maternal health care cannot be overemphasized, despite this fact, however, there is an increasing gap between the developed and the developing countries in terms of morbidity and mortality and mothers' survival at prenatal, delivery and postnatal periods. In spite of the great efforts that have been put forth to achieve the 8th "Millennium Development Goals", much work is yet to be done to assuring maternal health for women especially in Sub Saharan Africa

The study involved a survey of 196 women aged 15-45+ years in Ido/Osi LGA in Ekiti of Nigeria which established maternal health seeking as inseparable from the socio-economic and cultural contexts in which they occur. Employing field methods from Medical Sociology and Demography, the study argues that maternal health seeking transcends the boundaries of either of these disciplines and that their comprehensive understanding entails the collaboration of both. Its specific objectives encompassed: (1) an investigation of the influence of cultural beliefs and practices on maternal health seeking (2) examination of the relationship between the social demographic characteristics of women and maternal health seeking and; (3) an assessment of the impact of the existing social structure on maternal health seeking.

The model of behavioral change in public health, rational choice theory, location theory and feminist theory enable the study to highlight the links between socio-cultural variables and maternal health seeking by showing the strength of their separate and collective relationships.

Data were collected by triangulation of in-depth interviews and the survey questionnaire. The qualitative data were analyzed through manual content analysis to identify the socio-cultural variables associated with factors affecting maternal health seeking; quantitative data were analyzed by using frequency distributions tables for univariate while cross tabulation was used with the aid of SPSS version 22 for bivariate analysis, Microsoft Excel 2013 for the charts and STATA version 12 for the T-Test.

The result of the survey reveals that factors such as socio-economic, beliefs and cultural practices of the Yoruba people, to a large extent affect maternal health seeking. Some of the specific findings include: Patriarchy to great extent has a strong impact on maternal health seeking; majority of women in Yoruba community have strong beliefs in the efficacy of herbs in pregnancy management and child bearing; and that attitude of health workers also impair health seeking. The study therefore recommends that community mobilization should be geared towards ensuring that appropriate health-seeking behaviour becomes part of local social norms. Community education must address traditional beliefs about pregnancy related complications that are often blamed on women behaviour, fate, evil influences and other factors beyond the reach of the health care system. Due to the fact that Yoruba society is patriarchal in nature, men also should be educated on the intricacies that revolve around maternal health because, they dominate family decision-making. Also there is a need to strengthen policies and capacity building, training of health care providers, for improved quality of care and sustained research on reproductive health among the Yoruba people of Nigeria.

CHAPTER ONE

INTRODUCTION

1.1 Background and Outline of Research Problem

Globally, maternal healthcare system is an important segment of medical system in any society; this is as a result of the importance of mothers in the overall sustenance of human society. Despite the significance of maternal health care, however, there is an increasing gap between the developed countries and the developing countries in terms of levels of morbidity and mortality and mothers' survival at prenatal, delivery and postnatal periods (WHO, 1999). Universally, more than 50 million women suffer from poor reproductive health and serious pregnancy related illnesses and disability and every year more than 500,000 women die from complications of pregnancy and childbirth (WHO, 2002). Most of the deaths occur in Asia, but the risk of dying is highest in African countries (World Bank, 2004).

More than 99% of the world's maternal deaths are due to complication of pregnancy and childbirth occurring in the developing countries whereas less than 1% of these deaths occur in developed countries, demonstrating that maternal death could be avoidable given available resources and services (WHO 2002). In 2012, 40 million births in developing regions were not attended to by skilled health personnel, and over 32 million of those births occurred in rural areas (MDGs Report, 2014). Researches have shown that maternal mortality in 2013 put Sub-Saharan Africa at the highest region with 510 maternal deaths per 100,000 live births of women aged 15-49 compared to North Africa and Latin America with 69 and 77 respectively (MDGs Report, 2014). This is not unconnected to the problems associated with the socio-cultural beliefs and attitudes towards maternal health seeking (Dada, 2005).

Scientific literature in the area of public health has been dominated by the view that challenges of maternal health are primarily the result of unavailable, unutilized or unskilled health care with focus on the economic and biomedical factors working against improving maternal health (Thaddeus and Maine, 1994, Geller et al, 2006, Gil-Gonzalez et al, 2006 & Paine, 2009). However, there are evidences suggesting that in some cases when skilled, formal health care is accessible, some women choose not to utilize such care facilities. As interventions designed to increase access to skilled maternal health care have not yielded the desired results, research that focuses on maternal health seeking needs to consider other

factors, such as socio-cultural beliefs and practices, as potential contributors to improve maternal health seeking.

Cultural beliefs has a direct and weighty influence on the behaviour of mothers and their care givers during neo-natal, natal and post-natal periods, but there are inadequate researches and understanding of the proximate effect of cultural beliefs and attitudes of women in relation to maternal health seeking (Thadeus & Maine, 1994, Kyomuhendo, 2003, Thaddues & Nangalia, 2004, Geller et al., 2006, Gil-Gonzalez et al. 2006, Paine, 2009 & Sibley et al., 2009). As noted earlier, previous researches that focused solely on biomedical factors being responsible for maternal health challenges have largely neglected the reality that in most of the countries where maternal health challenges remain high, culture and its traditional practices have an important influence on women's decisions.

In spite of the great efforts that have been put forward by United Nations to achieve the 8th "Millennium Development Goals" which is aimed at:

> *eradicating extreme poverty and hunger; achieve universal primary education; promote gender equality and empower women; reduce child mortality; improve maternal health; combat HIV/AIDS, malaria and other diseases; ensure environmental sustainability and; develop a global partnership for development, much work is yet to be done to assuring maternal health for women worldwide.*

As a result of the above, there is a need to investigate factors affecting maternal health seeking behaviour among the people of Ido/Osi LGA of Ekiti State, Nigeria with a view to reducing the gap in knowledge in order to improve maternal health especially in the sub-Saharan Africa.

1.2 Objectives of the Study

Most researches have focused too narrowly on morbidity and mortality of women of reproductive age and their children, thereby, creating a lacuna in the area of factors affecting maternal health seeking behaviour among the people of Ido/Osi LGA of Ekiti State, Nigeria. This study therefore seeks to examine and understand the factors affecting maternal health seeking behaviour among the people of Ido/Osi LGA of Ekiti State, Nigeria.

Therefore, the specific objectives of this study are as follows;

i. To investigate the influence of cultural beliefs on maternal health seeking behaviour.
ii. To examine the relationship between the socio-demographic characteristics of women and maternal health seeking behaviour.
iii. To assess the impact of the existing social structure on maternal health seeking behaviour.

1.3 Research Questions

i. How do cultural beliefs influence maternal health seeking behaviour?

ii. What is the relationship between the sociodemographic characteristics of women and maternal health seeking behaviour?

iii. What is the impact of the existing social structure on maternal health seeking?

1.4 Statement of hypotheses

Hypothesis 1

Ho: Health workers attitude does not discourage (not affect) women attendance to hospital

H_I: Health workers attitude affect women attendance to hospital

Hypothesis 2

Ho: Lack of drugs does not discourage (not affect) women attendance to hospital.

H_I: Lack of drugs affects women attendance to hospital.

Hypothesis 3

Ho: Cost of drugs and services does not discourage (not affect) women attendance to hospital

$H_{I:}$ Cost of drugs and services discourage (affect) women attendance to hospital

Hypothesis 4

Ho: Some practices in the hospital are not against culture and religion

$H_{I:}$ Some practices in the hospital are against culture and religion

Hypothesis 5

Ho: Proximity of health facility does not affect women attendance to hospital

$H_{I:}$ Proximity of health facility affects women attendance to hospital

Hypothesis 6

Ho: Traditional centers are not better places to receive care than health care

$H_{I:}$ Traditional are better place to receive care than health care

Hypothesis 7

Ho: The church is not a better place to receive care than health care

$H_{I:}$ The church is a better place to receive care than health care

Hypothesis 8

Ho: Care during pregnancy is independent of outcome of delivery

$H_{I:}$ Care during pregnancy affects outcome of delivery

Hypothesis 9

Ho: Lack of drugs in the facility does not prevent women from attending maternity

$H_{I:}$ Lack of drugs in the facility prevent women from attending maternity

Hypothesis 10

Ho: Frightening equipment in the labour room does not prevent women from attending maternity.

$H_{I:}$ Frightening equipment in the labour room prevents women from attending maternity.

Hypothesis 11

Ho: Devotion of health workers to duty does not prevent women from attending maternity

$H_{I:}$ Devotion of health workers to duty prevents women from attending maternity

Hypothesis 12

Ho: Discrimination in services rendered to literate/illiterates does not affect women in attending health care

$H_{I:}$ Discrimination in services rendered to literate/illiterates affect women in attending health care

Hypothesis 13

Ho: There's no need to come back for checkup after delivery

$H_{I:}$ There's need to come back for checkup after delivery

Hypothesis 14

Ho: There are no special foods for pregnant women/nursing mothers

$H_{I:}$ There are special foods for pregnant women/nursing mothers

1.5 Significance of the Study

This study is significant in order to identify the factors that affect maternal health seeking behaviour among the Yoruba people of Nigeria in particular and in sub-Sahara African society at large. This will invariably pave way for improvement in maternal health seeking behaviour by recognizing the relative and specific demand of Yoruba people of Nigeria, as characterized by many rural areas in sub-Saharan Africa. No doubt the study is targeted at proffering lasting solution to factors affecting maternal health seeking behaviour especially in the area of education, sensitization, public and private sector intervention, and pave way for more research on maternal health among scholars.

By providing data that pinpoints the factors affecting maternal health seeking behaviour to examine the separate and collective influences of the identified variables on maternal health seeking, the study contributes significantly to the methodological and theoretical aspect in the field of Demography and Medical sociology. In addition, attempt is made towards a comprehensive analysis of the relationship that exist between the dependent and independent variables. Models of behavioural change, rational choice theory, location theory and feminist theory were employed as a deserving guide to the study.

This study will also stimulate sustained research on reproductive health particularly, among the Yoruba people of Nigeria and among the rural communities of sub-Saharan Africa. It will also give way to proffer lasting solution to many health challenges which, serves as a cog in the wheel of development of the developing nations. The outcome of this research will also gear up governments, donors and international agencies in taking steps to improve maternal health in Africa.

As noted by the World Bank (2004), women must balance the time they spend on their own health with the multiple responsibilities for care of children, collecting water or fuel, cooking, cleaning, and growing food and trade or other forms of employment. In many parts of the world, women's decision-making power is extremely limited, particularly in matters of reproduction and sexuality. Decisions about maternal care are often made by mothers-in-law, husbands or their family members (World Bank, 2004).

A study in Ghana reveals women who died of pregnancy-related complications found that 64% of the women had sought help from an herbalist or other traditional provider before going to a health facility. Families cited cost and the belief that the woman's condition would improve or that the woman was not ill enough to justify the cost involved, as the main reasons for not taking a woman to a hospital (Odoi-Agyarko, Dallimorre, Owusu-Argye, 1993).

In some cultures, mothers-in-law attend to most deliveries, and provide additional care or help is sought only if she decides that such care was needed. Thaddeus and Maine (2001) carried out a study on Maternal Mortality in Zaria, Nigeria and found that in almost all cases, a husband's permission was required for a woman to seek health services, including life-saving care. If a husband is away from home during delivery, those present are often unwilling to take the woman for care no matter how pressing the need appears to be. According to Maine (2002), despite the significant pressure put by the Benin government on women to have institutional deliveries, including fines, many women continued to deliver at homes, due to the honour brought to families if they were seen as "stoic" during labour and childbirth.

Also, Nwokocha (2004) carried out an extensive study on socio-cultural factors affecting pregnancy outcomes and submits that the prevalence of high maternal and infant morbidity/mortality among the Ibani of Rivers State, Nigeria, is linked to socio-cultural factors that influence perceptions, attitudes and practices of the people with regard to pregnancy. The research shows that pregnancy outcomes depend on the interaction of complex variables such as male role, socio-economic status of women, child spacing, access and use of maternal health facilities, among others.

Ajala (2000) carried out a study among the rural communities of Osun state in Nigeria, where the local conception of maternal and child health was examined. Similarly, the local people's perception of maternal and child health was identified and various attitudes and practices affecting health care provisioning in the rural communities of Osun state were analyzed. Relying on ethnographic methods of data collection, the study establishes that certain local attitudes were constraints against equitable access to maternal and child health care facilities. It also establishes that there are some other local practices which promote good health of the rural mothers and their children. Explicitly his findings show that illiteracy and low level of economic activities suffered by mothers were the major causes of maternal and child health care problems in rural communities.

Isiugo-Abanihe (2003) stressed the crucial role of the male factor in fertility and family health issues by observing that before the current concern for male involvement began, reproductive health issues and services had become synonymous with women's reproductive health, and men were 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 in men as decision makers in the home and society.

While many researchers have addressed maternal morbidity and mortality issues in sub-Saharan Africa, studies related to socio-cultural factors affecting maternal health seeking behaviour in the region on the other hand are not extensive. The few that exists have espoused improved access to maternal health services alone while creating the impression that socio-cultural factors affecting maternal health seeking behaviour is not equally a challenge experienced by women of reproductive age.

Importantly, however, most findings from previous studies solely relied on data generated using single method of social investigation and limited theoretical background whereas, this study intend to explore the strength of mixed method and theoretical triangulation to stimulate further research and develop a holistic framework for understanding maternal health issues in sub-Saharan Africa and assist in designing and redesigning acceptable health policies and intervention programmes based on findings from the study.

Also, in Ido/Osi Local Government Area, where this study was carried out, no such study has been undertaken despite the fact that the area is associated with an existing lack of mechanism to combat the problem of low levels of reproductive health amongst women. In lieu of this, the researcher of this study provides a wealth of information which could inform advocacies for better health amongst women within the reproductive age group in the Yoruba community of Nigeria in particular and in Sub-Saharan Africa in general.

1.6 The Scope of the Study

The scope of the study relates to respondents that will be involved in the research and geographical area of the study. The concern of the study is to investigate the factors affecting

maternal health seeking behaviour in Ido/Osi Local Government Area of Ekiti State, Nigeria in order to gain a better understanding of the effects of these factors on maternal health. Since this research centers on maternal health, women of child bearing age from different age, marital, educational, occupational and income categories were engaged in providing data for the survey. The in-depth interviews (IDI) were also used to complement the quantitative technique in the process of data collection.

1.7 The Study Area

Precisely, the study area is Ido/Osi Local Government Area with a population of approximately 221,196 (in 2017) as projected from 2006 provisional population census figure of 159,114 inhabitants with annual growth rate of 3.04. There are 13 communities within the Local Government Area jurisdiction. It is about 20 kilometers to Ado Ekiti, the state capital. The people are predominantly peasant and some are civil servants. Their major diet comprises food items such as yam, cassava, maize and their derivatives. The people are mostly Christians.

Ekiti State has 16 LGAs with a total population of 2,384,212 (NPC, 2006) with an annual growth rate of 3.04%. Women of childbearing age (WCBA) between ages 15 to 49 comprise 22% of the population, simply put ratio 1:4 and 5:20 The State consists of one relatively homogenous ethnic group referred to as Ekiti, and speaks the general Yoruba language The major occupational leaning of the people is traditional agriculture. Basic infrastructural facilities exist in the state. Roads linking all the 16 LGAs and to the capital city, as well as to other states of the federation were provided. Some of these roads, as in other parts of the country are in disrepair making it difficulties in accessing remote communities within some Local Government Areas. The telecommunication systems as well as most banks have their presence and provide their services in Ekiti state.

Specifically, the study area is Ido/Osi Local Government Area (LGA) in Ekiti State, Nigeria, with 221,196 estimated populations in 2017 as projected from 1996 population census of 159,114 inhabitants (NPC, 2006). There are 13 communities within the local government jurisdiction. It is about 20 kilometers from Ado Ekiti, the State capital city. The people are predominantly peasant and some are civil servants. Their major diet comprises food items such as yam, cassava, maize and their derivatives. The people of Ido/Osi Local Government Area are predominantly Christians.

Summary of Ekiti State Profile

Ekiti State of Nigeria came into existence on 1st October, 1996 with Ado-Ekiti as the state capital. The state has an estimated population of 2,384.212 million as at 2006. Ekiti State is entirely within the tropical region. It is located between longitude 4^0 45^1 5^0 45^1 east of the Greenwich Meridian and latitudes 7^0 15^1 to 8^0 $\mathbf{5^1}$ North of the Equator. It is situated South of Kwara and Kogi States as well as East of Osun State. It is bounded in the East and in the South by Ondo State. The state is mainly an upland zone. It rises above 250 meters above sea level. It lies within the areas underlain by metamorphic rocks of the basement complex. It also has a generally undulating land surface with a characteristics landscape that consists of old plains broken by steep sided out-crops dome rocks that may occur singularly or in groups.

Ekiti as a people settle in nucleus urban patterns, well linked with network of roads. There are sixteen Local Governments and more than 127 large and small towns (ancient and modern) located on hills and valleys that characterize the state from which the confinement takes its name. Ekiti that is Okiti" meaning Hills. The state is endowed with warm springs and the main staple food is pounded yam with vegetable soup. The Ekiti people are of Yoruba tribe and are culturally homogenous with their dialect known as Ekiti.

Profile of Ido-Ekiti

In terms of location**,** Ido-Ekiti is the headquarters of Ido-Osi Local Government Area of Ekiti State. It is situated almost at the focal point of Ekiti land along the routes from Lagos to Abuja. The route from Kwara also joins with that from Lagos at Ido Ekiti. Boundary towns such as Omuo Ekiti, Efon Alaave and Ikere Ekiti are almost equidistant from Ido Ekiti.

Historically, the Olojudo (The traditional ruler) shares Boundaries with the Oore of Otun Ekiti in the north; with the Oloye of Ove Ekiti to the east; Ewi of Ado Ekiti to the South and Ajero of Ijero Ekiti to the West.

History had it that it was the Olojudo and three other Obas (Kings) (Ajero,Oore and Owa Ilesa) that signed the Kiriji Treaty and the the Enactment for the Abolition of Human sacrifices in Ekiti land on behalf of Ekiti people.

In the days when Ekiti students depended more on trekking long distances to acquire education in faraway lands, mainly because of poverty and lack of educational and

transport facilities, the elders of Ekiti in their collective wisdom and understanding decided to locate the Ekiti Parapo, College, the Second Secondary School in Ekiti, at Ido Ekiti which is regarded as the geographical centre of Ekiti land. It was for the same reason that the first General Hospital in Ekiti was located in Ido Ekiti.

Ido has grown to become one of the fastest growing urban centres in Ekiti. Ido Ekiti is opportune to have the only Federal Medical Centre in the state situated in the town, there is presence of district headquarter of electricity supply company in the town. In addition, there is Federal School of Nursing and so many other thriving enterprises.

Profile of Osi-Ekiti

Traditions of Origin in Yoruba land had often been woven around the personality of Oduduwa the celebrated eponymous father of the Yoruba race in order to give a satisfactory answer and explanation to what had been wrapped in obscurity. To this, Osi Ekiti is no exception. These people being unlettered, all that is known is mainly is derived from oral traditions handed down from generation to generation. Since the period of unknown antiquity, there are three major traditional accounts of the Osi people, the following two appear authentic.

According to the first tradition, Ile-Ife is the creation spot of all races black or white. The tradition goes on to say that Ile-lfe was the home of Oduduwa who was the first ruler of the Yoruba race and that the first Olosi was one of his Senior Sons. The first Olosi according to the tradition left lIe-lfe during the waves of migration of other Sons of Oduduwa to found Osi Ekiti. The tradition adds that Osi was peopled with large retinue of migrants that followed Olosi to this new establishment. In the intelligence reports on ado district, the travelling commission of the North Eastern Yoruba province Captain N.A.C. Weir Supported this view very strongly when he noted that "Olosi was the second Son of Oduduwa and this was why his father gave him many valuable presents during his departure from Ile-Ife" it will be observed that no reason for the dispersal was given by this tradition but we learn or at least deduce that the first Olosi left Ile-Ife with a blessing.

This authenticated the genuine purpose for which Osi trace their origin to Ile-Ife. Running through the second tradition of origin, it says that the first Olosi was a son of Obalufon who himself was a successor of Oduduwa to the Ile-Ife throne. It adds that Osi was part of Ile-Ife before Obalufon died. Olosi, after the death of his father contested for

the Ife throne but narrowly lost. It was this loss of such a priced royal battle that prompted his leaving lle-ife with several sympathizers to found a new town called Osi Ekiti. He therefore became its first king, leaving Ife with his own traditional crown and other deities.

According to tradition, at the height of its powers Osi area of influence had covered a greater part of Yoruba land. The king of Osi was so domineeringly powerful that he commanded all other Olofin Sons "then dispersed to all parts of Yoruba land in search of their own settlement" to annually bring a white ram each to him during the annual "pagbo-padiye" festival a festival designated for the special worship of the Ori inu" (inner Head). The Purpose was to officially set a day apart in the year for special thanks-giving to Olosi.

Profile of Ayetoro -Ekiti

Ayetoro-Ekiti located in Ido/Osi Local Government area of Ekiti State was founded by Ayaopa bi ekun- a great hunter of the early 17th Century. Ayaopa with his elder brother Asagidigbi and their aged mother left lIe-Ife and settled at Oro now Iloro Ekiti. Ayaopa bi ekun would leave Iloro for the present Ayetoro on hunting expedition and would spend many days before returning to Iloro-Ekiti. He later got to a place full of rocks amid hills and then decided to stay believing that the place would be good for hunting and at the same time provide full security against external aggressions. He was later joined by his wife. The town was named Iyapa after the thunder Ayaopa bi ekun literally translated to "as swift in killing animals as Lion". The name of the town was changed to Ayetoro Ekiti in 1953 because of the derogatory meaning people were given to Iyapa Ekiti.

Profile of Ifaki-Ekiti

Ifaki Ekiti is a conglomeration of migrant groups from many parts of the Yoruba speaking people of Nigeria after the dispersal of prince and princesses from the ancient regime of Odudua (the founder of the Yoruba race) which occurred in the 17th century AD.

The name Ifaki which is a compressed name from "Ifa-Eki" is derived from the monumental incident of the settlers' activity of clearing a site for their central market near their Obas (king) palace. On that faithful day a piece of locally woven raffia cloth known as EKI' housed by a snail shell was found. This discovery was considered a spiritual symbolic gift' IFA' (Gift) from God. Thus the merging of the words IFA-EKI to IFAKI for clarity and meaningfulness of pronunciation was adopted by the entire migrant group

for the name of the community since the migrant group that transcend into a corporate entity known as Ifaki left their original settlement in search of more serene environments to live and peddle their trades arid profession or to establish themselves out of the pins of succession battles they have gone through for the thrones of their royal fathers.

At least, eighteen primordial sources of the migrants have been identified according to the top hierarchy of the ruling body in the town. These princes constituted themselves into the three categories of rulers in their area as Iwarafa, Aworo Ita Erinse and Army leader.

The major agricultural products of Ifaki town are yam, maize, and cassava in large quality for local consumption and sale to neighboring towns and villages. Logging is also a part of their economic activities.

Being a nodal town, Ifaki Ekiti serves prospective e businessmen and woman from parts of the country to engage in commercial activities as there exist such infrastructures like banks, post office, primary and secondary schools and a satellite campus of the state university. There is also Police post for security of life and property. Majority of the people are Christians, some practice. The vegetation is conducive for agriculture and the weather is not harsh. The roads linking the town to the neighbouring communities are fairly good but the roads within the town are not in good condition.

Profile of Usi-Ekiti

Usi-Ekitii is a Yoruba speaking town in Ido/Osi local Government Area of Ekiti State. History had it that Usi-Ekiti originated from Ile-Ife. The time of their departure from Ile-Ife falls within pre- history times since there were no written records. Historians depend on legends as their source of history of these times. According to legend, the progenitor of Usi people, Prince Usikorede, approached his father, Lafogido, the then reigning Ooni of Ife for blessing as he and his followers prepared to leave Ile-Ife to found his own Kingdom, just as his brothers (Princes) had done. Lafogido gave him his blessings and in addition gave him the following paraphernalia of royalty: a beaded crown, a beaded working stick, beaded horse tail, a sword, a brass cup and a piece of cloth which would be spread on his throne whenever he finally settled.

The main occupation of the people of Usi-Ekiti is farming which like in most part of the state is still practice with the traditional hoe and cutlass. With the improvement in agriculture in the state, the age old method of farming is hoped to give way to mechanized

agriculture.

The farm produce include the usual economic crops like the palm produce, rubber, tobacco, cotton, cashew and cocoa (though in a small scale). A wide variety of fruits like mangoes, grape, pawpaw, pineapples, banana, and oranges are also cultivated while some could be found growing wild in the forest. Subsistence crops include cocoyam, cassava, rice, plantains, beans, maize, yam, pepper, tomatoes, vegetables and groundnut

Profile of Aaye-Ekiti

Looking at the political structure of Aaye Ekiti, the Kabiyesi (king) is the head of the community and there are six high chiefs in hierarchy: Oniyao; Onisin; Olulede; Eleju; Olotu and; Rawa. The major traditional festival observe in Aaye are Osun (Ijesu) which marks the beginning of harvesting season of yam and Ogun festival that is; god of iron. The major economic activity of the people is farming. They are producer of yam, cassava, kola nut and palm products. There are two rivers (Eku and Ijo) in Aaye Ekiti which serves as tourist attraction to visitors.

Aaye Ekiti Market square provides a rich ancient facts which informed the historical highlights in this exposition. Farm products are sold in this market at every five days interval.

Profile of Ifisin Ekiti

Like other Yoruba communities, Ifisin Ekiti has the origin of the town traced to Ile-Ife. Geographically, Ifisin situates in a strategic location that shares boundaries with Aaye Ekiti, Ora Ekiti, Ido Ekiti, Igbole Ekiti, Osi Ekiti and Ifaki Ekiti. The community has its own share of Christian values, the Methodist Church is among the oldest denominations and Anglican Church was established in the l970s. There are other churches of different persuasions; there is a parish of the Redeemed Christian Church of God in ifisin.

The large expanse of boundary land gives room for expansion for physical growth. Ifisin Ekiti like any other Ekiti community is as old as the contemporary Yoruba town in the Federal Republic of Nigeria. Ifisin Ekiti is situated in Ido/Osi Local Government Area of Ekiti State, South Western part of Nigeria with a landed area of approximately over 9,000 square kilometers. It falls within the Ekiti District in Yoruba land. It lies close to the heart of Ekiti Land. The town enjoys the benefit of Proximity to the link roads to Abuja (The Federal Capital Territory of the Nation) via Ifaki Ekiti. Ikole Ekiti, Omuo Ekiti, Kabba and

Lokoja. The town also has a road connection to Lagos via Ido Ekiti, Ijero Ekiti, Aramoko Ekiti, Ilesa and Ibadan. It connects to Kaduna (the northern part of the country) via Ido Ekiti, Usi Ekiti, Otun Ekiti, omu Aran, Ilorin, Jebba and .kotangora. In addition, the town connects to Ondo State via Ado, ikere and Akure.

Its geographical location has its own unique advantages. Ifisin like most of her counterpart Ekiti communities has very limited land space. The communities are surrounded by small and big towns with which they share the little distances in between themselves. Towards Aaye Ekiti side, the town has only few meters while going towards Igbole-Ekiti is less than five kilometers. To some extent the inner farmlands on both side of the community of ifisin Ekiti has fairly large expanse of land where its shares some interior boundaries with Ifaki Ekiti, Osi Ekiti, Ora Ekiti and Ido Ekiti.

In terms of vegetation, Ifisin falls within the belt of deciduous forest. It is not too far from the transitional zone for the deciduous and pure Savannah. To its north one has to go about 50 to 60 Kilometers to reach the southern limit of the Savannah region which is the boundary for the Northern Region. As it is usually found around villages or old towns, virgin forest (known as Egan in Yoruba language) within a radius of half a kilometer or more are found sheltering and surrounding the town. The far off uncultivated areas are also thickly forested. Land is usually cultivated for farming purpose. Some of the land has been reduced to parklands with shrubs. In the forest around Ifisin Ekiti and in their farms are commercial trees like Iroko, Mahogany, Obeche, Arere (worm wood) and palm trees.

The resourceful Ifisin community falls within the naturally endowed belt in the supply of timber for the export market in Nigeria. Wildlife species in these forests include antelopes, deer, grasshopper, monkey, rabbits and snakes of different species. Birds of different shapes and sizes are found but games like the Elephant and the Crocodile are rare.

Looking at Ifisin Ekiti people, the population is slightly under twenty thousand inhabitants, majority of the indigenes live outside the town, in Nigeria and abroad. Indigenes and others who live in Ifisin Ekiti are mainly peasant farmers, civil servants including teachers and pensioners. With the advent of Western Education, Ifisin indigenes embraced it and the community is one of the producers of intellectuals in all fields of human endeavors in modern Nigeria. The community is blessed with fertile land where agricultural products such as: cocoa, kola nut, rice. Cassava strive well the climatic condition of the community also favours fisheries, poultry and dairy farming.

There is indication of presence of limestone as mineral resources in Ogbuluwowo hill area of the community which needs the assistance of geologist for further research. In addition, the presence of some artifact like stone coffin, stone mortal (for pounding yam), knife and many others at Isunrin Egbugbu area of Oomu's farm settlement qualifies Ifisin Ekiti as a center for tourism.

Profile of Igbole-Ekiti

No one is sure of the exact time Igbole was founded. History however shows that Igbole people moved out of Ile Ife not very early. The reason for this delay is not known but as a result of it, the Igbole people imbibe a lot of Ife culture. Ife cultural and artistic development reached its peak in 15th century at a time the people of Igbole had not moved out.

Religiously, Igbole has its own cult of religious activities in a unique way. None of the Igbole deities is connected with Olojudo in any form. Our own Elefon is quite different from any other one that could be seen in the neighbourhood. The songs are peculiar and while such masquerade in other places go to Ido yearly to perform; ours perform for our own Oba who puts on his ceremonial crown to welcome the Elefon to his Palace. The Oba of Igbole Ekiti is the head of the Oro cult on whose behalf the yearly festival is celebrated. The Ogun festival in Igbole Ekiti receives the blessings of Olugbole and the ceremonies highlighting the ceremonial year take place in the Palace.

Majority of the people of Igbole Ekiti involve in farming, their major agricultural products are: yam, cocoyam kolanut and rice. The tourist attraction centers include; Elejiu Plateau. Parts of the mineral resources deposited in Igbole Ekiti are lime and clay. Their market day (Oja Oba) comes up at interval of five days.

Profile of Odo-Ora Ekiti

Odo-Ora-Ekiti was founded by migrants from Odo-Ora Quarters of Ile-Ife. These migrants believed according to Odo-Ora local tradition to be descendants of Olofin/Obalufon moved in three separate lineage groups namely Ilemo, Ijisun and Igun during the dispersal of the first generation princes from Oduduwa and subsequent generation princes from Obalufon to establish kingdoms of their own. In their journeys, the Ilemo group under Obalemo, Odofrn and Abaparakisa settled temporally around Erin-Ijesa, Erio near Aramoko and unnamed site where they were dispersed by Isoko War and later moved to

Ipepe, a place between Ido Ekiti and present Odo-Ora Ekiti. After a while, some of the group which included Ejimo, Saloro and Abajigbo moved to Ibudo now Ido Ekiti while the remaining people under the Obalemo left for Ipole Obalemo, Igbo Obalufon and settled there with their deities Olofin/Obalufon and Epa (Masqurade). Sometime thereafter, the Ijisun group under Ejisun who stayed around Iloko-Ijesa finally settled at the northern part of Ipole Obalemo at a place called Owamereju with their deity called Oro (Ereju).

The third lineage group called Igun under Obaaro'Olofi settled temporarily along lIe-Ife/Ilesha road before settling at oke-lgun which was in the Southern part of Ipole Obalemo near Igbo Elefon. Each settlement was a separate entity but religious contacts, social activities and inter-marriage occurred. The situation continued until the three settlements suffered terribly from the rampages of Benins, Fulanis. Ibadan, and Eyos who carried away many of the people to Odo-Ora Village in Omu Aran, Oke-Onigbin. Ifon and among other places. This sad experience made the survivals of Ilemo and Ijisun settlement to move out of Ipole area and resettled at the present site named Odo-Ora Ekiti after their ancestral home in Ile-Ife. Obalemo Ogidilisu (Obalemo) led the Ilemo group who became the traditional ruler of Odo-Ora of Ekiti Meanwhile, the Igun people worried by the Eyos rushed to Odo-Ora Ekiti to meet Obalerno for protection, thereby becoming the third lineage group in the community subdivided into sixteen subgroups or compounds. In 1948, Oke-Ora Ekiti people led by their king, Oloja of Oke-Ora moved to Odo-Ora Ekiti while in 1952, the Ilogun people led by Obalogun also moved to Odo-Ora Ekiti. The two villages moved to Odo-Ora Ekiti for economic and commercial reasons and have since continued to live side by side with the people of Odo-Ora through political autonomous.

Christianity was introduced to Odo-Ora between 1902 and 1905. Cultural heritage The major traditional and cultural heritage are: Olofin obalufon which is held between April and May; Ereju is slated between July and August; Epa (Masquerade) normally hold between august and September; Ogun festival holding in August; Odun agba (nurin) always held between September and October; Celebration of Odo-Ora day always held in October and; Orisa Ora which holds anytime within the year. There are other minor festivals which are not celebrated by the whole community that are sectional in the three main lineages that formed the community**.**

It is believed that Odo-Ora Ekiti has some mineral resources still untapped. The town is endowed with dimension stone like granite, gneisses and feldspar. Agriculture is the main occupation of the people and it is the major source of income for many. The main cash crops are cocoa, kolanut and palmoil. There are tree crops that provide timber as raw material for wood-based industry. Food crops are yam, cocoyam, cassava, maize, plantain, banana, tomatoes, pepper and varieties of vegetable.

Profile of Oke-Ora-Ekiti

Oke-Ora people came from ile-ife as "ORA" and there is still a quarter at Ile-Ife called Ora till today. The history tells us that in the olden days there was a man in lle-Ife called Obagborowa abbreviated as Obagbua who was the first Olora. The then king in Ile-Ife showed this man a lot of affection to the extent that he permitted him (Obagbua) to come to his palace and see him at any time.

Meanwhile, Obagbua had a deity then known as EREJU which he and his people worshipped in Ile-If. Up till the present day, Olora is still the head of all Ejio (Ereju) worshippers in Ekiti. But because of the affection that the Obagbua had for the King, he accepted to be the priest of Obanifon. Obagbua started taking care of the god, worshipping it and making sacrifices to it on behalf of the king. The king presented Obagbua with a crown as promised. Obagbua bought a dog for the god and called it Aja Olofin (i.e Olofins dog). Olofin is the second name for Obanifon, the god Obagbua appeased for Oonirisa. Obagbua really believed in Obanifon and worshipped it beyond the expectation of the king himself. One day, Obagbua appeased Obanifon as he used to do every day and according to the tradition and belief of Yoruba people, they normally threw the Kolanut after appeasing god to know whether their sacrifice was accepted by the god or not. When Obagbua threw the kolanut, he discovered that Obanifon did not accept his sacrifice that day, he threw the kolanut three times and the situation remained the same, he became worried and confused because he did not know what he had done wrong to make Obanifon to reject his offering, immediately, he consulted his oracle (Ifa Oduede) to know what went wrong. The oracle said Ofinsinsin Omolore imole o ku Obagbua went to the palace of Ooninsa who made him the priest of Obanifon to inform him about the decision of the god to move out of lIe- Ife and settle in another land. When Obagbua informed the king, the king said he had given him the Obanifon totally and he should take him, to wherever he was going to settle *down.* Oonirisa prayed for Obagbua and blessed him that wherever he settled with the god (Obanifon) no evil would befall him and his people. When

Obagbua got home, he did not see Obanifon at the shrine where he used to appease him which indicated that it had left. Obagbua quickly consulted Ifa Oracle (Ifa Oduede) to know the whereabouts of Obanifon. He pleaded with Obanifon to open the eyes of his dog known as (Aja olofin) so that it could lead him (Obagbua) to where Obanifon settled. Obanifon told Obagbua to follow his dog that they will meet him under an Iroko tree, he told him the sign that would make him recognize to the Iroko tree. The history tells us that Obanifon stopped at six different places before settling at a place called Ora Ipole. When Obagbua settled down at Ora Ipole, he said he could not be worshipping the god himself because when Obanifon was in Ile-Ife Oonirisa did not appease the god himself. He appointed one of his men known as Odogun as the priest that will be worshipping Obanifon for him.

Among the above listed festivals, Agbaludi and Afayun is the most celebrated festival because as much as sixteen various communities will gather at Oke-Ora Ekiti to celebrate it with Olora. It usually comes up in the month of August every year. Oke-Ora people still maintain their bilateral relationship with the various towns in Ekiti according to the age long tradition and custom, especially the communities that are affiliated with EREJU. Some of these communities include: Ifaki Ekiti, Ido Ekiti, Orin Ekiti, Oye Ekiti, IIogbo Ekiti, Aaye Ekiti, Ara Ekiti, Esure Ekiti.

Profile of Orin-Ekiti

The history of Orin, like any other Yoruba town was not written but the facts were produced through oral interview, traditions, folklores and legends. The founder of Orin Ekiti was Apelua, he was one of the sons of Laruloa Ooni, precisely the eighteenth Ooni in Ile-Ife, the cradle of all Oduduwa descendants. The members of the council in the town were arranged in order of seniority. The chiefs were the eyes and the ears of the king and they were directly responsible to the king. They met regularly to take decisions affecting the town and these are passed to the entire people by town criers. The age long system of traditional administration of Orin Ekiti is patterned in such a way that all her citizens participate at different level, thereby creating a sense of belonging with full participation in the maintenance of peace, good governance and internal security of the town and her neighbours. A meeting of council of Elders referred to as Ajo Oru Orin under the chairmanship of Olorin holds every nine days. The council of chiefs (Ajo Nuri) also holds every year. The Olorin of Orin Ekiti is the head and the custodian of Orin traditions. His opinion is sought before major decisions are taken and his authority is final.

The social groups according to their status within the community also assist him. Some of the chiefs meet at the palace on a regular basis of nine days intervals. The aim of the two houses is unique and unanimous (for the progress of the town by revolutionizing her into small Lagos). Some hold their meeting in their leaders houses. The roles of some of the chiefs transcend their quarters while the jurisdiction of some chiefs covers only their quarters. Some are for their wards while others determine minor issue that affects the extended family system. The Iworos are other chiefs different from iwarafa (King makers), but they are also important in the town. They also commune with the Olorin. Women are not left out in the administrative role in the town. The women chiefs are known as Obirin-Ilu. Olorin (The King) is responsible for the installation of women's head that is also known as Anasin. The women chiefs in each quarter hold their meeting in Olorin's palace. The same Anasin presides over the meetings that involve all the women chiefs in the town. Eyesamo, Eyejero-Iwoye, and Eyejero-llere are the most senior chiefs in Iletin, Iwoye and Ilere respectively. They hold meeting in their respective houses and they preside over the meetings.

In terms of religion, traditional religion dominated the life of the people before the advent of Christianity. As a matter of fact, traditional religions dominated the Yoruba land, and Orin Ekiti is not left out of this. Some of the gods that are being worshipped are: Ogun (the god of Iron), Obanifon, and Epa e.t.c. Ancestral worship such as Erolupo is not an exemption. Ero is the festival that unites the generality of the people. Aworo (the chief priest) is also a chief among the Iworo. Ero, as people believe, wards off pestilence, and sudden outbreak of some terrible diseases. Those who are barren believe that Ero can give them children. Aworo Ero consults the Ero Oracle on behalf of the town and performs rituals.

As regards the educational facilities in the community, the first school in Orin Ekiti; Methodist Primary School was established in 1925. Also in 1928, the Roman Catholic Primary Schools have been amongst the most productive primary schools in the local Government Area since their inception. Also there is another modern nursery & primary school owned by the Roman Catholic Church Orin Ekiti. This was founded few years ago. The Catholic Church also stab1ished a modern school in 1957 named St. Michael's Modern School. Later the State Government faded out such institutions thus; it metamorphosed into a community secondary school known as Orin High school. This was founded in September 1979 with the population of about 800 students.

On medical and health facilities, when Orin was still under the Old Ero local Government, the Local Government established a Dispensary and Maternity Centre in the town. Under IDO/OSI Local Government this has been upgraded to Basic Health Centre. In addition, there are patent medicine shops, traditional herbal homes and one private clinic owned by Catholic Church supervised by a qualified medical Rev. Sister.

Talking of the geographical details of the community, Orin Ekiti is one of the town constituting Ido/Osi Local Government areas of Ekiti State. The population of Orin was about 30, 000 people according to the l99lcensus. Orin Ekiti share boundaries with Isan Ekiti, Aiyede Ekiti, Itaji Ekiti, and Ayegbaju Ekiti with Itaji Ekiti in the North East, Ipere Ekiti and Ido Ekiti in the North-West, Odo-Ora Ekiti in the South-west while Ifaki Ekiti is to the Eastern part. All these towns are linked with Orin Ekiti by some network of roads except Ipere Ekiti, Isan Ekiti, Ayede Ekiti and Itaji Ekiti. Some big towns Surrounding Orin Ekiti are Ifaki Ekiti which is about 4.2kms away, and Ido Ekiti the headquarters of Ido/ Osi Local Government Area (LGA) which is also a distance of about 4.8kms..

Orin Ekiti is situated on a well-drained plain between Ifaki Ekiti and Ido Ekiti. There are many rivers and streams in and around the town. The major river is Ero, known as "Omi Ero". Others are "Omigbala" which serves as a healing stream from whosoever is infected with one diseases or the other. Other streams are: Oloyu, Jere, Ebusu, Aparin, and Awere. The Ero River is the main source of water supply not only to the town but almost five local government areas in Ekiti State through pipe borne water. Although pipe borne water is provided for the town, people do go to these rivers and streams for their water supply whenever there is epileptic water supply by the state water corporation. Recently, another source of water for domestic use is from about six bore holes and ultra-modern borehole with a large reservoir.

Orin Ekiti lies in the rain forest belt with evergreen vegetation. The town's average rainfall is between 50'' 65" annually. The town enjoys two seasons: the dry season which is between November and March and the raining season which is between April and October. The main economic crops of the people are cocoa; Yams; Kolanut; Palm produce; cassava and; maize. The harvesting of these crops is done in the early part of the dry seasons, while the seed-bed preparation is during the latter part of the season. In addition to the above crops, the area is endowed with forest resources like timber and palm trees.

Profile of Ilogun Ekiti

Ilogun Ekiti is a typical rural and agrarian society located in Ido/Osi Local Government Area of Ekiti State, founded about three centuries ago by a famous herbalist called Ojiloogun and his wife Orisaloogun. Ilogun is a derivative of the name of the settler "Ojiloogun" which means "magical power"

In terms of size and population, the ancestral land covers about 20 square kilometers with a population of about two thousand people and shares boundaries with Ido Ekiti in the North/East, Odo-Ora Ekiti in the West and Ifisin Ekiti in the South

The major problem confronting the community is road network to the farm. The farm produce is usually brought to the market by head. This hinders the supply of food items to the market and most of the farm produces like cassava, tomatoes and other vegetables perish in the farm. There is no school in the community; people from Ilogun attend schools from neighbouring communities like Odo-Ora Ekiti and Aaye Ekiti. Besides, there is no health facilities situated in Ilogun.

Looking at their cultural heritage, there are two major rivers in Ilogun Ekiti: Ajamu and Ewaiyara. Ilogun Ekiti is also blessed with a fertile land; cash crops like cocoa, kolanut and timber are available. In addition, food crops like yam, maize, rice cassava and plantain are grown at subsistence level.

Profile of Ilogbo –Ekiti

The origin of Ilogbo people can be traced to Oduduwa, the founding father of the Yoruba race. The difference versions of the story of Oduduwa are woven around the origin of man. These various versions of the story are traced to cosmology, pilgrimimage, historical research and the Christian Bible. The Ilogbo people have their root in Ile-Ife as descents of Oduduwa, according to Ilogbo oral history. The major traditional festival of Ilogbo people are; Olua, Ereju, Egigun, Epa and Ogun. Majority of the Ilogbo people are farmers. They are great producer of yam. The town is known for commercial centre of yam. They also produce cassava, and maize in large quantity. Ilogbo Ekiti has two major markets square namely: Oba market which is open every five days and Better Life market.

Health Structure in Ekiti State, Nigeria

Similar to other states in the Nigerian federation, health care services is provided by both orthodox and traditional medical practitioners. In recent years, there has been a conscious effort to improve health care services in the state.

Ekiti State Ministry of Health provides guidelines for the regulation and coordination of traditional medicine practice but the question begging for answer is to what extent has the state government been able to achieve adherence to the said guideline?

There are 283 primary health care facilities at the Local Government (LGA) level, i.e., Basic Health Centres (BHC), Comprehensive Health Centres (CHC), maternity centres/dispensary centres, while the state has 17 secondary health-care centres, three specialist health facilities and one tertiary health facility. One federal owned tertiary health facility is also located in the state. Furthermore, there exist 163 registered private health facilities and 7 mission health facilities in the state.

State Ministry of Health provides overall direction for the organization of health services in the state while also having the responsibility for health manpower development and organization and implementation of secondary health care. The State acting through the ministry of health also provides technical assistance to the local governments as regards primary health care and disease control. The Local Government on the other hand organizes and implements primary health care activities at the grassroots level and also has the responsibility of funding and coordinating service delivery at local level. However, local governments have performed poorly in the funding and execution of primary health care programmes. This is sometimes hinged on the insincerity of responsible authorities and the lack of clear delineation of roles by the 1999 constitution. Thus, the responsibilities of Local Government are sometimes taken over by the state government in order to provide succour to the people.

Health Indicators in Ekiti State, Nigeria

A lot of the initiative of the state has been geared towards improving the health status of the population. However, the inequity that is the main bane of many health initiatives still persist. A sizeable proportion still lives below the poverty line while access to qualitative health care services in rural areas is still far from ideal.

Many communities are still grappling with the double burden of diseases with infectious diseases in gridlock with non-communicable diseases in a poor environment. Data from the Planning Research and Statistics department of the ministry of health for year 2008 fly presents an iceberg view of the true picture as the capacity for community generated data is still not adequate. Nonetheless, the currently available data gives the DPT3 coverage as 71%. Those fully immunized before the age of l2months as 32.881 and women with at least 2 doses of Tetanus toxoid as 38%. This data though not too bad still falls short of expected standard for achieving the millennium development goals.

In the year under reference, five thousand eight hundred and thirty five people were screened for HIV out of which 7.6% were positive. The pattern also reflects the disadvantaged position of females with a disproportionate infection rate of 9.5% compared to 5.2% for males. The number of people infected with HIV with access to ARV stands at 152. Furthermore, those co-infected with tuberculosis and HlV was 750.

The proportion of deliveries attended to by a skilled birth attendant was 54.7% while 17 1% of births were delivered by a trained traditional birth attendant. This falls short of acceptable standards. In addition, new born babies weighing less than 2.5kg accounted for approximately 10% of total live births. Moreover, the prevalence rate of underweight among children under 5 years of age who were weighed was 3.5%.

Health services provision and utilization in Ekiti State, Nigeria

Ekiti State has invested a lot in the past years on providing the populace with quality health care services. However, the great investments made in provision of health care services have not translated to quality access to care especially by the rural poor. 01. The 254 primary health care facilities, 196 offer antenatal and delivery services. Moreover, with only 21 facilities at the LGA level offering STI and counseling and testing services, many of the populace still lacks access to this valuable service, Only 2 centres in the state offer ARV treatment with the resultant lack of access to comprehensive care by those infected with HIV.

1.8 Operationalization/Clarification of Concepts

Socio-Cultural: A set of factors like income, education, customs, practices and behaviour that exist within a population and its influence on maternal health.

Access: Access means that maternal health care or facilities are within reach of women who need them. They can get to them easily and are not deterred from using the services available, either because of cost or poor treatment by staff or by any other socio-cultural barriers.

Maternal Health: Maternal health is the complete physical, social and psychological well-being of a woman of reproductive age (Turmen, 1993; WHO, 1994; Castle, 1995).

Maternal Morbidity: It is a state of being ill; here it refers to the ill-health patterns and risks of women of reproductive age, any injury, condition or symptoms on women that resulted from or worsen by pregnancy.

Maternal Mortality: It is regarded as a state of being liable to die or being dead. It is a situation of complete absence of health and termination of life. Any death that occur to women as a result of pregnancy related complications.

Prenatal/Antenatal Care: This refers to care that is given to an expectant mother from the time that conception is confirmed until the beginning of labour. In addition to monitoring the progress of pregnancy, it aims to provide appropriate support and information for the woman and her family, which allows them to make sensible, informed choices in respect of maternal health care.

Natal or Delivery Services: Delivery according to Tiran (1997) is the natural expulsion or extraction of the child, placenta and foetal membranes at birth. A delivery service is a major component of maternal health. The aim of a good natal care is to ensure that every expectant mother has a normal delivery and bears a healthy child or children (Akinsola, 1993). As soon as labour is established, the mother should be monitored continuously until the child is safely delivered. Even after delivery, efficient monitoring and care are necessary because there is risk of complication occurring after delivery. Emergency obstetric services should always be available to prevent death from complications.

Post Natal Care: The first 6-8 weeks following delivery is known as the puerperium. This is the period during which the Uterus and other organ and structures of the mother are returning to the pre-pregnancy state. There is risk of bleeding, pain and infection during this period hence there is need for medical attention. Six weeks after delivery, a full postnatal examination is usually carried out on women. The postnatal visit gives room for family planning advice and baby immunization.

Family Planning Services: Family planning includes both programme of controlling fertility and helping those who have problems of infertility. It implies the right of every family to plan to have as many children as they can care for and spacing the birth for maximum benefits.

Orthodox Facility: In the context of this study, it refers to either private or public (government owned) hospital or health facility. It is often used interchangeably with hospital in the study.

Social Structure: This is regarded as any relatively enduring pattern or interrelationship of social elements such as the class structure. Put differently, the more or less enduring pattern of social arrangement within a particular society, group, community, or social orgnanisation, e.g. the "social structure of health system in Nigeria". Although, no single agreed concept of social structure exist in the field of sociology, despite its widespread usage. The definition employed depends upon the theoretical perspective within which the concept is used. For the purpose of this study, social structure is conceived as the enduring pattern of the social organisation, arrangement and interrelationship that exist between orthodox and traditional maternal health care practices as it affects maternal health seeking behaviour.

Maternal Health Seeking Behaviour: it is regarded as the sum total of beleifs, attitude, pattern, practices and other factors influencing the decision making pattern of women of child bearing age towards access and use of maternal health care services.

1.9 Structure of Thesis:

Chapter one [Introduction]: The introduction sheds light on the background of the study; the research questions and justification of the study are presented herein. In addition, both general and specific objectives are discussed.

Chapter Two [Literature Review]: The section presents a review of various studies done in the areas of maternal health which includes socio-cultural beliefs and practices on maternal health seeking especially in developing countries and Nigeria in particular.

Chapter Three [Theoretical Framework]: This section, using theoretical perspectives, examines maternal health seeking behaviour and activities that shape such behaviour in order

to understand the socio-cultural factors affecting maternal health seeking. Based on this, Model of Behavioural Change in Public Health, Rational Choice Theory, Location Theory, and Feminist Theory were used in analyzing socio-cultural beliefs and practices of maternal health seeking.

Chapter Four [Description of Research Methodology]: The Research Methodology was designed by using the triangulation approach, owing to the fact that the use of multiple methods will compensate for the individual weaknesses inherent in each one of them. Both qualitative and quantitative research techniques that were used in generating data for the study are discussed extensively in this chapter. This section also presents pilot study conducted prior to the research proposal and health structure in Ekiti State, Nigeria.

Chapter Five [Presentation and Analysis of Research Results]: This section presents qualitative data generated from the fieldwork using the content analysis method. Each interview recorded in a tape was transferred verbatim for thorough reading and annotation of codable topics, themes and issues by examining the associations between identified socio-cultural variables and maternal health seeking. The researcher also ascertained that, explicit rules otherwise known as criteria of selection which was formally established before the actual analysis of data was strictly and consistently adhered to. The quantitative data generated from the fieldwork by examining the associations between identified socio-cultural variables and maternal health seeking. The data is presented in tabular and graphical forms and the analysis revolve around frequency distribution, cross tabulation and inferential statistics, using chi-square. Data from the qualitative methods were imported to the analysis where necessary.

Chapter Six [Summary and Conclusion]: Chapter six presents the summary, conclusions and recommendations and suggestion for future research.

1.10 Conclusion

This chapter introduced the research topic and discussed the rationale for the study. It unfolds the need to study factors affecting maternal health seeking in a Yoruba community of Nigeria with a bias in socio-cultural beliefs and practices of the people. Consequent upon this, the objectives of the study have been delineated with details which have been earmarked in accordance with the progress of the study. Finally, the structure of this thesis as regards the chapter sequence has been provided. In the next chapter, this study will present a review of the existing literature on maternal health seeking behaviour and other related issues relevant to the research topic.

CHAPTER TWO

LITERATURE REVIEW

A review of previous efforts to understand similar or related phenomena is very crucial to the success of any social research. To this end, this chapter presents a systematic review of various researches and studies that sought to have a broad understanding of the information available about the variables of interest of this study. General information is supported by findings from empirical studies and perceived gaps in the information available are discussed. The factors affecting maternal health seeking behaviour of women of reproductive age are considered amongst other determinants relating to maternal health as a whole.

Part of the review provides information on cultural beliefs; social demographic characteristics of women of reproductive age; the impact of existing social structure, gender and patriarchy, among others as determinants of maternal health seeking behaviour and by extension the consequences on health of women of reproductive age especially within the African context and Nigeria in particular.

2.1 The Influence of Cultural Beliefs and Practices on Maternal Health Seeking Behaviour

Considering the influence of socio-cultural interpretations of pregnancy threats on health-seeking behaviour, progress toward Millennium Development Goal 5 has been slow in some resource-limited countries (Falconer, 2010). At the beginning of the Millennium, maternal mortality ratio for sub-Saharan Africa alone was estimated to be nearly 50 times higher than what was reported by industrialized countries (Ronsmans and Graham: 2006). Unfortunately, trends show evidence of little maternal health improvement in sub-Saharan Africa over the last decade (Suzuki. 2007; AbouZahr, Wardlaw 2001; Graham. 2006; Falconer. 2010; Ronsmans, Lozano, Wang, Foreman, Rajaratnam, Naghavi, Marcus, Dwyer-Lindgren, Lofgren, Phillips & Atkinson, 2011; Hill, Thomas, AbouZahr, Walker, Lale, Inoue, United Nations 2012).

In developing countries, evidence suggests direct consequences of pregnancy and childbirth that continue to account for most maternal deaths (Ronsmans & Graham, 2006). These outcomes are mainly attributed to haemorrhage, sepsis, and hypertensive complications (Ronsmans & Graham, 2006; United Nations 2012). Structurally, these conditions are considered as outcomes of a complex web of social, economic, educational, political and cultural factors (Falconer AD: Millennium Goal 5. Howson, Harrison & Law 1996; Obstetric Gynaecology Reproductive Medicine 2010; Kotecha, Patel, Shah, Katara & Madan 2012). The provisions of health facilities and appropriate interventions, it is estimated that 90 percent of such maternal deaths could be avoided; especially when 15 percent of these complications develop unexpectedly and become life threatening (Falconer AD: Millennium Goal 5. Obstetric Gynaecology Reproductive Medicine 2010). Consequently, women are encouraged to receive continuous maternity care from skilled providers.

There is a particular interest in Ghana, where high rates of maternal mortality remain a public health issue. By 2007 Ghana Maternal Health Survey report estimates a maternal mortality ratio of 580 deaths per 100,000 live births (Ghana Maternal Health Survey, 2007). Due to the high maternal deaths, the Minister of Health declared maternal mortality as a "national emergency" during the 2008 Ghana Annual Health Summit (Ministry of Health, 2011). Research indicates majority (96%) of pregnant women in Ghana received Antenatal Care (ANC) from a trained provider, including, doctor, nurse/midwife or auxiliary midwife; about 77 percent of these women made four or more antenatal visits during pregnancy as recommended by WHO (Ghana Maternal Health Survey, 2007).

However, a skilled attendant is present at approximately half (55%) of all deliveries with 20 percent and 9 percent assisted by trained Traditional Birth Attendants (TBA), and untrained Traditional Birth Attendants, respectively. In addition, data indicates that nationally, 54 percent of births are delivered in health facilities, whilst about 45 percent occur at home (Ghana Maternal Health Survey, 2007). The situation is worse in some parts of the country, like Northern Ghana, where 71 percent of women are reported to have delivered at home and 25 percent at a hospital/clinic (Akazili, Livesy, Hodgson & James, 2011).

The Ghana Maternal Health Survey, 2007 reports that approximately 32 percent of the women, who did not have a skilled attendant at delivery, claimed it was not necessary to receive skilled attendant at delivery (Ghana Maternal Health Survey, 2007). It is important to note that this large proportion of women who perceive skilled birth attendance as not necessary, together with women who fail to utilize the service due to identified reasons, all

end up delivering without required skilled supervision. This is a grim reality, which warrants an in-depth understanding of the multiple factors that work against the use of facility-based services.

Previous studies indicate structural factors, including lack of financial or economic resources, transportation, and delivery supplies, lack of coordination and referral between TBAs at the community level and facilities can all inhibit women from using facility-based services (Ghana Maternal Health Survey, 2007; Mills & Bertrand, 2005; Seljeskog, Sundby & Chimango, 2006; Okafor & Rizzuto, 1994; Hoope-Bender, Liiljestrand & MacDonagh, 2006). Some studies show that barriers to access, especially financial ones, rather than traditional beliefs, were the main obstacles to delivery at health care facilities (Mills & Bertrand, 2005; Paula & Rob, 2001). However, other studies indicate client's negative perceptions of healthcare staff, including reports of unfriendliness at delivery also serve as barriers to obtaining skilled care (Okafor & Rizzuto, 1994; Mills & Bertrand, 2005; Seljeskog, Sundby & Chimango: 2006; Paula & Rob, 2001).

Furthermore, researchers emphasize socio-cultural influences on use and non-use of public health facility services in developing countries (Bazzano, Kirkwood, Tawiah-Agyemang, Owusu-Agyei & Adongo, 2008; Mathole, Lindmark, Majoko & Ahlberg, 2004; Mrisho, Obrist, Schellenberg, Haws, Mushi, Mshinda, Tanner & Schellenberg, 2009; Hunt, Glantz & Halperin, 2002; Geissler, Prince, Levene, Poda, Beckerleg, Mutemi & Shulman, 1999; Simkhada, Teijlingen, Porter & Simkhada, 2008). This includes extensive evidence provided on how gendered social roles and sex differences lead to inequalities in health-related options and outcomes for both women and men (Mumtaz & Salway, 2007; Bazzano, Kirkwood, Tawiah-Agyemang, Owusu-Agyei & Adongo, 2008; Mathole, Lindmark, Majoko, Ahlberg, 2004; Dako-Gyeke, Snow & Yawson, 2012).

In some contexts, it has been observed that a woman's use of antenatal and facility-based delivery services is the outcome of a complex interplay of gendered cultural hierarchies that locate pregnancy-related decision-making in remote authorities such as older female relatives or traditional birth attendants (Mumtaz & Salway, 2007; Bazzano, Kirkwood, Tawiah-Agyemang, Owusu-Agyei & Adongo, 2008). Also, a systematic review which analyzes determinants of antenatal care use in developing countries identified cultural beliefs and perceptions about pregnancy as key influential factors (Simkhada, Teijlingen, Porter & Simkhada, 2008). Historically, Ghanaian culture emphasizes pregnancy as a potentially dangerous period that requires spiritual protection (Allman, 1994; Allman, Parker &

Tongnaab, 2005). Thus, care for pregnant women is multifaceted, involving medical and psycho-social, economic and spiritual support.

To help address social, cultural and spiritual concerns, the contemporary growth of charismatic and evangelical Christian churches has provided a new avenue for many Ghanaian women to seek protection from the dangers they perceive from the natural and supernatural forces such as witches, wizards, and sorcerers (Sackey, 2002). In this regard, anecdotal reports suggest some women choose to deliver at prayer camps (i.e. residential locations established by various churches, where people can stay for any length of time in order to be healed or have their problems solved through nearness to the benevolent powers that emanates from the presence of a prayer leader) rather than in health facilities (Sackey, 2002; Omenyo, 2006; Van Dijk, 1997). Unfortunately, the exact extent of patronage of these camps for delivery is presently unknown (Sackey, 2002; Omenyo, 2006).

Also, Traditional Birth Attendants (TBAs) are noted to enjoy patronage due to their high sensitivity to socio-cultural norms together with a greater ability to incorporate psychosocial care into their services compared to modern health facilities (Hunt, Glantz & Halperin, 2002; Pfeiffer & Rosemarie, 2013; Shiferaw, Spigt, Godefrooij, Melkamu & Tekie, 2013). Gaps in the continued use of maternity services from a skilled provider in Ghana suggest need for further investigation into the socio-cultural context of provision and utilization of health care services during pregnancy and delivery. Socio-cultural perceptions, which allow or disallow use of pregnancy-related services including psycho-social, medical, and spiritual support, must be examined.

Most studies conducted on the influences of socio-cultural norms on use of maternity services in Ghana, have focused on rural communities (Mills & Bertrand, 2005; Bazzano, Kirkwood, Tawiah-Agyemang, Owusu-Agyei & Adongo, 2008; Addai, 2000). However, current records indicate that urban Ghanaian women do not necessarily deliver with the provision of health facilities.

An in-depth review of the influence of socio-cultural interpretations of pregnancy threats on health-seeking behaviour among the Ghanaians shows that emphasis is concentrated on maternal health seeking behaviour relating strictly to pregnancy outcome whereas, maternal health seeking behaviour transcend pregnancy outcomes. However, this study seeks to fill the identified lacuna such that factors affecting maternal health seeking behaviour is not limited

to pregnant women alone but, also extended to mothers with children up to two years in order to arrive at a more holistic findings on maternal health seeking behaviour.

In Nigeria, looking at the predictors of maternal health as perceived by pregnant women, it is observed that culture plays a leading role in everyday dealings including beliefs concerning pregnancy and childbearing. For instance, in the Western part of Nigeria which is dominated by the Yoruba, a pregnant woman is not expected to eat certain foods (snail, okro, and so on) or announce her state to members of her family to prevent spiritual attacks. This is corroborated by Geubbels' (2006), that this may attract the attention of evil spirits who may bring harm to the mother and child.

In situations where things go wrong during or after pregnancy, the woman is usually blamed for the consequences, hence her actions during birth is judged based on her adherence to certain cultural, traditional or religious beliefs as upheld by her and family members. A pregnant woman is compelled to adhere to the dictates of the elders in the family or society as backed by traditions and or religion. Mama (1996) revealed that in Nigeria, many women are denied their rights and are subjected to some cultural practices that greatly endangered their health. For instance, in the Northern part of the country, many still practice betrothing their children from the tender ages of twelve to older men for marriage, these children start to engage in sexual intercourse at an early age with their "husbands" and this is known to be detrimental to their development as they are too young to become mothers. This action endangers their health and that of their offspring.

In the Eastern part of Nigerian which is dominated by the Igbos, it is usually a thing of pride to have a non-eventful pregnancy, which is crowned by a vaginal delivery of the baby. Hence many women try everything they could in order to have vaginal delivery to maintain their ego (even at the expense or risk of their health), as it is culturally believed by the people that women who have not gone through normal delivery and gone through the pains of childbirth are not referred to as 'real women'. Some end up losing their babies or their lives in the process of trying to be a 'real women' (Mama, 1996). Western culture today often sees labour pain as something that should be 'fixed or stopped', in many cases embracing medical pain relief. There is though, a growing trend to try using natural therapies to minimize or negate the woman's need for pain relief (with their possible side effects) and incorporate this with 'hands on' physical and emotional support from the partner or chosen support people (Birth, 2010).

Apart from cultural beliefs, religion also affects maternal health or maternal mortality. Some Christians believed that the labour pain can be viewed as part of God's plan for mankind having disobeyed God's instructions after creation; hence, they refuse pain relief medications during pregnancy. Lack of interest or believe in drugs and medications could hinder effective service and care delivery, which non-Christians would refer to as a mere 'coincidence' or 'karma', or attribute this as the way God wants it to be. According to Birth (2010), what we believe is what we base our thoughts and emotions on and this in turn affects how we are biologically and how we relate with others in our social life. Primary health care facilities are provided by the government for the rendering of primary care services to pregnant women, but Rahman (2000) revealed that a woman's decision to attend a particular health care facility is as a result of personal need, social factors and the location of services.

Apart from cultural or traditional and religious beliefs, other cogent psychosocial factors limiting the quality of health among pregnant women are poverty, insufficient food, limited access to hospitals and lack of professional care. Cultural and religious elements could be identified as superstitious beliefs, level of spirituality and so on. The elements of culture and religion entrenched in social and mental factors that determine the extent to which people engage in health behaviours that could be either harmful or beneficial for them to attain their state of being (health). For pregnant women, it means that the elements of culture and religion are implicated in the factors that determine the extent to which they will engage in certain health behaviours.

These cultural and religious elements serves as hindrance to solving the MDG goal 5 as many of the women whom the professional care is meant for have beliefs and social norms contrary to the methods performed by the professionals in the care centres. To facilitate progress in the pursuit of the goal, it is highly imperative that the culture and religions practiced in the designated societies where these centres are situated be inculcated in the care and adequate awareness programmes for the enlightenment of these women so they can be more inclined to adhering to the fundamental health improving behaviours that will be introduced to them at the care centres. To achieve this, it is essential that counselors and psychologists be incorporated into these programmes to employ psychological methods like cognitive restructuring, behaviour modification and psycho-education among others to make these women more responsive to change and engage more in health improving behaviours than health impairing behaviours for the sake of themselves and their offspring. Understanding community level factors in the study of maternal health care is important because individuals

are nested within households and households are embedded in communities hence individual decisions can also be influenced by the characteristics of the communities in which they live (Mackian, 2003).

Maternal nutritional plane (Barker, 2004; Wu, Bazer, Wallace & Spencer, 2006) has been implicated in developmental programming and resulting in pre and postnatal changes that affect long-term offspring health and performance. A small amount of alcohol can cause permanent damage to the child. The use of alcohol during pregnancy can cause serious problems in children and adolescents including slow growth and developmental delay, unusual facial features, irritability, brain and neurological disorders and mental retardation. School-age children may have problems with learning, low tolerance for frustration, inadequate social boundaries and difficulty reading. Teenagers can have continuous learning problems, depression, anxiety and inappropriate sexual behaviour. Fetal alcohol symptoms are a more specific group of symptoms caused by alcohol intake. However, many pregnant women neglect these as their culture and religious practices may permit alcohol intake and when they give birth and the child begins to manifest the effect of the alcohol, they attribute the cause to other superstitious beliefs that the mother may have violated. This is to emphasize the importance of the need to develop maternal health as its impacts on the health of their offspring.

A critical review of the above predictors of maternal health as perceived by pregnant women shows that the study is limited to cultural and religious factors affecting maternal health seeking behaviour with little or no considerations for other factors like socio-demographic characteristics of the subjects involved. This identified gap is being taking care of in the current study.

Relating to the intercultural barriers to maternal health care, Guatemala Population Council (2010) stated that, while geographical and financial barriers still impede access to health services for indigenous peoples, cultural barriers have also played a role. Ethnographic data from Berry (2006, 2008) and other authors (Glei, Goldman & Rodriguez 2003; Hinajosa 2004; Roost et al. 2004; Replogle 2007) have demonstrated that Mayan women have a strong preference to stay at home for childbirth and be attended to by Mayan midwives (comadronas). The role of the comadrona is highly respected in most Guatemalan communities. A comadrona does much more than attend births – she provides spiritual guidance as well as prenatal and postnatal care, and she treats children's illnesses and women's gynaecological problems (Cosmimksy 2001; Mignone et al. 2009).

Specific comadrona practices differ per group and change over time. Guatemalan health authorities have recognised that comadronas are in close touch with the maternal health needs of the indigenous population in the rural areas, and have seen in them a medium to improve maternal and infant health (Hinajosa 2004). Since the 1980s, the Guatemalan Ministry of Health and Public Assistance (MSPAS) has offered formal training to comadronas in biomedical birthing physiology, the use of Western birthing instruments and the timely identification and referral of women with complications to the health facilities (Hinajosa 2004; Maupin 2008). However, this training and certification have not translated into a clear reduction of mortality ratios.

In addition, women feared the biomedical health services and perceived the quality of care as poor (Glei, Goldman & Rodriguez 2003; Roost et al. 2004; Berry 2006, 2008). Comadronas have been reluctant to refer women to hospitals because of women's rejection of these services and because women's birthing preferences were not respected there. In addition, the biomedical guidelines taught in the training courses for comadronas often contradicted their own experience and beliefs (Roost et al. 2004; Berry 2006; Replogle 2007; Berry 2008).

Marieke, Marta, Diana and Sandra (2013) submitted that in Guatemala, an alarming disadvantage in maternal health exists among indigenous populations, and lack of responsiveness of health facilities to cultural practices have contributed to this inequity. In recent years, the MSPAS has started a challenging transformation of the maternal health services in order to address these barriers and make the services more culturally appropriate. From their study findings, they conclude that much is still needed to really change biomedical service provider attitudes towards indigenous people and their obstetric practices. True recognition of the knowledge and abilities of comadronas is lacking and, while intercultural practices aims to integrate complementary practices, in the health facilities, biomedicine seems to be still the dominant discourse. They also suggest that a continued effort to change biomedical provider attitudes, as well as the strengthening of the comadronas' position is key in order to make the initiative a success and to improve the maternal health of indigenous women.

Available literature on intercultural barriers to maternal health care as discussed above tends to be more emphatically on the attitude of biomedical provider as a constraint to maternal health care. However, leaving the fact that there are instances where biomedical providers are of good attitude and facility well equipped yet patronage is low. Suffice to say therefore, that factors affecting maternal health seeking behaviour transcends but not exclude the attitudes of

care providers hence, the current study strive to look into several other factors beyond attitude of care providers.

Madagascar is regarded as one of the poorest countries in the world, 77% of households live below the international poverty line of $1.25 per day and 92% live on less than $2 per day, with the majority located in isolated rural areas (World Bank 2013; World Bank 2012). Impacts of the nation's political crisis 2009-2013 included the withdrawal or substantial reduction of almost all non-emergency international aid and major cuts to public service budgets - state spending on health dropped by 75% between 2008 and 2011 and a further 50% in 2012 (Ploch, Cook. 2012; IRIN 2011; IRIN 2012).

The national maternal mortality ratio, which was falling prior to the political crisis, rose back to an estimated 440 per 100,000 live births in 2010 (World Bank, 2011). Malagasy women have a 1 in 45 lifetime risk of death from pregnancy and childbirth (Population Reference Bureau, 2011) and 21% of deaths in women aged 15-49 are linked to pregnancy or childbirth (INSTAT, 2009). Despite progress made in increasing access to contraceptives and uptake of antenatal care, only 44% of births are attended to by a skilled health care provider (INSTAT, 2010). With an adolescent birth rate of 148 per 1,000 live births, Madagascar's teenage pregnancy rate is one of the highest in Africa (Binet, Gastineau & Rakotoson, 2009; UNFP, 2011) and sexually transmitted infections are found in 38% of the population and often remain undiagnosed and untreated (INSTAT, 2009; Leutscher, Jensen, Hoffmann, Berthelsen, Ramarakoto, Ramaniraka et al, 2005).

Maternal health studies in Madagascar have typically focused on biomedical factors, demographics or structural issues including weak health infrastructure, lack of access to quality health services (antenatal care, assisted delivery, emergency obstetrics, postnatal care), poor referral from the clinic and community to the hospital level, inadequate staffing and insufficient equipment or medical supplies and financial barriers to health (INSTAT, 2010; Sharp & Kruse, 2011; UNFPA 2010; Honda, Randaoharison & Matsui, 2011). Few studies have investigated the factors affecting maternal health seeking behaviour of this population.

The World Health Organization (WHO) defines 'maternal health' as the health of women during pregnancy, child birth and the postpartum period. Specifically, it encompasses the various health care dimensions of family planning, preconception, prenatal, intrapartum and postnatal care in order to reduce maternal morbidity and mortality (WHO, 2014). 'Maternal health practices' can therefore be understood to refer to the activities and habits of women

throughout these periods, which impact their health. Literature often refers to 'evidence-based practices' or 'best practices' as actions that have been evaluated extensively through scientific study and been found effective, in this case, resulting in the best possible maternal health outcomes (Gulmezoglu, 2003). It is with reference to these evidence-based practices (often expressed as recommendations) that we can compare different maternal health practices. In the same way, 'maternal health beliefs and traditions' can refer to the specific socio-cultural knowledge and customs - in general, the local understandings and corresponding actions that they provoke - regarding maternal health, that exist within a particular society.

Worldwide, the importance of understanding these maternal health practices, beliefs and traditions, and thus contextualizing maternal health, particularly in countries with high maternal mortality, has been recognized as playing a vital role in designing culturally appropriate interventions that are effective in reducing maternal mortality and improving public health (Gulmezoglu, 2003; Schim, Doorenbos, Benkert & Miller, 2007; UNFPA 2010; Thwala, Jones & Holroyd, 2011; Lori & Boyle, 2011).

Literature shows that native culture and religious beliefs have a strong effect on human infertility and assisted reproductive treatment. There are two types of infertility: the primary infertility and the secondary infertility. Primary infertility is a state in which a woman has never been pregnant or a state in which a man is unable to impregnate a woman. The Yoruba term for this is *agan* (barren). And, secondary infertility means that the infertile person has had one or more children in the past, but a medical problem is impairing further fertility. This could also be regarded as waiting period or *Idaduro* in Yoruba (Okonofua et al, 1997; Adegbola, 2007; Akande, 2008; Aluko-Arowolo, 2010). In South-Western Nigeria, however, infertility is viewed and interpreted within strong religious dogmas biases and solutions.

Amposah (1977) in his comparative study of West African traditional religion noted that everything that concerns the family, including its maternal healthcare and fertility is of interest to the ancestors. For this reason, it is not unusual to see among the Yoruba whenever an infertile person is going through trouble of non-conception that people often suggest that the ancestor(s) must be consulted to know the kind of divination they are to undertake to know the reason(s) behind the reproductive challenges. And when this is done, it is expected that the infertility problem would be remedied. In this sense, religion is devised to counteract biological problems and in this case infertility. Though, one may want to argue that with the coming of science, one does not need religion to explain certain issues including reproductive

matters. But this is not always the case because the modern church and to some extent Islamic clerics are still providing healing to diseases and ailment in Nigeria and elsewhere in Africa (Erinosho, 2006).

Religious responses, therefore, to Assisted Reproductive Technology (ART) deals with the new challenges and questions raised by ART for traditional and religious communities to ponder about. Chiwuzie and Okolocha (2001) however, opined that belief in traditional religions, Christianity and Islam has implication on the health seeking behaviour of infertile couple, in that they saw correlation between traditional beliefs (and practices) and poor health status of African women. It is not uncommon to see some Christians, especially, the Pentecostal sect, who believe that going to hospital is a sign of weak faith. Ironically the infertile women among the adherents of this sect even refuse to undergo any medical care once this is going to involve injections and oral medicine. This may on the long run be counterproductive to any treatment aimed at infertility.

Inhorn (2002) noted that belief in fertility, fecundity and infertility issues is regarded as mystery in most societies of Africa and therefore, unfathomable. This line of thought underscores the classical tradition of creation which centers on the axiomatic nature of God. Attempt to be equal to God in creative ability must be curtailed by sanction. Scott & Marshall (2009) and Rossides (1978) noted that the belief system in the west is a product of the Enlightenment Epoch, in which man is center/or super creature with limitless and perfect ability to know and to do all things. Hence science and technology are imperative to demonstrate man's inimitable perfection. Meanwhile, in spite of global understanding and illuminative insight brought about by science and technology, belief in witchcraft, magic and other spiritual powers is still rife in Nigeria and elsewhere in Sub Saharan African (Osakue & Martin-Hilber, 1998; Inhorn, 2002; Jegede & Fayemiwo, 2010). To assuage the stigma therefore, the childless women are made to pay repeated visits to herbal practitioners, diviners, spiritualists, *syncretic* groups of either Muslim or *aladura* sects of Christianity (Osakue *et al*, 1998; Akintan, 2001; Erinosho, 2006; Jegede, 2010).

However, recourse to ART to bring about conception is not altogether acceptable due to religious interpretation of the modality, despite the value and dignity attached to motherhood and children in Yoruba, Nigeria (Adegbola, 2007). All these religious activities are pointing to something peculiar in the health seeking behaviour of infertile men/women that no matter what, the majority are still consulting healing homes, prayer houses, as some could still not explain the mystery of childlessness. This limitation may not be unconnected with where they

live, their access to orthodox hospitals and general apathy due to low levels in education, income and other social vices (Aluko, 2014).

Following from the above discussion, religion is considered as having a great influence on the health seeking behaviour of the persons living with infertility, however, the issue of infertility could be as a result of a complex web of social, economic, educational, political and cultural factors. Besides, infertility is just one out of several maternal issues that could necessitate access and use of maternal health facilities. In other words, the ill-health condition of women of reproductive age is not solely the determinant of maternal health seeking behaviour. Owing largely to this empirical fact, this study serves as a bridge in the missing gap of factors affecting maternal health seeking behaviour.

A study on health care experiences and belief regarding pregnancy and birth among immigrant women of Somali refugee reveals that women in six receiving countries has identified that multiple factors can lead to adverse perinatal outcomes (Small et al., 2008). Research conducted by Vangen, Stoltenberg, Johansen, Sundby, and Stray- Pedersen (2002) reveals that Somali women in modern obstetric settings in Norway had a higher incidence of fetal death, fetal distress, and prolonged second stage of labour requiring operative delivery compared with non-Somali women. They concluded that circumcision (most often infibulation), low social status, suboptimal perinatal care, mental stress, poor nutrition, and intercurrent diseases such as tuberculosis, hepatitis, and parasitic infections all contribute to adverse outcomes.

Also, Johnson, Reed, Hitti, & Batra (2005) cited a higher incidence of gestational diabetes and perineal lacerations compared with U.S.-born Black and White women. Essen et al. (2000) have reported that even after migration to Sweden, Somali immigrants seem to maintain their cultural attitudes, strategies, and habits during pregnancy and childbirth and that these may contribute to a higher incidence of perinatal mortality and morbidity. Essen et al. (2000) also argue that as long as health care providers are unaware of cultural differences, which may lead to adverse perinatal outcomes, it is doubtful that women will change their beliefs and behaviours. When Johnson et al. (2005) compared U.S- born Black or White women with those born in Somalia, Somali women were nine times more likely to deliver at or beyond 42 weeks, and thereby the risk of adverse sequelae, such as oligohydramnios and fetal distress requiring caesarean delivery, was increased. A study by Wissink, Jones-Webb, Dubois, Krinke & Ibrahim (2005) found that health care providers' lack of knowledge and understanding of differences in practices, beliefs, preferences, and expectations regarding

pregnancy and childbirth were barriers to improving refugee women's care in the United States.

Herrel et al. (2004) described perceptions of diminished staff sensitivity to Somali women's individuality and care needs as a result of racial discrimination and stereotyping. The women also reported apprehension about cesarean birth and concern about the competence of medical interpreters.

Having review related literature on the influence of cultural beliefs and attitudes on maternal health seeking behaviour; it is observed that there is a link between the cultural beliefs and attitude of women of reproductive age and their access and use of maternal health care facilities at their disposal. The next section will dwell on the effect of social demographic characteristics of women of reproductive age and their maternal health seeking behaviour.

2.2 Socio-Demographic Characteristics of Women and Maternal Health Seeking Behaviour

There is no gainsaying the fact that there are constraints to utilization of maternal health services. Maternal health services aim at reducing maternal mortality and morbidity by ensuring that pregnant women remain healthy throughout pregnancy, deliver safely to healthy babies and recover fully from the physiological changes that occur during pregnancy. According to Obionu (2007) all pregnancies need quality maternal health services in order to ensure a good outcome for both the mothers and new-borns. The WHO (1998) noted the universally acknowledged fact that, millions of people in low and middle income countries, Nigeria inclusive, lack access to basic quality health care services. Donna and Barbara (2005) submit that, the picture is further worsened by the fact that about 99 percent of the causes of maternal mortality in developing countries are preventable.

Access barriers would be considered better indicators to utilization of health services than population per facility (WHO 1998; Moronkola, Omonu, Iyayi & Tiamiyu, 2007). It has been reported that the economic and social dimensions of the distribution of power between spouses, equally influences access and use of maternal health services, so also religion, spirituality, and traditional beliefs have also contributed to women's utilization of maternal health services. (Thaddeus & Maine, 1994; Nwakoby, 1994; Beegle, Frankenberg & Thomas, 2001; Uguru, Uzochukwu, Onwujekwe, Obikeze & Onoka, 2003; Chapman, 2003; Osubor, Fatusi, Chiwuzie, 2006; Tunde, 2007; Lindsey, Lubbock & Stephenson, 2008)

Apart from the constraints to utilization of maternal health services as reviewed above, it has also been established that there is influence of social factors on facility-based delivery. According to a report by the World Health Organization (WHO), a woman's lifetime risk of dying from pregnancy-related causes in high-income countries is 1 in 3800. However, in sub-Saharan Africa, the risk is 1 in 39 (WHO 2012). Universal skilled birth attendance is one of the most effective interventions available to reduce that risk, and in sub-Saharan Africa, skilled birth attendance is often equated with facility-based delivery (Penfold, Harrison, Bell & Fitzmaurice, 2007; Wang, Alva, Wang & Fort, 2011). Despite the WHO recommendations to encourage all women to seek facility-based delivery, several barriers have been recorded that prevent women in Africa from delivering in facilities.

Distance to the facilities (; Tann, Kizza, Morison, Mabey, Muwanga, Grosskurth, et al. 2007), rural residence (Adanu, 2010; Woldemicael, 2010; Faye, Niane & Ba, 2011), lack of health insurance and other economic factors (Babalola, & Fatusi, 2009**;** Spangler & Bloom, 2010; Hong, Ayad, & Ngabo, 2011) are some of the many logistical barriers repeatedly linked to lower rates of facility delivery.

Less well-studied, however, are the social factors that may serve as barriers for women. Social factors —drawing upon the medical sociological tradition that sees social structure, social interaction, and culture as critical to understanding health, illness, and care seeking (Cohen, Finch, Bower & Sastry, 2006; Schouten & Meeuwesen, 2006; Conrad & Barker, 2010; Holt-Lunstad, Smith & Layton 2010; Brown, Lyson, & Jenkins, 2011;) may include such things as community and family hierarchies that require women to seek permission before they can go to a facility, social norms that influence prevailing attitudes toward facility delivery, and the role of social networks in helping women implement decisions made regarding care seeking. The community or family hierarchy is the structure in which cultural ideas relating to autonomy, authority, and power (and the need for some to seek permission from others) are created, sustained, and changed.

In a study in Africa, for instance, only 12 of 111 women who delivered at a facility said they made the decision to go to a facility on their own (Telfer, Rowley & Walraven, 2002), this suggests the important roles that other people play in deciding for woman, as a significant majority would not take decision on their own. In rural northern Ghana, where much of the population is extremely poor and where most families rely solely on subsistence agriculture for survival and logistical challenges impede facility deliveries. These challenges have been documented for rural northern region and the rest of Ghana in no less than 14 studies, citing

cost, lack of health insurance, socio-economic factors, lack of transport, and being taken by surprise in the middle of the night as key factors in preventing facility delivery (Penfold, Harrison, Bell & Fitzmaurice, 2007; Adanu, 2010; Addai, 2000; Akazili, Doctor, Aboky, Hodgson, and Phillips, 2011; Bazzano, Kirkwood, Tawiah-Agyemang, Owusu- Agyei & Adongo, 2008; Crissman, Crespo, Nimako, Domena, Engmann, Adanu, et al. 2011; Crissman, Engmann, Adanu, Nimako, Crespo & Moyer, 2013; D'Ambruoso, Abbey & Hussein, 2005; Galaa & Daare, 2008; Gyimah, Takyi, & Addai 2006; Jansen 2006; Mills & Bertrand, 2005; Mills, Williams, Adjuik, & Hodgson 2008; Smith & Sulzbach, 2008).

Evidence suggests that social factors also play a role in whether women deliver at home or in health provided facilities. For example, researchers found that women who practice traditional religions in Ghana have lower rates of facility delivery, even when controlling for rural residence and socio-economic factors (Addai, 2000; Gyimah, Takyi & Addai, 2006). Such findings raise questions about the importance of social structures, social interactions, and cultural practices in influencing where women in northern Ghana deliver their infants.

The above review of available literature on the social demographic characteristic of women reveals that maternal health seeking behaviour is to a very large extent a function of the interplay of women social demographic factors such as occupation, marital status and education among others. There is no gainsaying the fact that social demographic characteristic of women is vital to the study of maternal health seeking behaviour. However, one cannot overrule the possibility of a situation whereby women that are considerably placed on the favourable side of social demographic status yet exhibit poor maternal health seeking behaviour or even find it difficult to access needed maternal health care facilities. Based on the foregoing, a review of the impact of the existing social structure on maternal health seeking behaviour is equally of great importance.

2.3 The Impacts of the Existing Social Structure on Maternal Health Seeking Behaviour

A review on disparities in utilization of maternal health care facilities is also critical regarding issues relating to maternal health seeking behaviour. Since the Millennium Declaration of 2000, one area of policy focus felt to be of particular importance to the reduction of maternal mortality is to increase the proportion of women that receive skilled antenatal, delivery and post-natal care (PNC) from the skilled health professional (Ridde & Diarra 2009). Evidence suggests that use of appropriate maternal health care services, especially skilled attendance at birth and timely referrals to emergency obstetric care

services, is strongly associated with substantial reductions in mortality and morbidity for both mother and newborn (Essendi, Mills, & Fotso 2010; Abor, Abekah-Nkrumah, & Sakyi 2011).

Despite this facts, disparities in utilization of skilled maternal health care services have been identified as an important factors impeding progress towards attainment of the maternal health-related Millennium Development Goals (MDGs) in many Sub-Saharan African countries (Zere et. al. 2010). Attempts to rectify disparities in utilization of maternal health care services in Africa must begin with an accurate account of their prevalence (i.e. who has poor access to maternal health care) and with some attention to potential etiologies and pathways. Most countries in sub-Saharan Africa currently monitor their progress towards meeting the maternal health-related MDG targets through aggregate population-based data. This masks the variations in health levels experienced by different ethnic groups within each country, making it impossible to see which communities are most at risk. This is made worse by the MDGs' numbers-based targets, which might encourage the concentration of efforts on those segments of the population who are the easiest and cheapest to reach.

To fully understand the maternal health situation of the whole population of a country, there is need for disaggregation of data along different dimensions, including ethnic identity. In particular, an examination of disparities in utilization of essential maternal health care interventions is critical for evidence-based decision-making and targeting limited health resources to underserved populations (Zere et al. 2012). Part of the objectives of this study is to examine disparities in utilization of maternal health care among the Yoruba people of Nigeria. The researcher of the study made some attempts to provide some evidences, based on existing social disparities in utilization of services as a foundation for policy-making and programmatic decisions in the maternal health sector especially in Nigeria and in Sub-Saharan Africa as a whole leaving a gap in the area of cultural beliefs and practices of the people which is very crucial in decision making regarding health seeking behaviour of women of reproductive age.

Looking at a study on allopathic and traditional maternity care providers in Ghana, it was revealed that maternal and neonatal mortality rates in much of Sub-Saharan Africa are tremendously high, particularly in Ghana. Studies conducted in Ghana in 2013 show a lifetime risk of maternal mortality of 1 in 66, and a neonatal mortality rate of 24 per 1,000 live births (UNICEF 2013, Welaga, Moyer, Aborigo, Adongo, Williams, Hodgson, Oduro & Engmann 2013). Almost 50% of maternal deaths in Ghana occur in the first 24 hours after birth, often caused by delays in seeking and receiving necessary medical care (Issah, Nang-

Beifubah & Opoku, 2011; Welaga, Moyer, Aborigo, Adongo, Williams, Hodgson, Oduro & Engmann, 2013;). Thus, efforts need to be geared towards intervention to improve maternal and neonatal outcomes surrounding the pregnant woman's decision of whether or not to seek medical care during pregnancy and delivery.

There is a pluralistic health care system in Ghana which consisting of both traditional and allopathic medicine. In seeking antenatal care, Ghanaian women use traditional medicine, allopathic medicine, or some combination of the two (Tabi, Powell & Hodnicki, 2006). The system of traditional healers has been widely used for centuries, and these healers typically live within the communities they serve (WHO, 1978). The advantages of Medical care through traditional healers cannot be under-estimated. Since traditional healers share history and culture with their patients, they provide care that complements their patients' belief systems and fits within their worldview of the causes of illness (Green & Makhubu, 1984; Freeman & Motsei, 1992; van der Geest, 1997; Jager 2005; Tabi, Powell & Hodnicki, 2006). Moreover, the affordability and ready access to traditional healers contributes to their patronage. Most communities have at least one traditional provider present (Tabi, Powell & Hodnicki, 2006; Ana, 2011; Hardy, 2008).

There are also considerable shortcomings; many aspects of traditional medicines were not scientifically proven or necessarily reproducible. Healers often rely on spiritual guidance for their treatments, and herbal medicines typically have limited or non-existent dosing guidelines, leading to potentially serious risks for patients due to over-dose (Green & Makhubu. 1984; Steenkamp, Stewart & Zuckerman. 2000; Hardy 2008). While some traditional healers undergo training through an apprenticeship, many are without any formal or recognized training (Ana, 2011). They are frequently characterized by a spiritual calling rather than completion of a formalized training program (Green & Makhubu, 1984; Nelms & Gorski .2006).

In most instances, patients often combine traditional and allopathic medicine (Hardy 2008; Warren, Bova, Tregoning & Kliewer 1982). Tabi et al. found that Ghanaian citizens frequently use both types of health care, considering the interplay between family, friends, employers, education, religion, and culture as factors dictating which health care system to rely upon. Additionally, it was also reported that people often sought "diagnosis" from allopathic medical providers, while seeking both "treatment and spiritual meaning" from traditional medicine (Tabi, Powell & Hodnicki. 2006). As observed by Green and Makhubu,

the "shortcomings of traditional healing should be balanced against its beneficial or useful functions, the same could be said for allopathic medicine" (Green & Makhubu. 1984).

A review of literature on determinants of maternal health service uptake revealed that contrary to the 2013 UN Millennium Development Goals (MDGs) progress report which shows that many regions of the world have made progress on the fifth goal of improving maternal health, the region of Sub-Saharan Africa is still lagging behind, and would not be able to meet the agreed targets of 'reducing by three quarters, between 1990 and 2015, the maternal mortality ratio' and 'achieving by 2015, universal access to reproductive health' (UN Department of Economic and Social Affairs. 2013). A 2010 review (Hogan, Foreman, Naghavi, Ahn, Wang, Makela, et al. 2010) of maternal mortality in 181 countries spanning 1980– 2008 reveals that in 2008, half of all maternal deaths occurred in only six countries (India, Nigeria, Pakistan, Afghanistan, Ethiopia, and the Democratic Republic of the Congo). The implication of this is that much work is still required in the area of maternal health especially in the area of health seeking behaviour of women of reproductive age.

Knowledge and perceptions of reproductive rights (RRs) among women of reproductive age is a very important factor in maternal health seeking behaviour. Reproductive rights (RRs) are basic to women's reproductive health (ICPD, 1994; Centre for Reproductive Rights [CRR], 2008), because these rights are inalienable and inseparable from other fundamental rights such as right to life, right to non-discrimination, right to privacy, right to food, shelter, health, security, livelihood, education and political empowerment. Enforcement of these rights is imperative since discrimination against women manifests itself in a wide and complex variety of ways, which can directly or indirectly, impact on their health (World Health Organization [WHO], 2003).

It has been stated that reproductive rights are human rights (CRR, 2008) and many problems have arisen as a result of violations of these RRs, hence the international community has identified the need for urgent action. These challenges include gender-based violence, HIV/AIDS, maternal mortality, teenage pregnancy, abandoned children and rapid population growth (UNFPA, undated) amongst others. This massive denial of human rights causes the death of millions of people every year; unfortunately many people neither know that they possess these rights nor the claim to them (Jegede, 2007). One thing that this position fails to establish is the fact that knowledge of a policy does not necessarily translate to compliance of such policy. There are several other factors that could debar women of reproductive age from taking advantage inherent in their reproductive rights

From the point of view of contextual determinants of maternal health care service utilization, it is an empirical fact that maternal health is a global concern. More than 358,000 women worldwide die each year during pregnancy and in the postpartum period; about 99% of these deaths occur in developing regions, with Sub-Saharan Africa and southern Asia accounting for 87% of maternal deaths (Kistiana, 2009; Brown & Small, 2012). The maternal mortality ratio in Sub-Saharan Africa is 500 per 100,000 live births (United Nations Population Fund [UNPF], 2012). The World Bank estimates maternal mortality ratio of 630 per 100,000 live births in Nigeria (World Bank, 2013) is an indication of the poor maternal health situation in the country. Most often, the high maternal mortality has been attributed to inadequate or non-use of maternal health care services, such as antenatal, delivery and postnatal care (Onah, Ikeako, and Iloabachine, 2006).

As observed by Doctor (2011), the use of maternal health care services differs significantly between northern and southern part of Nigeria, with the latter faring better than the former. Hence, the poor use of antenatal care (ANC) largely contributes to the overall high maternal mortality ratio in the country. The ANC policy in Nigeria also follows the latest World Health Organization (WHO) approach (Focused Antenatal Care) that seeks to promote safe pregnancies. The updated approach recommends at least four ANC visits for women without complications and emphasizes the quality of care necessary during each visit (National Population Commission [NPC] and Inner City Fund [ICF] Macro, 2009). The number of ANC visits a pregnant woman makes is important in preventing complications and adverse maternal health outcomes (Ikamari, 2004). ANC visits also provide an avenue for pregnant women to identify complications associated with pregnancy and benefit from other interventions including counseling on healthy lifestyles and the management of complications (Kistiana, 2009).

Despite the call of the International Conference on Population and Development (ICPD) to improve the use of maternal health care services and reduce maternal mortality, more than half the women in Nigeria (55%) attend fewer than the four recommended ANC visits (NPC & ICF Macro, 2009). Babalola & Fatusi (2009) found that this level of use of ANC in Nigeria was lower than in other countries in Africa. Attendance was as high as 88 percent for Benin, 83.4 percent for Cameroon, and 91.9 percent for Ghana. Several studies have established the relationship between demographic and socio-economic characteristics and ANC. Studies in Nepal and Bangladesh have shown that predisposing and enabling characteristics such as educational level, autonomy, household structure, household wealth, and place of residence

were significantly related to the use of ANC (Haque, 2009; Matsumura & Gubhaju, 2001). Current use of contraception and the frequent visit of health workers to respondents were significantly associated with the use of ANC (Abedine, Islam, & Hossain, 2008). Family size and access to a health care facility have been found to be strongly related to the use of maternal health care (Chakraborty et al., 2003).

Studies in Nigeria have revealed that the perceived quality of care, religion, ethnicity, income-yielding occupations, and saturation of mass media were also significantly related to the use of antenatal care (Awusi, Anyanwu & Okeleke, 2009; Babalola & Fatusi, 2009; Iyaniwura & Yussuf, 2009). Adamu (2011) found that the utilization of maternal health care service varies across the regions of Nigeria, and that education and family wealth index were strongly related to service utilization in all the regions. Maternal health care utilization is not only related to individual choice or characteristics but also to a large extent depends on the sociocultural arrangements of communities (Haran, & Hatcher, 2008). Understanding the role of community factors in studies of maternal health care service utilization is important because decisions to seek health care can be related to the characteristics of the community in which a woman lives (Mackian, 2003). Moreover, a social ecological perspective emphasizes the contribution of multiple relations of physical socio-cultural and environmental conditions to health behaviour (Stokols, 1996).

A study on knowledge and attitude of pregnant women towards antenatal exercise shows that safe maternity with improved neonatal outcomes is predicated on proper antenatal care services (Palaniappan, 1995; Awusi, Anyanwu & Okeleke, 2009). Exercise has become a fundamental aspect of women's lives and an important constituent of antenatal care (ACOG 2002; Barakat, Pelaez, Montejo, Luaces, & Zakynthinaki, 2011). Wang & Apgar (1998) submitted that empirical data on the impact of exercise on the mother, the fetus, and the course of pregnancy are still limited and results of the few studies in humans are often equivocal or contradictory. However, the American Congress of Obstetricians and Gynaecologists (ACOG 2002) recommended that pregnant women can exercise moderately for half hour on most days of the week.

In accordance with these recommendations, irrespective of the pregnant woman's physical fitness level, exercise should be low-impact, moderate-intensity, and regular (ACOG 2002; Ribeiro & Milanez, 2011). Studies have recommended that women should initiate or continue exercise in most pregnancies (ACOG 2002; Wolfe & Davies 2003; Ribeiro and Milanez, 2011) as it is safe for mother and not harmful to the foetus (ACOG 2002; Clapp III, Kim,

Burciu, & Lopez 2000, Riemann & Hansen, 2000). The health advantages of regular physical exercise in pregnancy include maintenance and improvement of physical fitness and cardiovascular endurance (Wolfe & Davies, 2003), prevention of excessive gestational weight gain and glucose intolerance (Mottola & Ruchat 2011; Chasan-Taber 2012), conditioning of the muscles needed to facilitate labour (Ribeiro and Milanez, 2011; Clapp III 1990; Kardel & Kase, 2007), and improvement in psychological adjustment to changes in pregnancy (Wolfe & Davies 2003). In addition, exercise in pregnancy is correlated with a decrease in many common challenges of pregnancy (Wadsworth, 2007) and the stress of exercises produces certain adaptation such as healthier placenta and increased ability to deal with short decrease in oxygen (Donald, 1994).

In spite of the fact that exercise programs during pregnancy and after childbirth are designed to minimize impairment and help the woman maintain or regain function while she is preparing for the arrival of the baby and then caring for the infant (ACOG 2002; Morkved, Bo, Schei, and Salvesen 2003; Stephenson and O'Connor 2000), it is opined that women are not meeting the exercise recommendations of the previous studies: (ACOG 2002; Pivarnik, Chambliss and Clapp et al., 2006; Evenson, Moos, Carrier & Siega-Riz, 2009). A myriad of factors not limited to beliefs and attitudes of women with respect to exercise in pregnancy (Clarke & Gross 2004; Krans, Gearhart, Dubbert, Klar, Miller & Replogle, 2005; Duncombe, Wertheim, Skouteris, Paxton & Kelly 2009; Ribeiro & Milanez, 2011), level of knowledge (Evenson, Moos, Carrier, and Siega-Riz, 2009; Krans, Gearhart, Dubbert, Klar, Miller & Replogle 2005; Moran, Holt & Martin, 1997), level of education (Ribeiro & Milanez 2011), safety concern of the pregnant woman and her physician (Wang, 1996), race/ethnicity, and previous involvement in constant exercise have been implicated as important factors predisposing to exercise engagement or phobia among pregnant women. Thornton et al. (2006) posited that identifying factors that affect beliefs and behaviors would objectively encourage a change in attitude.

Studies on birthing choices established that maternal morbidity and mortality remain overwhelmingly high in sub-Saharan Africa where, for instance, a woman's maternal mortality risk is 1-in-30, compared to 1-in-5600 in richer parts of the world. The decline in maternal mortality rate is also slow, although the majority of deaths could be prevented (Goodburn & Campbell, 2001; United Nations, 2010). Improving maternal health in Uganda poses a challenge. Perinatal and maternal health problems account for 20.4% of the total disease burden. Limited progress has been made in ensuring universal access to reproductive

health (Ministry of Health, 2010). Notably, the maternal mortality ratio remains high at 438 per 100,000, while the perinatal mortality ratio is 40 deaths per 1000 live births and pregnancies (Uganda Bureau of Statistics & ICF International, 2012).

Adherence to traditional birth practices influences the choice of place of delivery amongst numerous ethnic groups in Uganda. Among the Banyankole, for example, childbirth is regarded as a normal process that should take place at home, while among the Banyoro and Baganda, pregnancy and childbirth are viewed as risky and equated to a battle or a 'thorn-strewn path' that the woman has to tread. Maternal death among the Banyoro is regarded as a sad but normal event. Nevertheless, homebirths are admired. Women who deliver by Caesarean section are deemed lazy and are therefore not congratulated (Kyomuhendo, 2003). Indeed, amongst certain cultural groups, particular value is placed on unassisted births and women in labour are discouraged from communicating about their condition (Sargent, 1984; Bradby, 1999).

According to Amooti and Nuwaha (2000), home-based, unassisted deliveries have an element of self-efficacy that is founded on cultural institutional values and experiences. Despite their frequent lack of technical skills, traditional birth attendants (TBAs) are deemed a culturally appropriate and acceptable presence during delivery by many ethnic groups in Uganda. Advantages locally associated with TBAs include their accessibility and in some cases the belief that these women possess 'magical' abilities to change the sex of the baby and treat infertility (Waiswa et al. 2010). However, TBA practices remain controversial since they are associated with late referrals and the poor management of various medical obstetric conditions (Ministry of Health 2010).

In Uganda, the use of herbs, non-supine delivery positions and placenta disposal are all cultural preferences that are more easily put into practice in the home setting, and hence influence the choice of delivery location (Kasolo & Ampaire 2000; Kyomuhendo 2003). The practice of Female Genital Mutilation/Cutting (FGM/C), which in Uganda is practised by the Sabiny and Pokot people, can also influence birthing choices. It has been observed elsewhere that circumcised women may resist using biomedical services (particularly outside their own cultural setting) for fear of embarrassment (Lundberg & Gerezgiher 2008; Odemerho and Baier 2012).

Literature shows that, while homebirths among the Sabiny appear to be significantly high compared with national-level data, a preference for homebirths is not peculiar to Sabiny

culture (Magoma et al 2010; Waiswa et al. 2010). Furthermore, the perception of childbirth as a normal process where births should be unassisted has also been observed among the Banyankole (Uganda) and in rural Tanzania (Neema 1994; Magoma et al. 2010). Sabiny culture is perceived to be unique, however, in that the responsibility for ensuring a live birth is placed on the woman. Similar to the Banyoro of Uganda (Kyomuhendo, 2003), childbirth amongst the Sabiny is synonymous to a 'war' that should ideally be fought outside of a medical setting (unless major complications are anticipated) where the community retain control over the process and women can retain their traditional identity and status (Magoma et al. 2010).

However, Benintendi (2004) submitted that, for women with risky pregnancies or problematic birth histories to be compelled to opt for homebirths, and then be blamed in case of negative outcomes irrespective of the cause, has an element of victimization. It is therefore important that women and communities are made aware that, in some cases, the battle does not have to be fought alone (Kyomuhendo, 2003) or limited to the home setting and that the wellbeing of mother and child is of central concern.

As observed elsewhere (Bradby, 1999; Kasolo & Ampaire, 2000; Ruiz et al. 2013), Sabiny women and their communities attach importance to the use of herbs, upright delivery positions, the presence of close relatives during labour, placenta disposal and seclusion after delivery (widely practiced in the developing world), while FGM/C is associated with a desire for 'cultural privacy'. In addition, the Sabiny's need to display resilience, which displays elements of self-efficacy and cultural identity, restricts the utilization of postnatal services. Lack of understanding and the failure to accommodate such practice reveals a lack of cultural competence among health workers.

As reported by Waiswa et al. (2008), the Sabiny preference for homebirths is also linked to the value attached to TBAs and their culturally relevant approach whereby women preserve their identity and dignity. Traditional birth attendants can be considered the custodians of maternity tradition among the Sabiny, and carefully devised interventions that recognise their cultural importance are required. For example, the practice of women being escorted to health facilities by TBAs could be encouraged. Prolonged sexual abstinence in the Ugandan context is unique to the Sabiny. It has protective health benefits but also has potential for promoting extra-marital sex and possible exposure to sexually transmitted diseases. The Sabiny differ from other ethnic groups in that husbands face cultural pressures and can bear the brunt of stigma in case of non-compliance with cultural expectations. In many cases, women's failure

to access services may be detrimental to their health and that of their unborn/newborn child, or even fatal.

However, in many cases it may often be in their best interest to maintain harmony and respect within marriage and the community. Many of women's reservations concerning public health services were linked to health workers' limited cultural competence (Odemerho & Baire, 2012). This is evidenced by the fact that some women were not comfortable at health facilities, perceived such settings as foreign and found communication with health workers challenging. Reports of discrimination and abuse echo the more general marginalization of minority indigenous people (Stephens et al. 2006) that requires urgent attention.

A review on preferences for home delivery from provider perspectives revealed that more than half of maternal deaths (56%) worldwide in 2010 occurred in sub-Saharan Africa (World Bank, 2010), and most of these (60%) occurred during childbirth or the immediate post-partum period (Rogo, Oucho, and Mwalali, 2006). Delivery in health care facilities can avert maternal deaths by providing women with skilled delivery assistance, drugs to address labour complications and referral to a more advanced clinic or hospital if necessary (United Nations, 2012). Many women in Africa, however, continue to deliver their babies at home (Montagu, Yamey, Visconti, Harding & Yoong, 2011). Barriers to deliver at a health centre or hospital identified by women include long travel distances, unreliable or non-existent modes of transportation and the real or perceived cost of skilled care (Mills & Bertrand, 2005; Mills, Williams, Adjuik & Hodgson, 2008; Mrisho et al., 2007; Tann et al., 2007). In addition, women express a preference for delivery in the privacy of their own homes, where they also have more influence over factors such as the physical position in which they labour (Adamu & Salihu, 2002; Kyomuhendo, 2003).

Finally, women's level of trust in the quality of care they will receive at a certain facility has also been identified as an important factor in whether they choose facility-based delivery (Kruk et al., 2009; Kruk, Rockers, Mbaruku, Paczkowski, & Galea, 2010; Rockers, Wilson, Mbaruku, & Kruk, 2009; Shiferaw, Spigt, Godefrooij, Melkamu, & Tekie, 2013). Researchers also note that efforts to increase facility births in rural, low-income settings have had mixed success (Otchere & Kayo, 2007; Hounton, Byass, & Brahima, 2009; Mushi, Mpembenji & Jahn, 2010).

Few studies have explored the perspectives of the health care professionals responsible for providing delivery services in low-income, rural settings (Mrisho et al., 2007, 2009; Shiferaw

et al., 2013). This omission is important; 47.9 percent of the world's population still live in rural areas (United Nations Department of Economic and Social Affairs, 2011), and rural health care providers are uniquely positioned to identify the institutional or environmental factors that influence the use of facility-based delivery services that might not be readily apparent to patients or identified by urban providers.

The review of available literature relating to the impact of the existing social structure on maternal health seeking behaviour established a relationship between the two variables. In addition the next subsection will examine relevant literature regarding access and use of orthodox and traditional medicine.

2.4 Access and Use Orthodox and Traditional Medicine

The continuous unimpressive maternal health indicators in Nigeria and the country's inertia advance toward achieving Millennium Development Goal 5 indicate that policymakers need to pay more attention to basic issues that debar efforts at improving maternal health. Many studies have suggested that strategic policies should focus on providing free maternal and reproductive health services particularly in the rural areas especially among the poorest of the poor. Previous studies establish relationships among poverty, rural residence, and maternal health. For instance, Bhutta, Cabral, Chan & Keenan (2012) submitted a larger proportion of the global burden of maternal mortality is among women who are poor, uneducated, of indigenous origin, and from marginalized or rural areas. Ezeonwu (2011) also reported that poverty has a significant negative effect on maternal health because poor women are deterred from accessing and utilizing professional skilled health care service providers. Among adolescents who constitute a key proportion of Nigerian population, Rai, Singh & Singh (2012) found that even when appropriate services are in place, poverty was a key determinant in the way they utilized maternal health care services. Gilmore & Gebreyesus (2012) submitted that financial restrictions to contraceptive access, especially for the poorest women and those who are pregnant during adolescence, should be looked into by providing free or subsidized services at the point of maternal health care.

Looking at Nigeria as one of the world's largest producers of crude oil, it will not be out of point for one to recommend free maternal health care services for her citizens. On the contrary, expenditure on maternal health care remains very low despite the huge revenue from petroleum export. For instance, in 2010 the total government expenditure on health as a

percentage of the overall government expenditure was only 4% and the per capita total expenditure on health was $59.00 (WHO, 2012). This leaves the citizens with high out-of-pocket costs for health care services. Since families and individuals make tough choices between investing their very meager income on basic human needs (food, shelter, and clothing) and health care, seeking a health care option that employs the services of skilled attendants, though desirable, however, will rank lower for mothers particularly when there are cheaper alternatives such as the TBAs and mission homes.

It was suggested by WHO (2012) that simple but logical policy approach to increase seeking for skilled health care services among poor women is for the government to subsidize the cost of skilled services and, in this context, make such services free or offered at lower prices than the TBAs. To a large extent (especially for the poor), increasing access to health care services depends on reducing financial barriers to receiving care, particularly out-of-pocket costs. As evident in the work of Aboagye & Agyemang (2013), the delivery exemption policy in Ghana resulted in increased use of antenatal care in the country. In South Africa, eliminating user fees for maternal and child health care services also resulted in increased use of antenatal and child health care services (WHO, 2005). It will not be out of place if broader exemption policies that include reproductive and comprehensive maternal health care services is fully considered for Nigerian women.

In Nigeria, efforts needs to be geared towards increasing the demand for and utilization of skilled services by eliminating cost of maternal health care seeking and improve targeted education and outreach to women and their support system to ensure that they understand the importance of antenatal care, skilled attendance at delivery, and postnatal care. In addition, it has been argued that spousal, family, and community inclusiveness in the plan of maternal health care services are fundamental to improving reproductive and maternal health outcomes, a study conducted in Malawi suggests that involving men, as well as the extension of antenatal care services to men, can help overcome obstacles to improving maternal health care seeking at the community level (Aarnio, Chipeta, & Kulmala, 2013).

In their report on maternal and newborn health roadmaps, Ekechi, Wolman, and De Bernis (2012) noted that working with individuals, families, and communities, and ramping up human resources are the top two strategies for reducing maternal mortality. In addition, the WHO (2010) “Making Pregnancy Safer Initiative” emphasized the importance of the collective roles of women, their partners, families, and the larger community in improving maternal

health. It recommended that both improvement of maternal and newborn health services and actions at the community level are required to ensure that women and their newborns have access to skilled health care when they need it. Intense outreach, education, and engagement of the whole community will help improve outcomes for mothers.

Nigeria experiences several health systems-related physical and human infrastructural deficits that directly and indirectly debar efforts at improving maternal health. According to a WHO (2012) report, supportive legislation is a key first step in improving access to quality health care, and it must be followed by sustained political commitment and strong support from stakeholders so that policies are translated into actions on the ground. A clear maternal policy agenda that includes support for nursing and midwifery is still need to be articulated in Nigeria in order to meet the overwhelming health care needs. Such a policy agenda must address the country's weak health system particularly in maintaining a robust financing mechanism and ensuring access to quality maternal care provided by well-trained and adequately paid workforce at well-maintained health facilities.

Although Nigeria has made some efforts in improving the health system, they are not enough to make a significant impact on maternal health. For instance, the Federal Executive Council developed and approved the National Strategic-Health Development Plan that outlines a broad framework to strengthen the national health system and improve the health status of Nigerians (Nigerian Federal Ministry of Health, 2010). Concrete actions, however, are needed to implement appropriate policies and programs that are associated with the plan including those that relate to access to maternal health care and associated point of care and workforce supply chain infrastructure. There is need to emphasize that improving maternal health requires a comprehensive package that includes physical infrastructure and workforce development.

In addition, it is evident that issues relating to malaria, HIV/AIDS, tuberculosis, and hunger and malnutrition are funding priorities for major donor agencies and foundations (Esser & Bench, 2011; Kaiser Family Foundation, 2007; Shiffman, 2007). Such prioritization of disease-based medical interventions and medical education, though critical, has not turned the page for the overall health of women in developing countries including the Yoruba people of Nigeria. Without improvement on maternal health care seeking behaviour, for example, those priority projects and programs will be stalled. Maternal health problems also contribute to global health burdens. A broader health policy approach that also prioritizes women's health

is therefore essential. Such a policy must include the expansion and strengthening of the health workforce, particularly nursing, in order to provide adequate skilled maternal care to all women, even in the most remote areas of the world.

For Nigeria to make faster progress in improving maternal health outcomes, strategic policies should focus on reducing and removing all financial restrictions to maternal health services access and utilization. The emphasis on cost is essential due to the persistent poverty among women particularly in the rural villages. Policymakers must embrace the principle that a woman's financial and educational status and where she lives should have no bearing on maternal and reproductive health services that are available to her.

It has been observed that decisions women make for themselves during pregnancy and childbirth may have a direct impact on maternal morbidity and mortality. Culture is identified as one of the dominant influences in a woman's life that directly affects her decisions during this critical period.

In Matlab, Bangladesh, women and birth attendants had no consensus that atonic uterus, retained placenta, or a bad tear could cause postpartum haemorrhage (Sibley et al. 2009). Nigerian women did not associate edema with high blood pressure or convulsions, but celebrated it as an indication that the baby to be born would be male (Okafor & Rizzuto, 1994). In one culture, biomedical causes for death were not considered at all, but all deaths within 40 days postpartum were attributed to phobia from seeing an evil spirit (Jaffre and Prual, 1994). To the Kaqchikel in Guatemala, anything that occurs during labour is acceptable as long as the outcome is a 'normal' birth. All occurrences that would be classified as a complication are attributed to spiritual or social causes unrelated to the pregnancy and as such, do not require medical treatment. This is owing to the fact that each woman is viewed as a distinct and separate entity, information about childbirth based on one woman's experience are not applied to difficulties in other women's pregnancies or labours. Even when mothers and birth attendants are aware of medical interventions for obstetric 'emergencies, they often do not use them, relying instead on traditional practices and experience for ineffective care that leaves women at great health risk and even death (Berry, 2006).

Culture impacts a great deal on maternal mortality by influencing a woman's use of health care during pregnancy and childbirth. Within a subculture in Nigeria, prolonged labour is believed to be caused by food eaten during pregnancy, infidelity or failure to perform

necessary cultural rituals. The Eze Ukwu ceremony, given by a husband to celebrate his wife's tenth pregnancies, must be had before the birth of the eleventh child. If a woman finds herself in labour, efforts are made to delay birth until the ceremony is planned and completed, sometimes resulting in a prolonged labour and maternal or fetal death (Okafor, 2000). Women also intentionally avoid formal health care because they fear appearing weak, being subjected to a caesarean section, or experiencing what is perceived as dangerous; corrupt, insensitive, poorly organised, unclean, and untrustworthy care offered by orthodox health care (Asowa-Omorodion, 1997; Okafor, 2000; Chapman, 2003; Maimboiwa et al. 2003; Roost et al. 2004; Berry, 2006; Sibley et al., 2009). Practices and procedures in formal health-care setting conflict with women's cultural preferences and practices (Okafor, 2000; Roost et al., "2004; Berry, 2006). In Nigeria, women who give birth in the hospital and choose to use a traditional squatting rather than lithotomic position were required to clean their blood off the floor immediately after delivery (Jaffre & Prual, 1994). In many places an adversarial relationship exists between professional health-care providers and the more traditional birth attendants creating a cultural milieu where distrust, criticism, and, self interest characterise the maternity care offered to women (Jaffre & Prual, 1994"; Wall, 1998; Okafor, 2000; Kyomuhendo, 2003; Maimboiwa et al., 2003; Berry, 2006).

Traditional medicine has been defined as the alternative or non-conventional modes of treatment often involving the use of herbs in a non-orthodox manner as well as the process of consulting herbalists, mediums, priests, witch doctors, medicine men and various local deities when seeking a solution to diverse illnesses (Center for the Study of Religious and Culture, 2005). Traditional medicine includes herbal medicine, bone setting, spiritual therapies, circumcision, maternity care, psychiatric care, massage therapy, aromatherapy, music therapy, homeopathy and a lot of others. In the same vein, a Traditional Medicine Practitioner has been defined as "a person who is recognized by the community in which he lives as competent to offer health care by using vegetable, animal and/or mineral substances and certain other methods based on the social, cultural and religious background as well as the knowledge, attitudes and beliefs that are prevalent in the community regarding physical, mental and social wellbeing and the causation of diseases and disability"(WHO, 1996).

Specialists in traditional medicine include herbalists, bone setters, traditional psychiatrists, traditional paediatricians, spiritual therapists, local surgeons, traditional birth attendants (TBAs), occult practitioners, herb sellers and general practitioners among others. Yoruba land is characterized by forest vegetation as well as patches of derived savanna types arising

basically from human activities like bush burning for agricultural and hunting purposes (Lucas, 1978). The main traditional occupations of the people include farming, fishing, blacksmithing, pottery and indigenous medical practices.

Several local names have been used to describe Traditional Medical Practitioners in Yoruba land, and these include *Olosanyin, Elegbogi* or *Oniseegun* (Jacob, 1977) as well as *Babalawo.* Although *Oniseegun* and *Oloogun* are used as synonyms, they are distinct from *Elegbogi* in the sense that the *Oloogun* use charms, amulets and incantations in their magical practices. They are more dreadful in the community where they live. Different areas of specialization include general practitioners *(gbogbonise)* stroke and hypertension healers, bone settings *(teguntegun),* traditional pediatrician *(elewe onto)* and local traditional pharmacist *(lekuleja),* in addition to the charmers, diviners, necromancers and stargazers *(ateyanrin)* (Olagunju, 2012).

Orthodox Medicine is defined as medicine based on scientific methods and taught in western medical schools (Center for the Study of Religious and Culture, 2005). Traditional medicine has been the only source of health care in Nigeria in historical times. From record, the first practicing doctors were medical missionaries who settled in the 1850s as ship surgeons, medically qualified botanists and explorers who sailed into several Nigerian ports and navigated several large rivers from the 17th century onwards. No hospitals were built on the mainland until the later part of 19th century, but there were hospitals in offshore islands three centuries earlier. One Dr. Williams, a Briton was credited with carrying out in mid- 19th century, several vaccination sessions and dressing of wounds on indigenous populations along the West coast of Africa, including the Niger Delta and up to Lokoja (Schram, 1966). However, orthodox medicine was not formally introduced into Nigeria until the 1860s when Sacred Heart Hospital was established by the Roman Catholic Missionaries in Abeokuta (Metz, 1991).

The first set of Roman Catholic nuns in Nigeria had lived in a Convent on Broad Street, Lagos and later, led by one Sister Maria of Assumption, moved to Abeokuta and worked under Father Francois, founder of the first full-fledged land-based hospital, the famous Sacred Heart Hospital, in Abeokuta (HERFON, 2006). This was followed by the British Colonial Government providing formal medical services with the construction of hospitals and clinics in Lagos, Calabar and other coastal trading centres. Following this, a make-shift temporary civil hospital was built in Asaba (now in Delta State of Nigeria) in 1888. A

Government Hospital was also built in Calabar in 1898 as a result of the wide impact the first two hospitals made on the indigenous and the colonial personnel and their families (HERFON, 2006).

In recent times, more and more Nigerians and the Yoruba in particular, are consulting herbalists. Exorbitant medical bills of charges, in the face of chronic material poverty, of a wide range of people are a major factor bringing about this behavioural change. Consequently, Yoruba ethnomedicine that was once on the threshold of extinction, following its clash with some Western values, has started to regain its lost popularity as a significant component of our cultural heritage (Ogundele, 2007). There are lots of advertisements of herbal products on the newspapers, the media and other forms of information dissemination. The yearly herbal medicine trade fair in Nigeria and increasing publicity and patronage this attracts, regardless of the social, educative or religious background of the people, are indicative of acceptance of herbal medical practice (Ukwuomah, 1997). Similarly, there is currently hardly any newspaper in Nigeria that does not have a column on herbal remedies at least once in a week (Ogbulie, 2007). The National Demographic and Health Survey report (National Population Commission, 2004) indicate that only 32.6% of births take place in health facility. This means that the remaining 63% of births were handled by traditional birth attendants or proliferating church-established maternity centres. All these indicate that the people still hold a strong belief in their cultural and spiritual heritage.

In spite of the sophistication of orthodox medicine, traditional medicine is considered to have its potential significance especially among the Yoruba people of Nigeria.

Due to the fact that many herbal recipes are usually formulated by mixture of many herbs, it is believed that any parasite or pathogen will find it very difficult to develop resistance to it. There is few or no publication that ever reported any pathogenic resistance to any herbal formulation. This is quite unlike the orthodox medicine. According to the WHO (1992), for instance, *Plasmodium* spp (responsible for causing malaria fever) is now resistant to Chloroquine therapy, thus other therapies had to be developed.

The recommended Artesunate Combination Therapy (ACT) for treating malaria fever is hardly ever offered free in most public healthcare facilities. The average cost of malaria treatment based on ACT is estimated to be about N1, 500 (about US$ 10.00)

inclusive of cost of laboratory tests. This is a princely sum for the average Nigerian in the rural areas which are characterized with low household incomes (Mafimisebi, Oguntade & Mafimisebi, 2008). A traditional medicine therapy for the same ailment will cost less on the average or could even be procured for free, if the person could collect the medicinal plants and prepare the medication personally. Summarily, the cost of procuring orthodox medicine is believed to be increased by modern health technology involved. It is further argued by Mafimisebi et al (2008) that, there are several illnesses that orthodox medicine has no clue on its cure, but which traditional medicine can cure. One of such is pile. Anyone with pile undergoes hemorrhoidectomy (cutting of the haemorrhoids) from the anus. However, there is traditional herbal formulation that can treat it.

Traditional medicine is more accessible to most of the people in sub-Saharan Africa. In fact, it is reported that 60-85% of the population in every country of the developing world has to rely on traditional medicine. This is mainly because of a shortage of hospitals and health centres as well as medical and paramedical staff needed to manage orthodox health care delivery systems. The ratio of traditional medicine practitioners to the entire Nigerian population is estimated at 1:110 while that of orthodox medicine practitioners is 1:16,400 (WHO, 2003). Facilities are inaccessible for much of the population.

Traditional medicine enjoys wider acceptability among the people of developing countries compare with orthodox medicine. It was the only form of health care available to people before the advent of orthodox medicine. Traditional medicine blends readily into the socio-cultural life of the people in whose culture it is deeply rooted. For example, those that have fractured bones as a result of motor accident have their bones treated with herbs rather than having their legs amputated in the hospital and those who were to go through caesarian operations have their babies delivered through therapeutic incantations and herbs (Olagunju, 2012). Orthodox medicine only addresses a patient's biological manifestation of the illness and does not attempt to heal spiritual aspects of illness (Conserve Africa, 1995), which is taken care of in traditional medicine.

Inadequate medical personnel is one of the factors militating against orthodox medicine practices. In order to consult an orthodox doctor, the patient often has to undergo the complicated and time-consuming processes of registering at the records department, undergoing a series of money-gulping diagnostic tests, seeing a nurse before finally waiting in a long queue before consultation with the doctor usually takes place. Such obstacles are

absent in traditional medicine [8]. Worse still, many medical staff, believing they hold superior knowledge, treat patients inconsiderately, especially in Government hospitals.

Traditional medicine is considered as a potential source of new drugs, a source of cheap starting products for the synthesis of known drugs or a cheap source of known drugs. Besides, high and rising proportion of fake and adulterated synthetic drugs makes a lot of people to crave for natural products (Akunyili, 2004). Harmful capacity is not limited to traditional Yoruba medicine (Olson, 2006). Western medicine, however, also has potential for harm. A drug, which is supposed to treat just one ailment, could be accompanied by several side-effects, fatal effects from over-consumption of a drug, potentials of drug abuse, addiction and over-dependence. Doctors also have the tools at hand to harm or kill a patient at any time, especially when they are undergoing surgical procedures.

However, traditional medical practice, in spite of its popularity has been challenged on many grounds (Erinoso, 1998). One of such is that its popularity is based on the anecdotal experiences of patients. Osborne (2007) noted that the practitioners inflate the claims attached to advertisement and its products as well as not having scientific data about its effectiveness, thus making it difficult to ascertain legitimate and effective therapy and therapist. Erinosho (1998) noted that some of the other arguments against traditional medicine include: lack of the skills required for correct diagnosis of serious disorders; always unwilling to accept the limitations of their knowledge, skills and medicines particularly in complicated organic disorders; lack of standard dosage and have not been subjected to scientific verifications; even though the educated are convinced that the healers have supernatural knowledge and that this knowledge is medically useful, they have found them to be unscrupulous and dubious and; lack of the equipment required to conduct physical examinations.

In addition, imprecise diagnosis given by the traditional medical practitioners is also a factor affecting traditional medicine. For example, a diagnosis of “Stomach Ulcer” could mean indigestion, ulcer, cancer, of the stomach and many others. Such imprecise dignosis is because the traditional medical practitioner does not know the pathology of certain diseases. As a result, he tends to treat the symptoms rather than the disease, which can sometimes lead to further complications. The intangible aspects or occultic practices of traditional medicine cannot be verified scientifically. Witchcraft and evil practices of traditional medicine also

discredits this fom of medicine. A medicine is supposed to promote good health and remove mental, physican and social imbalance (Sofowora, 2008).

However, the entire literature review on maternal health seeking behaviour will not be complete if adequate search and review of scholars' works on the concept of patriarchy and gender is missing. In lieu of this the last section of this reviews presents a review of available studies on patriarchal/gender practices and maternal health seeking behaviour.

2.5 Patriarchal/Gender Practices and Maternal Health Seeking Behaviour

Patriarchal practices can be viewed as one of the reasons for the poor maternal health situation in Nigeria. Many have observed that traditional African culture has not been fair to women. According to Bwakali (2001), women stand to be victims of injustice in traditional culture not because of what the society did to them, but due to what the society did not do to them. However, this author like many others are of the opinion that injustices suffered by today's women and girls are from both angles. The traditional system defined the roles which both men and women should play in the family as well as in the community. On the one hand, boys were to grow up knowing that they were expected to be strong and hardworking, so as to be able to take care of their wives. While girls, on the other hand, were to be concerned with domestic activities and to be submissive. Women's success and happiness to a large extent will be determined by the husbands they were to marry, not the women themselves. Thus, they were robbed of every initiative and resourcefulness, which could enable them, to make decisions affecting them and the family generally.

Regarding maternal health, a number of cultural practices abound in different African countries which militate against women and their health, Nwokocha (2008) studied the Ibani people of Rivers State in Nigeria and submitted that pregnant women are prohibited from coming out of their homes during a popular (Nwaotam) festival, which lasts for three days, notwithstanding their conditions. If there is a violation, the consequences range from inflicting severe injury up to death of the woman or girl.

There are also nutritional taboos for pregnant women. For instance, most of the Yoruba community and other areas of Nigeria, pregnant women are forbidden from eating snails in spite of the rich protein content which they and the foetus greatly need at such time. There are other unhealthy practices which are found in other parts of the region, which are also applicable to other parts of Africa. For instance, cases of female genital mutilation are found

in different parts of the State; while wife battery are equally reported, not just in Nigeria but in Uganda and other parts of Africa and beyond (Bwakali, 2001). Rape, which is also a common practice in several parts of the world, this occurs in every thirty-six seconds in South Africa (Bwakali, 2001); just like widow inheritance is not uncommon in parts of Africa so also is for teenage girls to be married off by force. The afore-mentioned practices have untold consequences on maternal health.

Patriarchy seen in the light of wholesome inequity has been perceived as an over-arching category of male dominance (Barrett, 1988), a situation carefully sustained by men through ages (Sen *et al.*, 1994). While it has been claimed by some men that such gender relationship is responsible for peace at homes and the society generally, skepticism and suspicion about the genuineness of such assertion among women and the likely consequent breakdown in spousal/household communication can have indirect impact on maternal health seeking. However, the tendency is high for couples that lack confidence in themselves to seek assistance from other people. The consequence in the long run is that the intimacy and agreement that should necessarily follow decisions on maternal health care seeking are lost.

The pervasiveness of patriarchy as a system that does not discriminate against either patrilineal or matrilineal societies, but conceived in terms of the difference in magnitude of its application to both societies have been highlighted. Gray (1982) argued that men are always in control of the myth system, even in matrilineal societies. Ottong (1993) expressed the same view by stating that the male plays a very dominant role in the social structure; he is, as a matter of right, the head of the family, and is seen and regarded in certain circumstances by the wife (or wives) as the lord and master whose decision is always final. Even in the exceptionally few matrilineal societies, authority relations are still patriarchal, although patterns of descendancy and inheritance might be governed by the principles of matrilineal (Ottong, 1993).

Never the less, consciousness about the consequences of male dominance on women folk for the past few decades has been increasing and appears to be waxing stronger by the day. Mill (1970) opined that the principle, which regulates the existing social relations between males and females, is not only wrong in itself, but also one of the chief hindrances to human development. She observed that such principle should be replaced by an alternative, which will be embedded in perfect equality, admitting no power or privilege on the one side, or disability on the other. Consensus among feminist and liberal writers on the negative implications of male dominance is evident (Nwokocha & Eneji, 2004). Patriarchy is viewed

in some quarters as an institutional mechanism that serves to limit women's economic autonomy relative to men's. The result is that women unwittingly depend almost entirely on men, which has implication for the involvement of the former in family decisions, including reproductive health, even when they are directly affected.

Studies have shown that socialization into sexuality and gender roles begins early in the family and community and are reinforced through the interplay of familial, social, economic and cultural forces, which are subsumed in patriarchy (Obura, 1991; Sen *et al.*, 1994; Moore and Helzner, 1996; Isiugo-Abanihe 2003). Similarly, Isiugo-Abanihe (1994a) maintained that cultural dictates shapes behaviours; one's environment affects her reproductive attitudes, perceptions and motivations. To corroborate this assertion, Oke (1996) has observed that the use and non-use of health services are determined by one's socio-cultural environment, which, in most cases, is shaped by its patriarchal structure. Erinosho (1998) has also noted that many culture bound syndromes are effectively managed through an informed knowledge of their cultural contexts and the background of patients.

Some socio-cultural factors, which not only prevent women from getting out of their homes to utilize maternal health facilities, even in emergencies, but also prohibit them from eating certain foods, have been identified (Jafarey & Korejo, 1995). For instance, in parts of Nigeria, cultural taboos discourage pregnant women from eating certain fruits, vegetables, rice and other high-calorie foods that ordinarily reduce susceptibility to diseases and malnourishment during the period (Mbugua, 1997). Most of these restrictions are given in order to sustain the myth surrounding a particular tradition or to emphasize the sacredness of a custom conceived as inviolable.

Another factor affecting maternal health seeking behaviour in Africa is associated with gender equality. Researchers studying women in Northern Nigeria also found a gender measure in decision making for a child being fully vaccinated (Babalola, 2009). The curvilinear relationship between maternal conjugal decision-making power and child immunization is curious. Indeed, it is not clear why the positive relationship between conjugal power and child immunization is reversed at higher levels of conjugal power. Nonetheless, a few studies have found a similar relationship in sub-Saharan Africa (Smith, Ramakrishnan, Ndiaye, Haddad & Martorell, 2003). One could possibly infer that in a society where gender norms absolutely restrict women's participation in household decision making power process, women with high conjugal power tend to be those who live separately from their husbands and have limited access to substitute caregivers with whom to share the

responsibility of household chores and childrearing thereby making limited time available for them to take their children for immunization (Babalola 2009).

Hindin (2000) found that women in Zimbabwe who did not have a say in household decisions were more likely to have low Body Mass Index (BMI) than women who did have some say. Researchers studying women in Nigeria have recently found that gender equality is significantly associated with whether a woman has a facility for delivery (Singh, Bloom, Haney, Olorunsaiye, & Brodish, 2012) and whether her child is fully immunized (Singh, Haney & Olorunsaiye, 2013).

In considering attitude and practice of males towards antenatal care, Nuraini and Parker (2005) submit that antenatal care is a key strategy for reducing maternal mortality and a crucial determinant for safe delivery. ANC is the attention, education, supervision and treatment given to the pregnant mother from the time confirmed until the beginning of labour in order to ensure safe pregnancy, labour and puerperium. Male involvement functions should seek to address men's own health needs and concerns as well as the needs of their female partners. In their view, if adequately supported, many men will rise to curb traditional practices that might endanger their partner's health.

It was also stated by Nanjala & Wamalwa (2012) that, lack of knowledge by male partners of complications associated with delivery, cultural beliefs, high fees charged for deliveries at health facilities and un-cooperative health workers are major contributing factors to low male partner involvement in child birth activities, hence, improving the levels of education and income of male partners, addressing the cultural beliefs and practices, improving health care provider-client relationship and sensitizing men on complications associated with pregnancy and child birth can contribute significantly in enhancing male partner involvement in promoting deliveries. Men's presence and their participation at the health facilities during antenatal care visit of their wives will help boost the morale of their wives and also bring about a greater sense of commitment of both parents to having healthy mothers and babies (Stycos, 1996).

Males are generally excluded from participating in routine care because the medical system does not accommodate them and the community considers maternal care as exclusively preserve of women. Males tend to be decision makers within the family and often govern behaviour regarding the availability of nutritious food, women's workload and the allocation of money, transport and time for women to attend health services, yet, men are often unable

to make informed choices because they have not been included in maternal and child health services. Singh, Darrooh, Vlassof and Nadeau (2006) stated that male involvement should not be seen as limited to men's participation in clinical services. In practice, male involvement includes the wide variety of actions that men take to support and protect the health of their wives and children. Men can positively influence maternal and child health issues in a variety of ways and have a right to the information they need to make decisions to protect their own health and that of the family.

Male involvement includes men making informed decisions with their partners or seeking and sharing information about appropriate health behaviour and care during pregnancy, child birth and postpartum. Men can encourage and support antenatal care attendance, ensure good nutrition and reduce workload during pregnancy, assist with birth preparations and provide emotional support for their wives at home.

According to Jose (2010), Nigeria has one of the worst maternal health indicators across the globe. In most African countries, maternal health issues which include family planning, pregnancy and childbirth have long been regarded exclusively women's affairs (Mullay, Hindin & Becker, 2005). It has been noted that men's involvement in maternal health is an encouraging strategy for promoting maternal health (Cohen & Burger, 2000). Mullay, Hindin & Becker (2005) observed that involving husband/partner and encouraging joint decision-making among couples may provide an important strategy in achieving women's empowerment; this will ultimately result in reduced maternal morbidity and mortality. Stycos (1996) also observed that men's behaviour and involvement in the maternity care of their pregnant partners can significantly affect the health outcomes of the women and babies.

Secka (2010) opined that, globally it is estimated that nearly 500,000 women die annually from causes related to pregnancy and child birth and 99 percent of these deaths occur in developing countries. It is sometimes seen as a sign of weakness or bewitchment in some cultures when a man follows his wife to clinic. Many men believe that their participation in Prevention of Mother to Child Transmission (PMTCT) would signal weakness and lack of masculinity and power to other men (WHO, 2012).

In 2002, a longitudinal study was conducted in the United States with a sample size of 5404 women and their partner which explored the effect of father involvement during pregnancy on receipt of prenatal care and maternal smoking. The findings of the study indicated that women whose partners were involved in their pregnancy care were 1.5 times likely to attend

prenatal care in the first trimester and smokers reduced smoking by 36 percent as opposed to those whose partners were not involved in their pregnancy care (Martin, Mcnamara, Millot, Halleh & Hair, 2007).

Literature on socio-cultural factors of gender roles in women's healthcare utilization revealed that 62 percent of births in Nigeria occur at home, 36 percent of women received no antenatal care, only 39 percent of births were delivered by a skilled provider and 56 percent of women did not receive any post-natal care within 41 days of delivery Nigeria Demographic and Health Survey (2000). Several factors lead to such horrendous statistics and dismal performance on maternal health status indicators such as economic, environment, health, social and culture (Jenna, Muller & Quiros, 2009). The last two, socio-cultural factors are the less studied. Culture reinforces the gender roles and life style of husband and wives, making it difficult for the females to exercise her rights including reproductive rights and behaviors. Social and cultural norms concerning gender roles powerfully shape women's autonomy (Jejeebhoy, 2002).

On one hand, Jejeebhoy, (2001) opined that in many homes in South Western Nigeria, husband's permission is required before a wife could seek healthcare and it depends on whether the husband sees the ill health as strong enough to warrant hospital treatment. Adewuyi, (1999) defined gender ideology based on data from a case study of a rural Ekiti Yoruba village in South Western Nigeria as beliefs about the nature of women and men and their appropriate behaviours in society on reproductive decision making. Men are believed to be head of households, have authority over family members and decide on what happens in the household ranging from social, economic, cultural and health related issues. Renne (1993) opined that men have superior knowledge over the women. Adding a voice to this subject, Omideyi, (1987) observed that many women are denied their rights and subjected to some cultural practices that greatly endanger their health in Nigeria. On the other hand, Mama, (1996) women are deprived of decision making positions both in the private realm of the family and the public sector and others make decisions that directly or indirectly affect their lives on a daily basis. This scenario makes it difficult for women to access health care even in emergency situations.

Few studies have examined explicitly the relationship between socio-cultural factors and maternal utilization of health services especially as it relates to gender roles in sub-Saharan Africa including Nigeria. For instance, Longwe, (2002) noted that the trend in developing countries is much worse, as studies from various countries of sub-Saharan Africa indicate that

maternal mortality has not only continued to be high, but is indeed increasing after the launch of the Safe Motherhood Initiative (SMI) in Kenya in 1987. Similarly in Nigeria, not only the Federal Ministry of Health set Year 2006 as the target year that maternal mortality would have been reduced by half, but to the contrary the situation of maternal health in Nigeria was even much worse than in previous years (Shah & Say, 2007).

Education of women has a powerful role in health utilization outcomes. It acts as catalyst for changes and a transformer of high female autonomy. Parpart, Connelly & Barriteu (2000) observe that the hallmark of Kerela's success in health care use by female is to better female education and autonomy. Others have equally confirmed that education of women as an important determinant of health and a valuable public good in its own right (Obermeyer, 1993; Wall, 1998). Scholars like Preston (1991), Mosley (1984) and others have suggested that culture and social systems were more important determinants of health than health systems itself (Wall, 1998; Soares, 2005). Also, researchers have added to the literature on the distal determinants of health such as political, social, macro-economic and cultural factors (Mosley & Lincoln 1984; Mosley, 1984; Preston & Haines 1991). Similarly, Subramanian, Belli & Kawachi (2002) observe in their own dimensions of women autonomy and maternal health utilization in a North Indian city ascertain the influence of women's autonomy on the use of care during pregnancy and child birth in the study area. They further assert that the influence of women's autonomy on the use of health care appears to be as important as other known determinants such as education.

The cultural perspective on the use of maternal health services suggests that medical need is determined not only by the presence of physical disease but also by cultural perception of illness (Marmot, 2005), influenced by individual perceptions of the efficacy of modern health services and the religious beliefs of individual women (Lieberman, 2007) and decisions about maternal care are often made by husbands or other family members (Bloom, Wypij & Das Gupta, 2001). It was found out that a husband's approval has a greater effect on pre-natal care utilization than whether a wife wanted the pregnancy or a wife's level of education (Addai, 2000). Although, women in higher socio-economic groups tend to exhibit patterns of more frequent use of maternal health services than women in the lower socio-economic groups, factors such as education appear to be important mediators (Marmot, 2005; Adetunji, 1991; World Health Organization (1998).

Cultural tenets appear to structure women's education thereby de-accelerate female autonomy and their capacity to decide or partake in the decision making process of the family or

household. In a study investigated among women from four local governments in Benue State, Nigeria, Biratu & Lindstrom (2006) showed that education and domicile play significant roles in the health-seeking behaviour of pregnant women.

Addai, (1998) equally confirmed that women's and husband's education have a strong relationship with maternal health care utilization while women's autonomy had a weak relationship with various form of ante-natal and delivery care usage in his study. Leslie & Gupta, (1989) added that cultural practice of the Hausa people plays a major role in determining women's choice of place of child delivery in addition to poor hospital services and nature of attendants which may violate women's privacy. In consonance with the above finding, Kistiana, (2009) opined that ethnicity, religion and traditional belief are often consistent markers of cultural background and are thought to influence beliefs, norms and values in relation to child birth and service use by women. Certain ethnic or religious groups may be discriminated against by staff making them less likely to use health care services. Kistiana, (2009) argued that socio-cultural beliefs and the need for immediate and specialized services have hampered women's ability to access services in many low and middle income countries including Nigeria.

The game of effective reduction of maternal mortality should not be left alone with the provision of facility but re-engineered towards behavioral change. In a cross-sectional study in Nigeria, Gabrysch & Campbell (2009), found that efforts were required to improve men's attitudes and knowledge in order to make them appreciate and be active participants in the fight to reduce maternal mortality, which begins with utilization of the available health care facility. In an exploratory study which focused on socio- cultural factors affecting pregnancy outcome among the Ogu speaking people of Badagry area of Lagos State, Nigeria, Lawoyin, Lawoyin & Adewole (2007) found that the culture of the people of Ogu Community was very dominant in shaping their reproductive behavior.

In a study among childbearing women in Ibadan North Local Government Area of Oyo State Nigeria, Ajiboye & Adebayo (2012) reveals that husband's decision or preference of ANC and privacy constituted the prominent factors that influenced the choice of ANC as well as place of delivery. In another study among pregnant women in Ife Central Local Government Area, Osun State, Nigeria, Ewa, Lasisi, Maduka, Ita, Ibor and Anjorin, (2012) with a stratified sample of 102 pregnant women revealed among others that lack of knowledge about the existing services in ANC and husband's acceptance of the services rendered as the major factors influencing its utilization. Using community- based research, Onasoga, Afolayan &

Oladimeij, (2012) found that most pregnant women had little or no contact with the health care system for reasons of custom, lack of perceived need, distance, lack of transportation, lack of permission, cost and/or unwillingness to see a male doctor.

Owumi & Raji (2013) found that factors like husband's approval, money for treatment, and personal cultural preferences still had negative effects on the maternal health seeking behaviour in the Benin Republic. A secondary data based study from the Zimbabwe Demographic and Health Survey (ZDHS) between 2005 and 2006, Muchabaiwa, Mazambani, Chigusiwa, Bindu & Mudavanhu, (2012) found age, education, wealth, polygamy and religious affiliation among other variables. Commonly held beliefs and norms that could be religious or cultural, shape the way individuals perceive their own health and the health services available. Religious and cultural beliefs have been found to be sources of exclusion from maternal healthcare utilization in India and Africa (Stephenson, Baschieri, Clements, Hennink, & Madise, 2006). Although most studies have ignored polygamy, it is a customary practice that is associated with traditionalists.

Stephenson, Baschieri, Clements, Hennink & Madise, (2006) found that women in polygamy were less likely to report for delivery at a health institution. Maternal healthcare utilization is constrained by women's lack of decision making power, the low value placed on women's health and the negative or judgmental attitudes of family members (World Health Organization, 2005). Women with more self-sufficiency in decision making, which is determined by society and culture, have also been found to be more likely to use maternal healthcare (Stephenson, Baschieri, Clements, Hennink & Madise, 2006).

Education has been found to be a source of exclusion in studies conducted in India and different countries in Africa. Mekonnen & Mekonnen (2002) found education linearly increasing with utilization of maternal healthcare in Ethiopia. Navaneetham & Dharmalingam (2000) found uneducated women less likely to use maternal healthcare, but found no differences in utilization among the educated. It is discovered that education assists women placing autonomy resulting in women developing greater confidence and capabilities to make decisions regarding their own health (Addai, 1998). The significant impact of education on delivery at health institutions is evidence that educated women have better knowledge and information on modern medical treatment (Addai, 1998). The link from education to higher utilization of health services extends to better health outcomes like lower child and maternal mortality (Boyle, Racine, Georgiades, Snelling, Hong, Omariba, Hurley and Rao-Melacini 2006). Poor use of antenatal care among Nigerian women has been a great concern to public

health because of its life threatening and other negative consequences to the health of mothers and the child (McCarthy & Maine 1992; Kabir, Iluyasu, Abubakar & Sani 2005; Dairo & Owoyokun, 2010).

Biratu & Lindstrom (2000) looked into the significant determinants of antenatal care service use in Nigeria, specifically focusing on Ibadan. Four hundred women in two randomly selected local government areas of Ibadan were surveyed to achieve the study objective of investigating the factors that are associated with antenatal care use in Ibadan. The study revealed a significant difference in residence, religion and age in relationship with antenatal care use in Ibadan.

White, Dynes, Rubardt, Sissoko & Stephenson (2013) studied the factors that are significantly associated with the usage of antenatal care services in rural northern Nigeria. The study was explicitly done in a village setting of Kumbotso in Kano, Nigeria. The study used data from 200 women of childbearing age in the village community to assess factors that significantly determine antenatal care use in the village. The study found that women education and the education of the husband were positively associated with antenatal care use among rural women. The higher the educational status attained by both spouses, the higher the use of antenatal care among women. In a community-based survey of maternal health conducted in Yirgalem town, South West Ethiopia, Fayomi & Igbokwe (2009) found that a husband's approval has a greater effect on prenatal care utilization than whether a wife wanted the pregnancy or a wife's level of education.

Cultural factors have also been noted to affect the utilization of maternity care services in Africa (World Health Organization, 1998). In consonance with the above assertion, Bloom, Wypij & Das Gupta, (2001) corroborates that in many parts of Africa, women's decision making power is extremely limited, particularly in matters of reproduction and sexuality.

A study on cultural background and socio-economic influence on women coping with postpartum depression note that pregnancy and childbirth might be similar worldwide, but how Postpartum Depression (PPD) is conceptualized and experienced by women of diverse cultures might be quite different (Oates, Cox, Neema et al, 2004; Teng, Robertson & Stewart, 2007; Morrow, Smith, Lai & Jaswal 2008; Bina, 2008). How women define PPD and their attitudes toward it will be a strong influence in how they utilize and access social support networks and mental health care services. Moreover, lack of knowledge about and understanding of PPD can limit help-seeking behaviour. Culturally determined barriers

include fear of stigma and lack of validation of depressive symptoms within the family and within the ethnic community. New mothers suffering from postpartum depression might not have any knowledge of PPD. They might be reluctant to reveal feelings to family and friends and to seek help for their challenges (Dennis & Chung-Lee, 2006).

In some cultures it might be perceived that it is inappropriate to seek external help for depressive symptoms. Medical assistance might seem inappropriate if PPD is not understood to be a medical problem (Holopainen, 2002; Rodrigues, Patel, Jaswal & DeSouza, 2003; Ugarriza, 2004; Teng, Robertson & Stewart, 2007). Rodrigues et al. (2003) found that Asian Indian mothers suffering from PPD perceived their symptoms to be natural sequelae of childbirth and were therefore unlikely to access health care services. It has been reported that in Asian Indian communities, maternal depression often goes unrecognized, leaving the mother isolated within her own family (Hearn, Iliff, Kirby, Ormiston & Parr, et al. 1998; Goyal & Lee 2010;).

Barclay & Kent (1998) observed that the difficulties of new immigrant mothers are exacerbated if they come from cultures where women are held in high esteem and valued and supported during the postnatal period. Cultural beliefs can serve in positive and protective ways when the mother and family participate in traditional customs and rituals that bolster the mother's network of support. Assigning value and respect to the mother's role can improve the mother's overall postpartum health. When cultural expectations and beliefs are not met, the woman can be susceptible to depression. Oates et al. (2004) found that recent immigrant mothers might find themselves bereft of the emotional and practical social support they would normally expect in their home country.

2.6 Conclusion

This chapter presented a review of the literature directly relevant to the research problem and objectives outlined in chapter one. Following from the literature review, it can be argued that most of the findings from previous studies solely depend on data generated using single method of social investigation and limited theoretical background whereas this study explores the strength of mixed method and theoretical triangulation to stimulate further research and develop a holistic framework for understanding maternal health issues in sub-Saharan Africa.

What is also evident is that there is an empirical gap in the scholarship on how socio-cultural factors affect maternal health seeking behaviour. In addition, while many researchers have addressed maternal morbidity and mortality issues in sub-Saharan Africa, studies related to factors affecting maternal health seeking behaviour in the region on the other hand are not extensive. Summarily, in this chapter the researcher have interrogated the secondary literature and examined how other authors have dealt with the issue relating to maternal health and specifically factors effecting of maternal health seeking behaviour and in so doing revealed gaps in the current scholarship that this research will address.

CHAPTER THREE

THEORETICAL FRAMEWORK

Gray et al (2007), made it known that there are numerous options open to the researcher in choosing a theoretical perspective bearing in mind that, the many different kinds of social theory vary in terms of the specific concepts they contain, how complete or well-articulated they are and in the way they are expressed on paper with words or diagrams. In compliance with the three major key points regarding the relationship between theory and research viz a viz: the compatibility of scientific method with a variety of theoretical approaches to data; the prime motive of creating and expanding theory for research and; its influence on the researcher's topic for investigation as well as its conclusions. By using some theoretical perspectives, this section examines factors affecting maternal health seeking behaviour in a Yoruba community of Nigeria. The following theories will be examined for this study; Model of Behavioural Change in Public Health: Health Belief Model, Rational Choice Theory, Location Theory and the Feminist Theory.

Also in this chapter, a conceptual framework for factors affecting maternal health seeking behaviour in the society is presented.

3.1 Model of Behavioural Change in Public Health

The pattern of utilization of maternal health facilities is found to involve the interplay of several factors. According to Jegede (1998), patients are in dilemma of therapeutic choice because many factors account for their action and this is governed by the health belief of the people. Lewin's seminal field theory (1935) was one of the early and most far-reaching theories of behaviour, and most contemporary theories of health behaviour owe a major intellectual debt to Lewin. Theories that focus on barriers and facilitators to behaviour change and those that posit the existence of stages are rooted in the Lewinian tradition.

3.1.1 The Proponents and Origin of Health Belief Model

During the 1940s and 1950s as accounted by Champion & Skinner (2008), researchers began to learn how individuals make decisions about health and what determines health behaviour. In the 1950s, Rosenstock, Hochbaum, and others, from their vantage point at the U.S. Public Health Service, began their pioneering work to comprehend why individuals did or did not participate in a certain health screening program (Champion & Skinner, 2008). This and related work led to the birth of Health Belief Model (HBM). In the last three decades, considerable progress has been made in understanding determinants of individuals' health-related behaviours and ways to stimulate positive behaviour changes. Value expectancy theories, which include both the HBM and the Theory of Reasoned Action (TRA) and its companion, the Theory of Planned Behaviour (TPB), matured during this time.

Historically, the HBM was developed in the 1950s by social psychologists in the U.S. Public Health Service to explain the widespread failure of people to participate in programs to prevent and detect disease (Hochbaum, 1958; Rosenstock, 1960; 1974). Later, the model was extended to study people's responses to symptoms (Kirscht, 1974) and their behaviours in response to a diagnosed illness, especially adherence to medical regimens (Becker, 1974). Although the model evolved gradually in response to very practical public health issues, its basis in psychological theory is reviewed here to understand its rationale for selected concepts and their relationships, as well as its strengths and weaknesses.

During the early 1950s, academic social psychologists were developing an approach to understanding behaviour that grew from learning theories derived from two major sources: Stimulus Response (S-R) Theory (Watson, 1925) and Cognitive Theory (Lewin, 1951; Tolman, 1932). S-R theorists believed that learning results from events (termed reinforcements) that reduce physiological drives that activate behaviour. Skinner (1938) formulated the widely accepted hypothesis that the frequency of certain behaviour is determined by its consequences or reinforcement. For Skinner, the mere temporal association between a particular behaviour and an immediately following reward was regarded as sufficient to increase the probability that the behaviour would be repeated. In this view, Champion & Skinner (2008) submitted that concepts such as reasoning or thinking are not required to explain behaviour. Cognitive theorists, however, emphasize the role of subjective hypotheses and expectations held by individuals, believing that behaviour is a function of the subjective value of an outcome and of the subjective probability, or

expectation, that a particular action will achieve that outcome. Such formulations are generally termed "value-expectancy" theories. Mental processes such as thinking, reasoning, hypothesizing, or expecting are critical components of all cognitive theories.

Cognitive theorists believe that reinforcements operate by influencing expectations about the situation rather than by influencing behaviour directly. When value-expectancy concepts were gradually reformulated in the context of health-related behaviours, it was assumed that individuals value avoiding illnesses/getting well and expect that a specific health action may prevent (or ameliorate) illness. The expectancy was further delineated in terms of the individual's estimates of personal susceptibility to and perceived severity of an illness, and of the likelihood of being able to reduce that threat through personal action.

3.1.2 Underlying Principles of Health Belief Model

According to HBM model, health seeking behaviour can be explored from three perspectives, namely:

i Those which utilize mainly psychological processes and variables to explain decisions;

ii Those which utilize individual demographic characters and health care delivery systems to explain decision; and

iii Those, which explain decisions as a result of social psychological processes (Igun, 1982).

Of those that predicate decisions mainly on individual psychological variables, the most well-known example is the Health Belief Model (HBM). This model was suggested by Rosentock (1966) and modified originally to explain preventive health behaviour, but it has since been applied to illness behaviour.

The model assumes that the beliefs and attitudes of people are crucial determinants of their health related actions. The model holds that, when cues to actions, such as assumptions are present, the variations in utilization behaviour can be accounted for by beliefs concerning four sets of variables. These are:

i. The individual's view of his/her own vulnerability to illness;

ii. His/her belief about the severity of the illness- this may be defined in terms of physical harm or interference with social functioning;

iii. The person's perception of the benefits associated with actions to reduce the level of severity or vulnerability; and

iv. His/her evaluation of potential barriers associated with the proposed action (this may be physical, psychological or financial) (Jegede, 1998).

As a result, a mother must consider the benefits of preventing the disease. She must also take into consideration the cost or inconveniences involved in seeking modern health care services, for instance in most of Sub-Saharan Africa where many woman are not financially self-reliant.

The model was then subsumed under two broad headings, that is:

i. Health seeking behavior; and

ii. Decision-making process.

For a person to remain healthy he/she must take positive decisions and act upon them. Decision-making, therefore, depends on three factors which are: human nature; culture; and nature and pattern of health related behaviours.

For a person to make health decisions he/she must first believe that he/she is susceptible to that particular disease and also that the degree of susceptibility may either be severe or mild. In his study, Rosenstock (1974) observed that susceptibility is at three levels which are:

i. High susceptibility- a situation in which a person expresses a feeling that he is in real danger of contracting a disease;

ii. Medium susceptibility- a situation in which a person believes that even though he/she is immune to a disease, yet a particular moment, he/she is likely to be adversely tormented; and

iii. Low susceptibility- a situation in which an individual completely denies any possibility of him/her encountering a disease.

Among the Yoruba, as in most traditional communities, many women do not attach much importance to prenatal and postnatal checkup at orthodox facilities, believing that pregnancy

management is a natural thing. Marshall (1974) has, however, argued that although someone may feel highly susceptible, the seeker's response potential is enormous. The individual may not take actions unless he/she believes that becoming ill will result in serious organic or social impairment.

The ability to take action depends on several factors regardless of the level of susceptibility, and these factors have been identified and categorized as:

i. Personal dispositional factors such as age, sex and marital status; and

ii. Personal enabling factors such as income, place of residence, transportation, occupation, education, and insurance scheme.

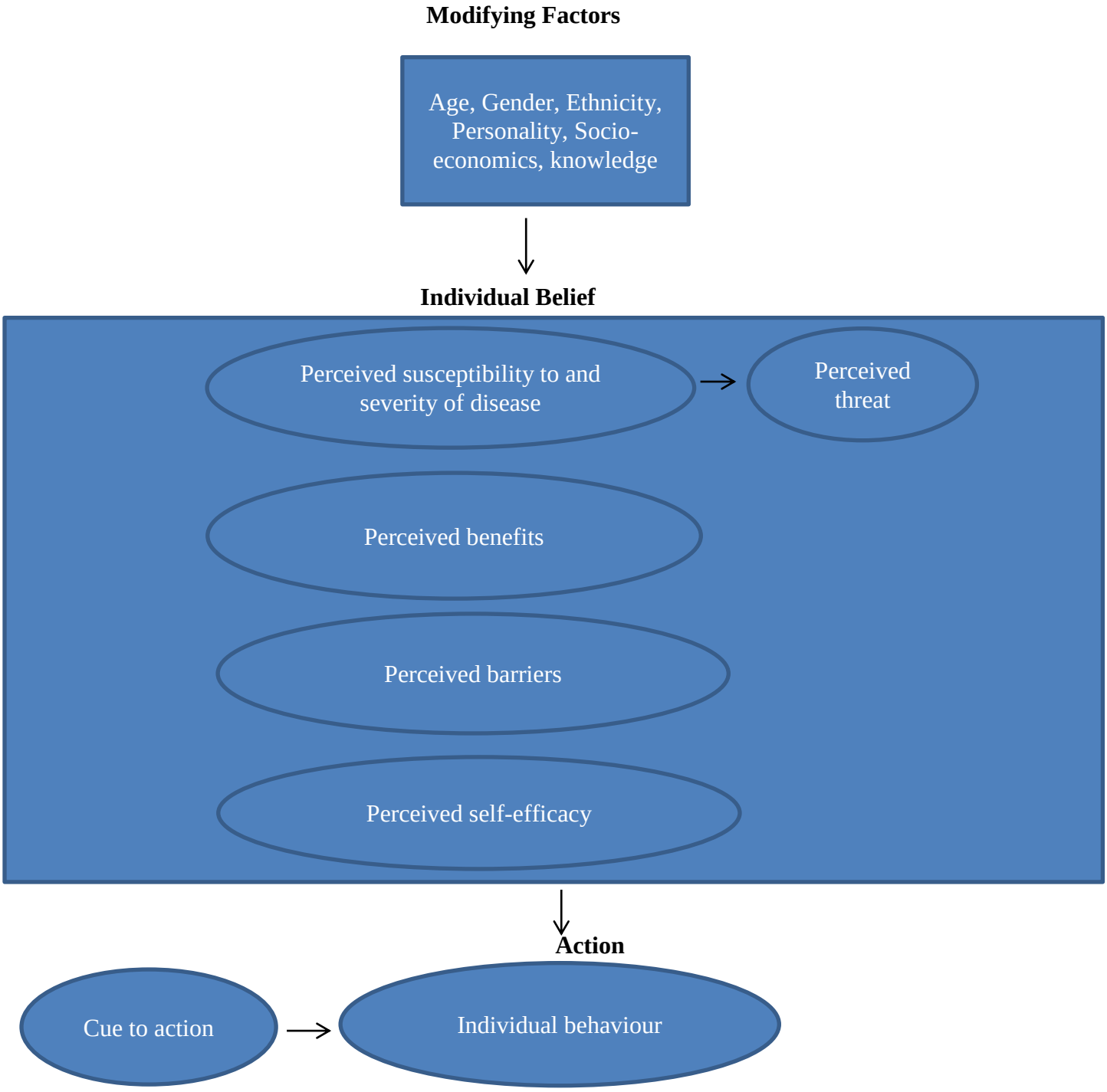
In most Sub-Saharan Africa communities, maternal health seeking is affected by demographic, social, cultural and economic status of the women (Feyisetan, Asa & Ebigbola, 1997). These factors propel them to act based on their beliefs in their vulnerability to the risk of non-compliance. Associated with this belief is the knowledge and acknowledgement of the level of severity of the ill health and other "costs" involving use or non-use of maternal health facilities. Therefore according to Feyisetan, et al., (1997: 22)

> "*The extent of which modern methods are adopted may still depend on the people's conception of the causes of ill-health and on their level of conception about the efficacy of such methods*".

In traditional Yoruba land, illness is conceived as either natural or supernatural while death is regarded as a result of preternatural or supernatural manipulations. Women are expected to do their best to ensure their survival while spiritual consultations are made as supplements to the natural course of health seeking: nutrition, sanitation and medication (Odebiyi, 1977, 1989).

Belief is part of the whole social structure and it changes according to the social changes that may be taking place in the system. Being subject to change itself, health-seeking behaviour is also bound to change. Since this research also examine why users use maternal health facilities in certain situations and why they may not use it in some other situations there is need to understand human behaviour with respect to maternal health care.

Figure 3.1 The Components and Linkages of Health Belief Model



Source: Field Survey, 2016

3.1.3 The Application and Relevance of HBM to Maternal Health Seeking Behaviour

The HBM contains several primary concepts that predict why people will take action to prevent, to screen for, or to control illness conditions; these include susceptibility,

seriousness, benefits and barriers to certain behaviour, cues to action, and most recently, self-efficacy. If individuals regard themselves as susceptible to a condition, believe that condition would have potentially serious consequences; believe that a course of action available to them would be beneficial in reducing either their susceptibility to or severity of the condition, and believe the anticipated benefits of taking action outweigh the barriers to (or costs of) action, they are likely to take action that they believe will reduce their risks. In the case of medically established illness (rather than mere risk reduction), the dimension has been reformulated to include acceptance of the diagnosis, personal estimates of susceptibility to consequences of the illness, and susceptibility to illness in general.

Looking at the concept of perceived susceptibility which refers to the beliefs about likelihood of getting a disease or condition, for instance, a woman must believe there is a possibility of complications during the process of child bearing (prenatal, natal and postnatal) before she will be interested in seeking maternal health care services.

Perceived severity which connotes the feelings about the seriousness of contracting an illness or of leaving it untreated include evaluations of both medical and clinical consequences (for example, miscarriage, haemorrhage, pain and death) and possible social consequences (such as effects of the conditions on work, family life, and social relations). The combination of susceptibility and severity has been tagged as perceived threat.

Even if a woman perceives personal susceptibility to a serious health condition (perceived threat), whether this perception leads to behaviour change will to a large extent be influenced by her beliefs regarding perceived benefits of the various available actions for reducing the disease threat. Other non-health-related perceptions, such as the financial status or obeying family member especially the husband, may also influence behavioural decisions. Thus, individuals exhibiting optimal beliefs in susceptibility and severity are not expected to accept any recommended health action unless they also perceive the action as potentially beneficial by reducing the threat.

Also, the potential negative aspects of a particular health action that is, perceived barriers, may act as impediments to undertaking recommended behaviours. A kind of non-conscious, cost-benefit analysis occurs wherein individuals weigh the expected benefits of the action with perceived barriers. For instance, a woman of childbearing age may feel attending health facility could help her, but it may be expensive, have negative side effects, be unpleasant,

inconvenient, or time-consuming. No wonder why Rosenstock (1974) submitted that, combined levels of susceptibility and severity provide the energy or force to act and the perception of benefits (minus barriers) provide a preferred path of action.

Most of the early formulations of the HBM included the concept of cues that can instigate actions. Hochbaum (1958), for instance, thought that readiness to take action (perceived susceptibility and perceived benefits) could only be geared by other factors, particularly by cues to trigger action, such as bodily events, or by environmental events, such as media publicity on importance of maternal health care or availability of certain immunization. Although, there have not been extensive studies on the role of cue and cue to action, nonetheless, the concept of cues as triggering mechanisms is appealing.

Self-efficacy is defined by Bandura (1997), as the conviction that one can successfully execute the behaviour required to produce an outcomes. Bandura distinguished self-efficacy expectations from outcome expectations, explained as a person's estimate that a given behaviour will lead to certain outcomes. Outcome expectations are similar to but distinct from the HBM concept of perceived benefits. In 1988, Rosenstock, Strecher, and Becker suggested that self-efficacy be added to the HBM as a separate construct, while including original concepts of susceptibility, severity, benefits, and barriers. Suffice to say therefore, that the assurance of a woman's capability (in terms of patriarchy, affordability, accessibility among other factors) to access health care facility in order to achieve a desired result (such as safe delivery or remedy to infertility) is a factor in the equation of the health seeking behaviour.

At this juncture, it is very germane to note that self-efficacy was never explicitly incorporated into early formulations of the HBM. The original model was developed in the context of circumscribed preventive health actions (attending antenatal care or accepting immunization) that were not perceived to involve complex behaviours.

A number of studies align with the importance of self-efficacy in initiation and maintenance of human behavioural change (Bandura, 1997). For behaviour change to succeed, people must (as the original HBM theorizes) feel threatened by their current behavioural patterns (perceived susceptibility and severity) and believe that change of a specific kind will result in a valued result at an acceptable and affordable cost (perceived benefit). They also must feel themselves competent (self-efficacious) to overcome perceived constraints to take action.

Besides, diverse socio-demographic, psychological, and structural variables have the potential to influence beliefs and, thus, indirectly influence health seeking behaviour. For example, socio-demographic factors, particularly educational attainment, are believed to have an indirect effect on maternal health seeking behaviour by influencing the perception of susceptibility, severity, benefits, and barriers.

3.1.4 The Strengths of HBM

A review of HBM studies conducted between 1974 and 1984 combined new results with earlier findings to permit an overall assessment of the model's performance (Becker, 1974; Janz & Becker, 1984). Summary results provided substantial empirical support for the model, with findings from prospective studies at least as favourable as those obtained from retrospective research. Perceived barriers were the most powerful single predictor across all studies and behaviours. Although both perceived susceptibility and perceived benefits were important overall, perceived susceptibility was a stronger predictor of preventive health behaviour than sick-role behaviour. The reverse was true for perceived benefits. Overall, perceived severity was the least powerful predictor; however, this dimension was strongly related to sick-role behaviour. As there has not been an updated evidence review of HBM studies since 1984, this is the most current synthesis available. A new up-to-date review would help to confirm or modify these conclusions

The HBM has been used for over half a century to predict health-related behaviours and to frame interventions to change behaviours. As indicated by the reviewed research, it has been useful in predicting and framing several health-related (like cancer and HIV/AIDS) behaviours (Steers et al, 1996; Wight, Abraham & Scott, 1998; Zak-Place & Stern, 2004; Lin, Simoni & Zemon, 2005; Hounton, Carabin & Henderson, 2005).

3.1.5 The Criticisms of HBM

Although the HBM identifies constructs that lead to outcome behaviours, relationships between and among these constructs are not defined. This ambiguity was responsible for variation in HBM applications. For example, whereas many studies have attempted to establish each of the major dimensions as independent, others have tried multiplicative approaches (Champion & Skinner, 2007). Analytical approaches to identifying these relationships are needed to further the utility of the HBM in predicting behaviour.

One of the most important limitations in both descriptive and intervention research on the HBM has been variability in measurement of the central HBM constructs. Several important principles guide development of HBM measurement. Construct definitions need to be consistent with HBM theory as originally conceptualized, and measures need to be specific to the behaviour being addressed (barriers to immunisation may be the same as barriers to antenatal care) and relevant to the population among whom they will be used. To ensure content validity, it is important to measure the full range of factors that may influence the behaviour. Using multiple items for each scale reduces measurement error and increases the probability of including all relative components of each construct. Essentially, validity and reliability of measures need to be re-examined with each study. Cultural and population differences make applying scales without such examination prone to error. Champion & Skinner (2007) submits that only a few studies using the HBM that have developed or modified instruments to measure HBM constructs have conducted adequate reliability and validity testing prior to research.

A major method of testing construct validity is to test theoretical relationships. Ambiguity about the relationships among theoretical constructs in the HBM makes tests of construct validity more difficult. HBM relationships between constructs have not been well described. It is possible that one of the variables may mediate relationships between the others. Temporality of relationships is also an issue. When health beliefs and behaviours are measured concurrently, apparent relationships between them might well turn out to be spurious. These factors may have contributed to the frequent lack of scientific rigor in measuring HBM constructs.

Its simplicity has enabled researchers to identify constructs that may be important, thus increasing the probability that a theoretical base will be used to frame research interventions. Its simplicity, however, also creates some of its major limitations.

Several challenges remain when considering the HBM as a theory to predict health related behaviours. First, perceived threat is a construct that has great relevance in health-related behaviours. The HBM couples severity with perceived susceptibility— a strength, compared with models that conceptualize threat as perceived risk alone.

However, the relationship between risk and severity in forming threat is not always clear. A heightened state of severity is required before perceived susceptibility becomes a powerful predictor. It may be that perceived susceptibility is a stronger predictor of engagement if

severity in health-related behaviours is perceived as higher versus lower. If this is true, a multiplicative variable should be computed that combines perceived susceptibility and severity, rather than considering each alone.

Relationships among other constructs in the HBM also should be tested more thoroughly. For instance, perceived benefits and barriers may be stronger predictors of behaviour change when perceived threat (perceived severity and perceived susceptibility) is high than when it is low. Under conditions of low perceived threat, benefits of and barriers to engaging in health-related behaviours should not be salient. This relationship, however, may be altered in situations where benefits are perceived to be very high and barriers very low. Threat may not need to be high if perceived barriers are very low (for example, if maternal health care facilities are available at very convenient locations). Therefore, the predictive power of one concept may depend on values of another.

The HBM is limited, in that it is a cognitively based model and does not consider the emotional component of behaviour. Witte (1992) considered fear an essential part of a health-related behaviour, defined as a negative emotion accompanied by a high state of arousal. An experimentation of adding fear to a model that predicts mammography behaviour found relationships between HBM constructs and fear that might be useful predictors (Champion, Skinner, & Menon, 2005; Champion, Menon, Rawl, & Skinner, 2004). Fear was significantly predicted by perceived risk, benefits, and self-efficacy; fear, together with barriers, then predicted actual behaviour.

Inclusion of an emotional construct might help explain relationships among HBM constructs (Rogers & Prentice-Dunn, 1997). Finally, cues to action are one component of the HBM that is often missing from research. Cues to action will have a greater influence on behaviour in situations where perceived threat and benefits are high and perceived barriers are low. We know little about cues to action or their relative impact because this construct has not been identified clearly in research.

3.2 Rational Choice Theory

Rational choice theory was pioneered by a sociologist called George Homans, who in 1961 laid the basic framework for exchange theory, which he grounded in hypotheses drawn from behavioural psychology. During the 1960s and 1970s, other theorists (Blau, Coleman, and Cook) extended and enlarged his framework and helped to develop a more formal model of rational choice. Over the years, rational choice theorists have become increasingly mathematical.

The basic principles of rational choice theory are derived from neo-classical economics as well as utilitarianism and game theory (Levi *et al* 1990). The focus in rational choice theory is on actors. Actors are seen as being purposive or acting intentionally as a means to an end or goal towards which their actions are aimed. Actors are also seen as having preferences or values for utilities. Rational choice theory is unconcerned with what these preferences, or their sources, are. Of importance is the fact that action is undertaken to achieve objectives that are consistent with an actor's preference hierarchy.

Although rational choice theory starts with actor's purposes or intentions, it also take into consideration at least two major constraints on action. The first is the scarcity of resources; actors have different resources as well as differential access to other resources. This is in line with the fact that maternal health facilities are not within the reach of the poor people, the majority of whom encounter health problems in their day - to- day subsistence activities, have little or no access to health care and where they have access they do not have enough resources (money) for procurement due to high cost. Alternatively, for those with lots of resources, the achievement of ends may be relatively easy.

Related to scarcity of resources is the idea of opportunity costs, or *"those costs associated with foregoing (sic) the next most attractive course of action"* (Friedman & Hechter, 1988: 23). In pursuing a given end, actors must keep an eye on the costs of foregoing their next most attractive action. An actor may choose not to pursue the most highly valued end if his/her resources are negligible, if as a result the chances of achieving that end are slim, and if in striving to achieve that end he/she jeopardizes his/her chances of achieving his/her next most valued end. Actors are seen as trying to maximize their benefits, and that goal may involve assessing the relationship between the chances of achieving a primary end and chances for attaining the second most-valuable objective (Ritzer, 1996).

A second source of constraints on individual action is social institutions. As Friedman and Hechter put it:

> *An individual will typically, "Find his or her actions checked from birth to death by familial and school rules; laws and ordinances, firm policies; churches, synagogues and mosque; and general factors. By restricting the feasible sets of course of action available to individuals, enforceable rules of the game-including norms, laws agendas, and voting rules which will systematically affect social outcomes"*(Friedman & Hechter, 1998: 23).

These institutional constraints provide both positive and negative sanctions that serve to encourage certain actions and discourage others. In many parts of the world, women's decision-making power is extremely limited, particularly in matters of reproduction and sexuality; mothers-in-law, husbands or their family member often make decisions regarding maternal care. Also, to a large extent, religion plays a vital role in decision making about potential health.

Friedman & Hechter (1998) enumerate two other ideas that they see as basic to rational choice theory. The first is an aggregation mechanism, or the process by which the separate individual actions are combined to produce the social outcomes. The second is the growing sense of the importance of information in making rational choices. At one time, it was assumed that actors had perfect, or at least sufficient, information to make purposive choices among the alternative courses of action open to them. However, there is a growing recognition that the quantity or quality of available information is highly variable and that variability has a profound effect on actors' choices.

In choosing between alternative actions, a person will choose that one for which, as perceived by him/her at the time, the value (V) of the result, multiplied by the probability (P) of getting the result, is the greater, (Homan, 1974). Here V represents the value of the result or goal to be achieved whereas P stands for the probability or chance or likelihood of achieving the result.

Basically, people examine and make calculations about the various alternative actions open to them. They compare the amount of rewards associated with each course of action. They also calculate the likelihood that they will actually receive the rewards. Highly valued rewards will be devalued if the actors think it unlikely that they will obtain them. On the other hand, lesser-valued rewards will be enhanced if they are seen as highly attainable. Thus, there is an

interaction between the value of the reward and the likelihood of attainment. The most desirable rewards are those that are both very valuable and highly attainable. The least desirable rewards are those that are not very valuable and are unlikely to be attained (Ritzer, 1996).

In order to make rational decisions, four stages must be fulfilled:

i. They must be exposed and have access to health care service,

ii. They must evaluate the messages received from awareness programmes,

iii. They must take definite decisions about whether they will use the modern health care services or not taking into consideration the advantages and disadvantages as well as the potential barriers of using it, and

Iv. They must act upon the decision they have taken.

Rationality means that mothers accept use of maternal health facilities as the best optimal therapeutic choice for preventing ill-health. With this belief, they choose to use maternal health facilities, but non-rational women of reproductive age only accepted the goal of preventing themselves against ill-health and unsafe delivery but were skeptical about using maternal health facilities as the only appropriate therapeutic measure of achieving the goal (Jegede, 1998).

A rational action involves a utilitarian consideration between competing alternatives for specific ends. This emphasizes the choice between means and ends, that is, a woman may accept and use maternal health facilities, while another may only accept what is good but may not believe that it can solve her problem. This brings to focus the pathways to achieving the goal of good health.

Zola (1964), on his own, postulates that some people whose condition demands a rationally positive action refuse to take such action even when their lives are seriously in danger. He concluded that there is something about these people or in their background which has disturbed their rationality, otherwise they would actually seek aid. Blackwell (1963) and Green et al (1974) revealed that people delay seeking cure because of conflict between a strong feeling of susceptibility to disease and of a feeling that there are no efficacious methods of preventing or controlling the disease.

3.3. Location Theory

3.3.1 The Origin of Location Theory

Models of the location of economic activity had begun to be developed in the first half of 18th century. In the context of formulating a scientific theory of rent and in analyzing the spatial configuration of production, attention was given to the location of primary producers, especially agricultural production. Among the forerunners of location theory, von Thunen (1875) is concerned primarily with the location of agriculture.

Not surprisingly though, given the growth of secondary activity that occurred in European countries in the second half of the last century, and the social changes that accompanied this growth, it was issues associated with the location of *manufacturing* activity that directed the economic theory of location.

The Neo-classical economics as the orthodox theory of the time provided the conceptual tools for the development of location theory. The contribution of Alfred Weber (1929) represents the first systematic treatment of problems of industrial location and marks the origin of modern neo-classical location theory, which carries on through the work of Palander (1935); Losch (1939; 1954); Hoover (1948; 1968); Greenhut (1956); lsard (1956); & Smith (1971).

Lloyd and Dicken (1972) provide a definition for the object of location theory. Although, in general, economists steer clear of spatial considerations, there has, nevertheless, been an on-going interest in the construction of general principles and theories that explain the operation of the economic system in space. The central problem is the search for the explanation of general locational tendencies and patterns.

Certainly until the end of the war, when American writers took up the problems of location, interest in, and contributions to, the theory of location was much stronger in Germany than elsewhere. Isard (1956) attributes this strength to the confluence of the ideas of the German historical school, which gave attention to spatial implications of economic development and to the impact of Walrasian economics upon German economists**.**

Smith (1971), likewise, describes industrial location analysis as 'the study of the spatial arrangement of industrial activity'. This subject-matter has remained the same from the time of Weber. Smith specifically alludes to the role of decisions in location theory.

3.3.2 The Principles and Relevance of Location Theory in Contemporary Health Issues and Understanding Human Behaviour

In classical location theory, the spatial pattern of economic activities is explained mainly in terms of transfer costs, which include both freight charges (transport costs) and the costs of insurance on materials and goods on route and losses incurred by deterioration of, or damage to material in route. Hoover (1948) remarked that the expense and inconvenience of shipping finished products to distant customers and procuring materials from distant sources prompt producers to locate near their markets or their sources of raw materials; in other words, industrialists tend to locate where aggregate transfer costs are at a minimum (Estall & Buchaman, 1968).

The notion of transfer costs has strong implications for the location of public facilities. Public facilities such as maternal health facilities have important characteristics, two of which are relevant to maternal health seeking. First, the services they produce are mostly for women of reproductive age, which serve as significant final consumer. Second, maternal health services generally require personal contact between the facility providers and the users. Owing largely to these two characteristics, maternal health facilities generally ought to be located primarily with an eye to distribution, and thus oriented toward the users' accessibility depending on the transport situation and the locations that are more likely to minimize travel costs are those at strategic points in the transportation network. With regard to most maternal health facilities, transport costs assume greater importance than transfer costs partly because distribution in this case involves mainly the movement of users to points where facilities are available. Non-monetary criteria are very important in the location of maternal health facilities. The relevant variables in this regard refer to social or human entities to which it is difficult, if not impossible, to assign monetary values (Erinosho, 1982). It is not possible for instance, to know how much monetary benefit results from suitable access to maternal health facilities.

However, inefficiently located health facilities may lead to more costly services and consequently the public ends up receiving less for its tax payments (Erinosho, 1982). Efficient locations are necessary if societal resources are not to be unduly wasted in overcoming distance unnecessarily. An efficient set of locations of maternal health facilities can reduce maternal morbidity and mortality, save human effort and monetary resources that can be devoted to many other things (Abler *et.al* 1977).

3.3.3 The Strengths and Weaknesses of Location Theory

Most writers, going back to the earliest years of location theory, criticise the models of previous generations for their lack of realism, or for over-simplification which seems to limit their usefulness in one way or another (for example Smith, 1979). In fact, adding or changing assumptions makes no difference to the 'realism' of the models.

It is claimed that despite simplifying and unrealistic assumptions, scholars, including geographers, cannot do without the type of framework that neo-classical location theory provides. Adams (1970) explains why economic man is an 'extremely useful individual'.

Pred (1967) finds the present body of geographic location theory unsatisfactory because it is based for the most part on two sets of unrealistic simplifying assumptions, namely economic man and static equilibrium. However, the use of simplifying assumptions such as these is standard practice in the social sciences and must remain so. It must be recognised that one cannot deal with the total complexity of reality all at once. One is guilty of oversimplification if one force more weight on the conclusions than the assumptions will permit them to bear. Explaining human conduct is a complex exercise and, if the object is to construct useful theories, it may be impossible to avoid these complexities.

3.4 Feminist Theory

The birth of feminism was as a result of the published works of protest in the western world. With few exemptions, the first appearance of these was in the 1630s and proceeds for about another fifteen decades as a thin but persistent trickle. To date, feminist writing persistently became a significant collective effort, growing in both the number of its participants and the scope of its critique.

The record of feminism, however, is not one of smooth, uninterrupted development. Women are often seen as minority and a subordinated group. Feminist protest of this minority status always threatens, and therefore is opposed by men, who were considered to be more powerful and dominant majority. The avenues for public feminist protest expand and contract as societies swing between moments of liberationist change and receptivity on one hand and era of greater conservatism and repression on the other.

The high points in the record of feminist activity and writing occur in the liberationist periods of modern western history; a first flurry of productivity in the 1780s and 1790s with the debates surrounding the American and French revolutions; a far more organized, focused

effort in the 1850s as part of the mobilization against slavery and for political rights for the middle class; massive mobilization for the suffrage in the early twentieth century; and in the 1960s and 1970s, the modern, broad based, multifaceted movement brought about a brand of radical social thought known as contemporary feminist theory, which has continued to grow in range and complexity (Ritzer, 1996).

In western societies (as earlier mentioned), the record of critical feminist writings could be traced back to about 500 years (Rossi, 1974; Spender, 1982; Donovan, 1985; Lerner, 1993;), and there has been an organized political agitation by and for women for more than 150 years (Bolt1993; Chafetz and Dworkin, 1986; Matthews, 1992;).

3.4.1 The Underlying Principles of Feminist Theory

Feminism x-rays the society from the vantage points of a hitherto unrecognized and invisible minority, women, with an eye to discovering the significant but unacknowledged ways in which the activities of women subordinated by gender and variously affected by other stratification practices, such as class, race, age, coaxed heterosexuality, and geo-social inequality.

Feminist theory is generalized, wide-ranging system of ideas about social life and human experience developed from a woman-centered perspective. The varieties of contemporary feminist theory include; gender difference, gender inequality, gender oppression and third wave feminism.

The Radical feminists perceived society as patriarchal. From this point of view, men are the ruling class, and women, the subject class. The family is seen by some radical feminists as the key institution oppressing women in modern societies. For radical feminists, patriarchy is the most important concept for explaining gender inequalities in the society. Although literally it means ‘rule by the father’, radical feminists have used it more broadly to refer to male dominance in society. Owing to this perspective, patriarchy involves the exercise of power by men over women. Within the Yoruba culture, women are subject to their husband to the extent that decisions concerning their health are made by their husband. Kate Millett (1970) was one of the first radical feminists to use the term and to provide a detailed explanation of women’s exploitation by men.

Millett (1970) is of the opinion that political relationships that exist between men and women cut across all aspects of everyday life, such relationships are organized on the basis of patriarchy, a system in which 'male shall dominate female'. She believes that patriarchy is the most pervasive ideology of our culture, its most fundamental concept of power'. It is more rigorous than class stratification, more uniform, certainly more enduring'.

To Walby (1990), the concept of patriarchy must remain central to a feminist understanding of society. She says that patriarchy is indispensable for an analysis of gender inequality'. Like other feminists, Walby sees violence as a form of power over women. The use of violence, or the threat of violence, helps to keep women in their place and discourages them from challenging patriarchy. This to a great extent has implications for maternal health seeking.

3.4.2 The Relevance of Feminist Theory in Contemporary Times as Applicable to the Understanding of Human Behaviour

The term patriarchy was not new to social theory, but Millett (1970) made use of it in a unique way. Derived from Greek "patriarche", meaning head of the tribe, it was central to seventeenth-century debates over the extent of monarchical power; here supporters of absolute rule claimed that the power of a king over his people was the same as that of a father over his family, and that both were sanctioned by God and nature. Millett seemed to take such familial power as her starting point, so that the principle of patriarchy appears to be twofold: male shall dominate female, elder male shall dominate young. It was, however, only the first of these principles that she explored, and she did not distinguish between male power within the family and in society as whole. Despite the efforts of some writers either to restrict the term to strictly family-based power (Randal, 1987; Cocks, 1989), or to substitute the term "male domination" when referring to social relations more generally (Thompson, 2001), its use as a shorthand for a social system based on male domination and female subordination became widespread amongst feminists.

Millett's central claims were simple, and they essentially represented a formalization of the ideas that were already current in the new women's movement. She argued that in all known societies, relationships between the sexes have been based on power, and that they are therefore political. This power takes the form of male domination over women in all areas of life; sexual domination is so universal, so ubiquitous and so complete that it appears 'natural' and hence becomes invisible, so that it is perhaps the most pervasive ideology of our culture

and provides its most fundamental concept of power. According to Millett, the patriarchal power of men to women is basic to the functioning of all societies and it extends far beyond formal institutions of power. It supersedes class and race dichotomies, for economic dependency means that women's class identity is a tangential, vicarious and temporary matter, while sexism may be more endemic in our society than racism.

Millett argued that patriarchy is primarily maintained by a process of conditioning, which begins with childhood socialization within the family and is reinforced by education, literature and religion to such an extent that its values are internalized by both men and women; for some women this leads to self-hatred, self-rejection and an acceptance of inferiority. She further argued that, despite the success of this "interior colonization", patriarchy also rests upon economic exploitation and the use or threat of force. This means that its history is a record of man's inhumanity to woman and that the African girl whose clitoris is cut out all in the name of female circumcision regardless of the attended pains and the health implications on her is an insignia of oppression and slavery. In all societies too, patriarchy relies upon sexual violence and rape. In this context sexual relations between men and women are but an expression of male power, and Millett devoted a large section of her book to 'deconstructing' the portrayal of sex in the work of four major twentieth-century writers: D. H. Lawrence; Henry Miller; Norman Mailer and; Jean Genet so as to reveal the crude sexual domination involved. According to her, love, too, can be but a confidence trick, part of a patriarchy ideology designed to hide the realities of power; not until patriarchy has been overthrown and sexuality radically transformed can men and women relate as equal human beings.

For many writers, the task of understanding patriarchy involved the identification of women's oppression across cultures and nations and over time. Thus for example Adrienne Rich's account of patriarchy explicitly abstracted the position of women from any social context: he stated ' under patriarchy, a woman may live in purdah or drive a truck; she may raise her children in a kibbutz, or be the sole breadwinner for a fatherless family, she may serve her husband his early morning coffee within the clay walls of a Barbar village or march in an academic procession; whatever her status or situation, her derived economic class or her sexual preference, she live under the power of the fathers, and have access only to so much of privilege or influence as the patriarchy is willing to accede to her, and only for so long as she pay the price for male approval (Rich, 1975).

Similarly, Andrea Dworkin (1974) linked the pre-revolutionary Chinese practice of foot-binding to the girdle, high heels and eyebrow plucking dictate by American fashion, claiming that for all women pain is an essential part of the grooming process and that is not accidental, it serves to prepare women for lives of childbearing, self-abnegation and husband-pleasing. Mary Daly (1973 and 1978) too claimed that such horrors as foot-binding, witch-burning, genital mutilation and modern American gynaecology are all essentially similar manifestations of the universal system of male tyranny, so that the situation of women is basically the same across the globe, and even outer space and the future have been colonized

3.4.3 Strengths and Weaknesses of Feminism

The above raised analyses had an intuitive appeal and contained a kind of truth. It is not necessary to believe in the immutable and biologically based 'badness' of men (as portrays by feminist) to agree that women in radically different societies or situations frequently have experiences in common, involving sexual exploitation, lack of reproductive freedom and marginalization from 'male-stream' economic, social, political and intellectual life; these experiences may reflect the systematic (that is, non-random) exercise of power by men over women. Nevertheless, the idea that all women are united in a common sisterhood that transcends all man-made divisions can be dangerously misleading.

In the first place, a too-easy comparison of women's experiences across the centuries and within and between contemporary societies trivializes the depth of suffering experienced by some women.

Similarly, attempt to compare the experiences of women in very different contemporary societies that are based on the premise that these are essentially 'the same' conceal the vast gap in experience that is involved. For example, lack of reproductive rights meant something very different to the Romanian woman during the Ceaucesco dictatorship forced to bear at least six children, the Chinese woman forced by the "one child" policy to abort her second, the white American career woman whose contraception has failed and the Puerto Rican woman sterilized against her will.

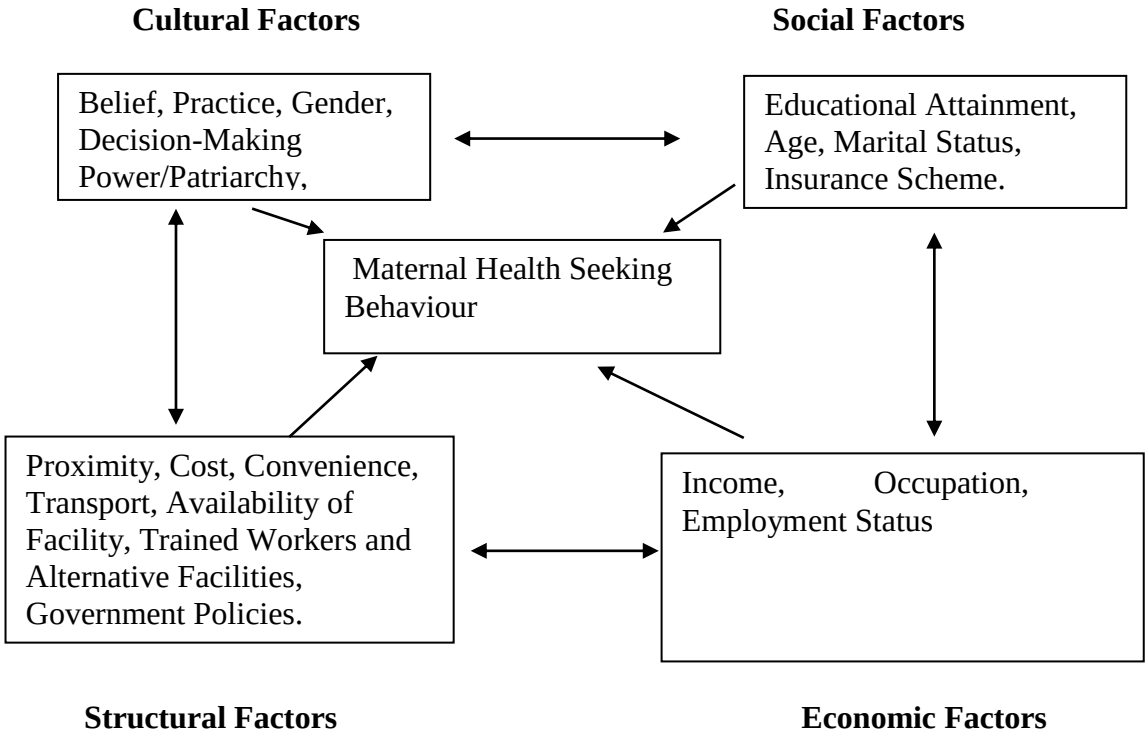
For many women, Millett's ideas were a revelation, enabling separate pieces of knowledge and experience to click into place, and transforming the way they saw the society (Tobias, 1975). The radical feminist concept of patriarchy has however, been heavily criticized by

other feminists, and has been accused of being both politically counter-productive and based on sloppy, over-ambitious and dangerously misleading theoretical assumptions (Rowbotham, 1982; Beechey, 1979).

3.5 Conceptual Framework for Factors Affecting Maternal Health Seeking Behaviour

The situation within which maternal health seeking behaviour is being exhibited are considered to be influenced and determined by four major factors identified as; cultural, social, economic and structural. Each of these factors is embedded with various variables (as identified in the diagram below). In other words, each or combination of some of the identified variables are proximate determinants in maternal health seeking behaviour.

Figure 3.2: Conceptual Framework for Factors Affecting Maternal Health Seeking Behaviour



Source: Field Survey, 2016.

As the dependent variable, maternal health seeking is likely to be influenced by the independent variables embedded in the socio-economic and cultural life of the people. The economic status of women in terms of her occupation and her income is a paramount factor to be examined in the equation of maternal health seeking. Similarly the social factors such as

educational attainment, marital status, age at marriage and insurance scheme may also determine whether a woman will seek health facility or not and the type of facility she visit.

Moreover, the framework indicates that cultural factor such as beliefs; attitudes and practice and gender issues in terms of decision-making power within the family unit and patriarchy are likely to be proximate determinants of maternal health seeking. To a large extent men's involvement in reproductive health decisions may also impinge forcefully on use of maternal health facilities.

In addition other factors affecting maternal health could also include cost, proximity, availability of the facility, government policies, convenience, availability of skilled workers and alternative facilities amongst others.

3.6 Conclussion

A theory is considered as a set of ideas that provides an explanation for a phenomenon or issue (Haralambos and Holborn, 2008). This is more the reason why sociologists place emphasis on theory in providing an explanation for human behaviour in society as part of the rudiments in sociological enterprise. In spite of the fact that, there are no facts without theory, it is also expedient to state that no amount of theory can explain everything or account for the infinite amount of data that exist, or encompass the endless ways of viewing reality. This is the reason why sociologists are selective in their choice of theory as largely informed by their priorities and perspectives and the data they define as significant.

Specifically, the theoretical triangulation of rational choice theory, behavioural change models and feminist theory were used as theoretical framework which produces such variables as beliefs, attitudes, access, decision making power, individual demographic characteristics and structural concepts as search lights for the study.

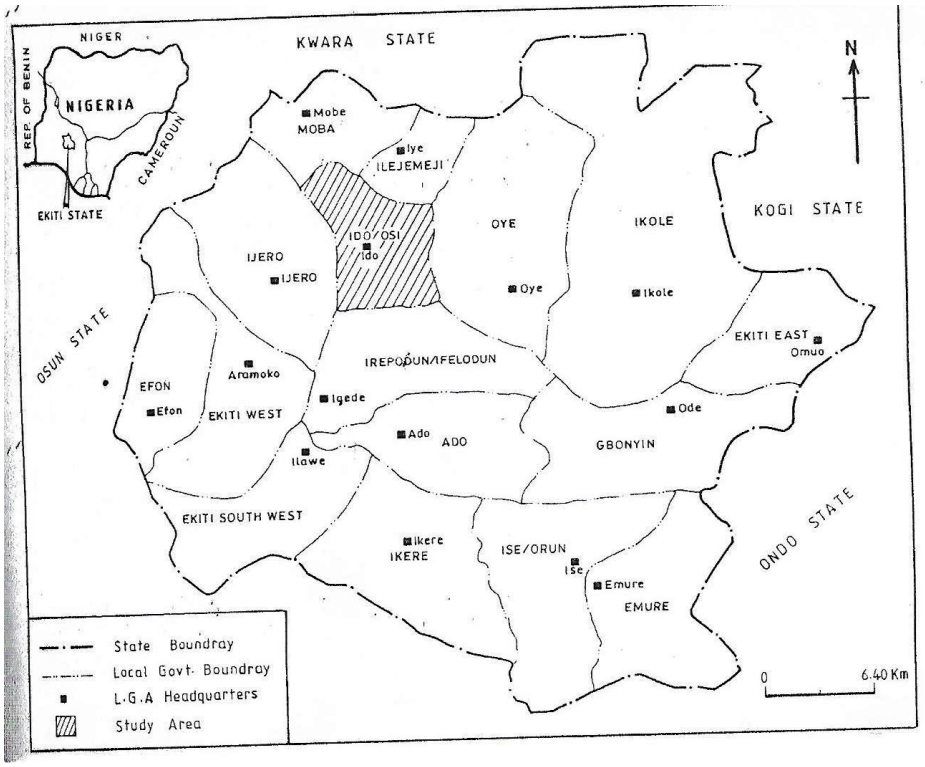
CHAPTER FOUR

RESEARCH METHODOLOGY

4.1 Research Design

Exploratory design was adopted for the research because it enabled the researcher to achieve a better and clearer understanding of factors affecting maternal health seeking behaviour among the Yoruba people of Nigeria. Qualitative methods such as interviews were undertaken to complement the survey research (quantitative). The primary aim of selecting the mixed methods rested on the importance of confirming, cross-validating, or corroborating findings within this single study. By using both qualitative and quantitative methods, it served to compensate for the weakness inherent within one method with the strength of the other (Cresswell, 2003). Equal priority was accorded to the two methods by integrating the findings from both methods during data interpretation and analysis phase of the study. By so doing, it strengthened the knowledge, claims and conclusions made in the study.

Figure 4.1Map of Ekiti State of Nigeria Showing the Study Area (Ido/Osi LGA)



Source: Ekiti State Surveys, Ado-Ekiti, Nigeria. 2017

4.2 Sample Population

A cross-section of women of child bearing age who were pregnant or who have child(ren) of not more than 24 months old were selected as respondents, using a multi-stage sampling technique. 200 questionnaires were administered.

As regards the qualitative approach for the study, twelve semi-structured (in-depth) interviews were conducted; four among orthodox health workers and traditional birth attendants respectively, which assisted in gaining further insight on factors affecting maternal health seeking, which the survey did not readily elicit. These participants were selected purposively in respect to their status in the community.

The study has been guided by the proposed sample stated above. The rationale for proposing this sample size was due to the time frame and limited resources available for the research. This implies that studying a larger sample might require more time than that allocated to the fieldwork and with the possibility to also generate more data than a single researcher could handle within the time required for the study.

4.3 Sample Design and Technique

A systematic random sampling technique was used for this study. A systematic sampling is a type of probability sampling method in which sample members from a larger population are selected according to a random starting point and a fixed, periodic interval, it is calculated by dividing the population size by the desired sample size.

The sample for the study began by obtaining a complete list of enumeration areas in Ido-Osi LGA, demarcated for the 2006 census. An Enumerated Area (EA) refers to a compact area carved out of a locality with well-defined and identifiable boundaries. According to the National Population Commission's demarcations, there are 160 EAS in Ido-Osi LGA with an estimated 125 households per EA and an average number of 8 persons per household. This gives an estimate of 1000 persons per EA and 20000 (125 x 160) households in all. The LGA is divided into 11 political wards. There are 13 communities that made up of these 11 political wards. These are in Ido/Osi Local Government Area (LGA) in Ekiti State of Nigeria. The thirteen communities are Ido Ekiti, Osi Ekiti, Ayetoro Ekiti, Ifaki Ekiti, Ilogbo Ekiti, Usi Ekiti, Igbole Ekiti, Orin Ekiti, Aaye Ekiti, Odo-Ora Ekiti, Ilogun Ekiti, Oke-Ora Ekiti and Ifisin Ekiti.

The study samples were drawn from all the political wards of the LGA in Ekiti State, in order to generate representative data. A sampling frame of women who constitute survey respondents for the study did not exist and it was therefore expedient for the researcher to construct one.

The next stage involved selection of households for sampling. A total of 200 households were sampled, that is, selected number of households (snh) in all the wards using a systematic random sampling technique. A table of random numbers was used in selecting the household that will participate in the survey (n^{th}). The chance of a household being sampled in the 11 wards that makes up the EAs is:

$$\frac{TNH}{}$$

$$n = \quad SnH \qquad \text{where:}$$

n = selection interval

TNH = Total number of households in the EAs (20000)

Snh = number of household to be selected for the survey (200)

n^{th} = selected household to participate in the survey

$$\frac{20000}{}$$

n = 200 =100 (sample interval).

In summary, 18 respondents were selected from each of the political wards except in "Ido ward 1" where 20 respondents were drawn due to it, being the local government headquarters and having the largest number of households in the LGA. In all, the total number of respondents was 200.

Since the target population were women of child bearing age who were pregnant or who had child(ren) of not more than 24 months old therefore, the woman that fall within this category in each selected household served as respondent. However, where in a household that had more than one woman of child bearing age who was either currently pregnant or has had a baby within the last twenty four (24) months at the time of the study, a simple random technique (which allowed each of these women to pick a folded paper, with only one of them getting the piece that would qualify her as a respondent for the study) was adopted to select

the one that would finally be interviewed. In a situation, whereby there was no woman that falls within the category of defined characteristic to be included in the study, then the next household with the desired sample within the EA was considered.

As regards the qualitative approach for the study, eight semi-structured (in-depth) interviews were conducted; four among orthodox health workers, traditional birth attendants (TBAs) and community/religious leaders respectively, which assisted in gaining further insight on factors affecting maternal health seeking, which the survey did not readily elicit. These participants were selected randomly in respect to their status in the community. Two of the orthodox health workers were selected from health facilities located in Orin/Ora ward and the remaining two from Usi and Ayetoro ward II respectively while each of the traditional birth attendants (TBAs) were selected from Ilogbo, Orin/Ora, Aaye/Ifisin/Igbole and Ayetoro I wards respectively and two community/religious leaders were also selected from each of the two political constituency in Ido/Osi LGA. The selection was done primarily, based on convenience and other factors like suggestions and Information derived from gate keepers within Ido/Osi LGA. It was assumed that these set of people have better knowledge of the activities in the communities, especially the traditional birth attendants' centers where the interviews were conducted.

4.4 Research Instruments

The fieldwork commenced with the qualitative aspect of the research, which provided invaluable insights for understanding the study area. For most studies employing triangulation, qualitative data is of immense significance and necessarily precedes the survey method (Nwokocha, 2004). By setting out to investigate the factors that could directly or indirectly affect maternal health seeking behaviour in Ido/Osi LGA of Ekiti State, Nigeria, the construction of the questionnaire relied heavily on indepth interviews undertaken with gate keepers, community leaders, traditional birth attendants, orthodox health providers and religious leaders within Ido/Osi LGA. Information derived from these key informants helped to construct the questionnaire.

4.4.1 Questionnaire

In most cases, when we want to elicit the data needed, asking questions is perhaps the only direct way of doing so, whether in a formal or informal setting. In the field of sociology, demography and the social sciences in general, questionnaires are the foremost instrument used to elicit information from respondents.

In this study, the independent variables were built around such factors as:

i Cultural beliefs and practices;

ii Socio-economic status;

iii Educational attainment;

iv Perception of health workers and services;

v National health policies;

vi Use of alternative medicine.

The design of the Questionnaire for the study was guided by a pilot study. This method facilitates a proper understanding of the target population and their culture. Pilot research for the study involved interviews with gate keepers, community leaders, traditional birth attendants, orthodox health providers and religious leaders within Ido/Osi LGA.

The questionnaire used for the study consisted of different types of information and questions that will answer the research question. Hence for the purposes of clarity and proper arrangement, it was sub-divided into parts. The first part of the questionnaire contained an introductory letter which introduced the researcher and set out the nature and purpose of the study followed by instructions on completing the questionnaire. A classificatory section requesting profile information about the research subjects and other sections containing questions relating to the subject was provided.

In the introductory letter, it was mentioned that the questionnaire seeks the perception of the respondent regarding factors affecting maternal health seeking behaviour in the Yoruba community of Nigeria. In addition, the purpose of the research was clearly stated that the information derived from the respondents will be used purely for academic purpose. The researcher also assured the participants (in writing) that any information

provided would be treated as strictly confidential. Finally, the introductory aspect was concluded by thanking the participant in advance for their anticipated co-operation and the researcher signed against his name to build confidence among the participants.

The instructions for completing the questionnaire were general guidelines directing the respondents on how to answer the questions. Different type of questions will, as it is to be expected, be guided by different types of instructions. In this study, the general instruction for answering the questions in the questionnaire requested the respondents to tick the appropriate response and supply information where necessary.

The classification section of the questionnaire contained questions concerning socio-demographic information about the respondent. The answers to the questions in this section provided profile information about the unit of the study. The questions under this section related to the respondent's age, marital status, highest educational qualification, occupation, religion, monthly income, husband's monthly income and number of children ever had.

The real purpose for requesting the socio-demographic information of the respondent was to enable the researcher gain a deeper understanding of the relationship between these characteristic of women of child bearing age in Yoruba community of Nigeria as the area being studied and the dependent variable of factors affecting maternal health seeking behaviour. In addition, it helped in providing a clearer examination of the effect of factors affecting maternal health seeking. In other words, the data generated in this section enable us to classify the respondents of units under study. It is for this reason that this section of the questionnaire is regarded as the classification or classificatory section.

Every research has a core subject matter which is the focus of the study. The core subject of a study is defined by the objectives and hypotheses of the research effort as stated earlier in chapter one. This section of the questionnaire contained questions leading to information or responses that enable the researcher to meet the earlier stated objectives and enabled him to analyse the research questions and test the stated hypotheses in the study. The core subject-matter section is divided into two aspects. The first aspect which was demarcated as section "B" featured questions about health seeking behaviour while the second aspect which was demarcated as section "C" sought respondent's perception of health workers and services. The nature of the questionnaire was designed in a way that accommodated a combination of open and close ended questions

As identified by Tulle & Hawkins (1980), there are three types of errors which can result from the questionnaire itself. In other words, poor questionnaire design can lead to three types of errors. First, the generation and collection of data different from that intended or needed by the researcher. This is referred to as surrogate information error. In this study, the researcher dealt with the possibility of this problem through careful questionnaire construction. The draft copy of the questionnaire was subjected to scrutiny and approval by the researcher's supervisors and external reviewer through the School of Humanity Higher Degrees Committee of the University of Kwa-Zulu Natal.

Secondly, it is said that a poor questionnaire design can affect the response rate both to the overall instrument and to specific items in the question. This is most likely to occur if the questions are unnecessarily long, convoluted and ambiguous. As part of the observations made by external reviewer at the proposal level of this study, the questions were reduced considering the physical condition of the research subjects; that is they are pregnant women and nursing mothers. In this respect, the researcher made amendments to the extent that it minimized the time spent by the respondent in filling the questionnaire.

Finally, the most critical challenge in questionnaire construction is measurement error. Two similar questions, asking essentially the same thing, can yield very different answers. Thus, a poorly constructed questionnaire can result in unreliable and invalid data. Being aware of the implication of the foregoing, the questionnaire construction for this study was guided by comments made by the research committee who approved the study.

In accordance with Miller (1977:76), the appropriateness of any questionnaire or interview depended on a number of factors. In this respect, the construction of the questionnaire was guided by the following considerations:

(i). The questionnaire was prepared in a way that it commenced with easy questions that the respondent will enjoy answering.

(ii) The topics and questions were arranged in a sequence that making it natural and easy for the respondent to follow.

(iii) The language used was at the level of the respondent, and the words used were more common usage that has the same meaning for respondents.

(iv) Long drawn questions that tended to be ambiguous and confusing were avoided.

(v). Ambiguous wording of the questions, as well as biased and leading questions was avoided.

(vi) Questions were asked in such a manner that it established the frame of reference the researcher had in mind.

(vii) In formulating questions, attempt was made as much as possible to suggest all possible alternativeness for the respondent to choose from.

(viii) In most cases, questions were restricted to a single idea or a single reference.

(x) In some issues that seemingly looked like unpleasant orientations, the respondent was given a chance to express positive feelings first so that the respondent was not placed in an unfavorable light.

(xi) The researcher made use of direct questions as much as possible.

(xii) Most of the questions were open-ended with a few close –ended.

(xiii) Most of the open-ended questions were formulated in pairs, asking for the pros and then the cons of a particular issue. For instance, "what are the local traditions and practices that you considered to promote maternal health in this community?" Followed by, "what are the local traditions and practices that you considered as detrimental to maternal health in this community?"

(xiv) Open-ended questions which usually required thought and elaborate writing were kept to a minimum and placed at the end of the questionnaire to ensure that they are answered.

(xv) The questionnaire was pre-tested with a selected number of respondents' who were representatives of the original participants that made up the survey. They were encouraged to ask questions, and to point out questions that were difficult to understand or answer. This process helped a great deal in refining the final version of the questionnaire.

Having given due consideration to the formulation of the questionnaire, a six day training programme was arranged for the four field assistants. The training centers on the basic skills and ethical issues on how to administer questionnaire. The field assistants were also trained on the nitty-gritty of protecting human research participants.

4.4.2 In-Depth Interview (Qualitative Technique)

As part of human interaction, having a conversation with an individual is considered a usual phenomenon. In so far as the act of interviewing is concerned, one may be tempted to think that it requires no special skills or preparation. This from a social science perspective is a very shallow insight into what scientifically focused interviews entails. It requires much preparation in terms of the nature and form the interview will take place and the objectives that need to be achieved.

For the purpose of this study, the researcher paid visits to the twelve selected interviewees, and at the point of first contact and subsequent visits, he explained his mission to investigate the factors that affect maternal health seeking in the Yoruba community of Nigeria. In addition, the researcher informed the interviewees that they were selected randomly because they meet the criteria to be respondents in the study. The detail of the selection process has been discussed earlier in this chapter.

In practice, most researchers prefer conducting interviews in a non-directive manner, in other words, to refrain from giving opinion, to avoid expressions of approval and disapproval. Ideally, in most cases, an interviewer will devote some time trying to establish rapport or understanding and familiarity between him or her and the interviewee. This may be achieved ordinarily by engaging in an informal discussion before the interview proper starts. By so doing, the interviewee will gain the assurance that he will be criticized or judged, that they can talk freely and can rely upon a sympathetic audience. It is hoped that they will talk with honesty and openness (Haralambos & Holborn, 2008). As much as the researcher partially align with this relatively passive approach, on certain occasion a more active and aggressive approach was adopted in order to get a more qualitative data from the interviewees (Becker, 1970). Interestingly, the researcher is familiar with the study area hence; there was little or no difficulty in establishing a rapport with the interviewees.

Apart from the two hundred respondents that participated in the quantitative method (questionnaire), twelve other participants were also interviewed. The in-depth interview used in the study as a qualitative method served in complementing the data from the survey. In-depth interview was considered due to its advantage over other methods of interviewing, for instance, in-depth interview can utilize larger samples compare to participant observation method, in lieu of this, generalization are more justified in making use of in-depth interview as a qualitative method.

The interview schedule was conceived on the premise that factors affecting maternal health seeking behaviour should not be limited to the views of pregnant women and nursing mothers alone rather the views of other key players in the community is equally essential in other to have a more reliable and holistic understanding of the phenomenon. Based on this, the targeted participants for the in-depth interview were: community leaders, traditional birth attendants, religious leaders, orthodox health providers. These participants were selected randomly in respect to their status in the community and because they met the criteria to be respondents in the study. Precisely, two of the orthodox health workers were selected from health facilities located in Orin/Ora ward and the remaining two from Usi and Ayetoro ward II respectively while each of the traditional birth attendants (TBAs) were selected from Ilogbo, Orin/Ora, Aaye/Ifisin/Igbole and Ayetoro I wards respectively and two community/religious leaders from each of the political constituency of Ido/Osi LGA.

The interview schedule was structured in a way that the questions that were asked cut across both specific and general issues regarding maternal health seeking behaviour of the people of Ido/Osi Local Government Area with the ultimate aim of extracting the salient issues in line with the focus of the study. This is done in other to complement the findings from the quantitative data.

One of the major clear advantages of in-depth interview is that the concepts and words used by the interviewer and interviewees alike were easily clarified; the researcher's concepts are less likely to be imposed on the social world; there is benefit of exploring issues to a greater depth; and the researcher does not limit the responses to fixed choices. For these reasons the researcher find the use of in-depth interview to be of greater advantage for generating new hypotheses and theme which the researcher would not otherwise have thought of.

Another major reason for the use of in-depth interview method in this study lies in its rear nature and evidence of practicality. One can arguably say that there is no other method which allows access to so many groups of people of diverse background, status and different types of information. With the use of in-depth interview, the researcher have been able to source for data from diverse participants (interviewees) ranging from educated health workers to traditional birth attendants (TBAs) with little or no formal education; community and religious leaders regarding issues on factors affecting maternal health seeking in Yoruba community of Nigeria.

By collating information through in-depth interview about what the interviewee says concerning himself or herself potentially offers the social researcher access to huge storehouses of information which was later used as data for the study. In other words, the researcher is not limited to what he could immediately perceive or experience on the field, but he is also able to cover as many dimensions and as many people as resources permit within the limit of the study (Ackroyd & Hughes, 1981).

As a matter of fact, in-depth interview could be considered as more flexible than any other research method. It is a very useful method in extracting simple factual information from participants (interviewees). The use of in-depth interview has assisted the researcher a great deal in extracting information from participants regarding their attitudes towards maternal health care services, their past or present cultural behavior as it affect maternal health seeking, their socio-economic challenges, feelings, expectations and other emotions that could not be observed directly. As an in-depth interviewer, one can explore each question or issue in as much depth or superficiality as he wishes (Haralambos & Holborn, 2008).

The arguments mentioned so far, though, may not absolutely explain why social scientists especially sociologists should sometimes choose to use in-depth interview in preference to all other research methods. However, the use of in-depth interview should not be seen as an alternative to questionnaires and they are not likely to produce exact or more valid data as that generated by other methods rather, it is used to fill the lacuna in the data generated by the use of questionnaire (quantitative method).

However, in gaining access to the interviewees the researcher was able to build on these premises by taking the following steps: first, the researcher notified the interviewees beforehand about the proposed interview; second, he took time to give a detailed explanation of the intention and objectives of the interview to the interviewees and making it clear that by cooperating they will be making an important contribution to a good cause especially in the area of maternal health. In addition, the researcher guaranteed anonymity of the respondents by assuring them that the data being sought is strictly for academic purpose. Also, the researcher sought for their cooperation during the conduct of the interview. In other words, the researcher pleaded for their understanding in advance. The interviewees' consent was also sought as regards holding the interview for more than one session if need arises.

As part of the preparation for the interviews, the researcher gathered and read materials contained in the literature review. In addition, the researcher prepared some outline material for the interview on the basis of the research questions, the materials read and the stated hypothesis. The researcher provides an interview guide which ensured the uniformity of questions for the purpose of comparison of responses from the interviewees. The questions were drawn in such a way that elicited discussion by the interviewee. In other words, the questions did not produce "yes" or "No" responses. The question centers on three broad categories which, the responses captured information on the interviewee, the community setting and factors affecting maternal health seeking behaviour. In all, twelve interviews were conducted; four among traditional birth attendants (TBAs); orthodox health practitioners and community/religious leaders respectively.

4.4.3 Executing the Interviews with Key Informants

In order for smooth execution of the interview, the researcher upon meeting the interviewee reiterated the purpose of the interview. Despite the fact that this was previously communicated; the researcher also indicated the broad areas the interview was intended to cover, ranging from the assessment of the facilities available in the community to factors affecting maternal health seeking. In addition the researcher dealt with ethical issues like promising anonymity, explaining the methods to be used for recording the interview; the researcher sought the interviewee consent to get the voice recorded with his smart phone (Infinix hot note), and notes were taken as a backup. Besides, the interviewer followed a predetermined outline once the interview started.

Furthermore, the researcher guide the interview process by using the following devices: defining the purpose in a clear terms, encouraging the interviewee to respond actively to the questions, probing them to get an in-depth and qualitative understanding of concepts and issues not adequately presented, asking for clarification of the interviewee positions where the response sound ambiguous, offering support for the views of the interviewee to encourage him or her to ascertain his or her position.

In addition, the interview was controlled as much as possible to ensure that the interviewee did not evade questions. Part of the measure put in place to control the interview was that a steady pace was maintained in the course of the interview. As much as possible, the interview was conducted in a manner that it does not get bogged down in irrelevancies; most of the questions asked were centered on the study objectives. The researcher made sure that neither

party speaks for too long at a time. In addition, the interviewer watched out for non-verbal cues, which include: tone of voice of the interviewee, eye contact, body position, gestures, facial expression, pauses, interruptions, nurture rapport (but not intimacy) with the interviewee. This was achieved by giving deserving and continuing rewards to the interviewee (e.g. nodding and support are part of the forms of rewards used); timing the rewards provided; acting within the bounds of acceptability, (the interviewer ensured that he appeared in a neat and semi-formal dress, such that he did not appear to be too formal so as to gain a sense of belonging and acceptability); the researcher showed enthusiasm for the interview thereby giving the interviewee the needed zeal to see it as a very important event and above all; the researcher was being patient with the interviewee throughout the process of the interview.

The setting of the interview is very crucial for the success of the interview. The researcher ensured that the setting was convenient for the interviewee and also conducive in terms of encouraging uninterrupted and steady conversation. In certain instances were particular settings became inconvenient, the researcher decided to move the interview to another setting to avoid distraction and enhance smooth recording of the interview. In most cases, it was the interviewee that suggested the setting for the interview because of the familiarity with his or her environment.

As a qualitative technique, semi-structured in-depth interviews were used to collect information from key informants i.e., persons based on their experience and position in the community. The use of this technique allowed for the understanding of the issues that surrounds maternal health seeking such as the beliefs and practices of the people towards maternal health to be investigated. In addition, it generates information in a personalized manner and affords the interviewee a higher degree of anonymity. It also creates the benefit of conducting such interviews where it is most convenient for the interviewee without interference or objection by others. The interviews conducted involve four Traditional Birth Attendants (TBAs) i.e. two TBAs selected purposively from each of the two political constituency that made up Ido/Osi LGA and four orthodox health personnel (Medical or Senior Nursing Officer); one interviewee from each of the four strata of orthodox health facilities (Basic Health Centre, Comprehensive Health Centre, General Hospital and Specialist/Teaching Hospital) within the local government. In addition, four community and religious leaders were also interviewed.

4.5 Combining Methods and Triangulation

It is hard to view quantitative and qualitative methods as mutually exclusive. Increasingly, sociologists are combining both approaches in single studies. The rather partisan, either or tenor of debate about quantitative and qualitative research may appear somewhat odd to an outsider, for whom the obvious way forward is likely to be a fusion of the two approaches so that their respective strength might be reaped (Bryman, 1988).

Data derived from the interviews (qualitative method) conducted during the pilot study was very useful in generating the questions for the questionnaire and the hypotheses that was tested in the study. It was also used to aid measurement. For instance, it helped the researcher to operationalize complex concepts (like: aseje, asoro, e.t.c) in the questionnaire through an understanding of what the concepts mean to the Yoruba people of Nigeria. The researcher used interviews to clarify these concepts before including them in the questionnaire.

Sometimes research might employ one main method but find out in the long run that this leaves lacuna in the data which need to be filled. Both qualitative and quantitative methods were combined in order to fill the gap inherent in each of the method so as to generate a more reliable and comprehensive data.

4.6 Ethical Consideration

Ethical issues in research on human subjects was given due consideration. Such consideration rests on principles of beneficence, non-maleficence, autonomy/justice and confidentiality. The researcher sought permission from local community leaders, the Chairman of Ido/Osi Local Government Council, and the Primary Health Care (PHC) Co-ordinator in charge of health care facilities in the local government area to conduct this study. The researcher ensures that participants were taken through an informed consent process, during which the aims, objectives, risks and benefits of the study were duly explained. Only those who consented to participate were involved in the study. The researcher also asked permission to audio record all interviews before the interview. All interviews were conducted in private or semi-private locations with attention to maintaining confidentiality. All audio files and transcripts were stored on password-protected computer. In addition, The National Institutes of Health (NIH) Office of Extramural Research certifies that the researcher has successfully completed a training course on “Protecting Human Research Participants”.

The identified research problem in this study is such that will benefit women of childbearing age, which forms the major cohort of participants. In order to guard against study participants being maginalised or disempowered, the researcher earlier conducted a pilot study to establish trust and respect with the participants to detect any marginalization before the main study began. This is a core idea of action/participatory research as posited by Cresswell (2002).

In developing the central intent and questions for the study, the researcher clearly described and made known the purpose of the study to the participants. This is to ensure that the respondents are not subjected to any form of deception. The purpose of the study was also written on the front page of the survey instruments that the responses of the participants are purely for academic purpose with the address of the institution boldly printed on it.

As a precaution to anticipated ethical issues that may arise during the data collection stage of the research, the researchers needed to respect the participants and the sites of the research. The researcher ensured that participants were not put at risk, considering that participants who are mostly pregnant women and nursing mothers. The researcher took into consideration the special needs of pregnant women and nursing mothers.

Prior to the field work, the researcher developed an informed consent form for participants engaging in the research. This form acknowledges that participants' rights have been protected during data collection. In line with Creswell's (2002) guideline, the consent form includes the following.

(i) The participants' right to participate voluntarily and the right to withdraw at any time, so that the individual is not being coerced into participation.

(ii) Describing the procedures of the study, so that individuals can reasonably expect what to anticipate in the research.

(iii**)** The right to ask questions, obtained a copy of the results, and have their privacy respected.

(iv) The benefits of the study that will accrue to the participants. In addition, before data collection, the researcher gained the permission of the Chairman of the Local Government Council and the Primary Health Care (PHC) Co-ordinator being the gatekeepers in order to provide access to study participants at research sites. This was facilitated by writing a letter that spelt out the extent of time, the potential impact, and the outcomes for the research.

The researcher ensured protection of the anonymity of individuals, roles, and occurrences in the study. For instance, the researcher disassociates names from responses during the coding and recording process of the survey.

After the analysis, the data will be kept for a period of five years. Sieber (1998) even recommends a reasonable period of between five to ten years. Thereafter the data will be discarded so that it does not fall into the hands of other researchers who might appropriate it for other purposes.

In the interpretation of data, researchers need to provide an accurate account of the information. This accuracy may require "debriefing" between the researcher and participants in quantitative research (Berg, 2001). It may include, in qualitative research, using one or more of the strategies to check the accuracy of the data with participants or across different data sources.

The ethical issues do not end with data collection and analysis; they also extend into the actual writing and dissemination of the final research report. Based on this, the researcher strictly refrains from using such language or words that are biased against persons because of gender, sexual orientation, racial or ethnic group, disability, or age. The publication Manual of the American Psychological Association (5th ed.) (American Psychological Association, 2001) suggests three guidelines. First, present unbiased language at an appropriate level of specificity. Second, use language that is not sensitive to labels. Third, acknowledge participants in a study.

4.7 Data Analysis Procedure

Both qualitative and quantitative data were presented separately. In the final analysis, qualitative data were analyzed using manual content analysis. The procedure started with the transcription of tape recordings of in-depth interviews. This was followed by the examination and (later) separation of various responses that shed light on the study objectives. By adopting this method, responses from in-depth interviews were imported into analysis on the merit of their applicability to the thematic issue under examination.

For the statistical analyses of data collected through questionnaires, the Statistical Package for Social Sciences (SPSS) version 17 was used. Both descriptive and inferential statistics were used for analytical purposes. Frequency, simple percentage, pie chart, bar chart, curve and cross-tabulations form part of the descriptive analysis which were elaborated by both the univariate and bivariate analysis, while the univariate analysis describe the socio-demographic characteristics of the respondents; the bivariate explain the relationship between the dependent variable and each of the independent variables. By making use of chi square, the dependent variables were examined and explained by the strength of each independent variable on it (the dependent).

Chi-square is a measurement of how expectations compare to results. The data used in calculating a chi square statistic must be random, raw, mutually exclusive and drawn from independent variables and mostly is drawn from a large sample. The chi square statistic usually shows any discrepancies between the expected results and the actual results.

In looking for a specific statistical test for data analysis, hence, there is need for **chi-square**, which is a statistical test used to compare expected data with what is collected.

What a chi-square will reveal is whether or not there is a large difference between collected numbers and expected numbers. If the difference is large, it shows that there may be something responsible for a significant change. A significantly large difference will allow us to reject the **null hypothesis**, which is defined as the prediction that, there is no interaction (relationship) between variables. Basically, if there is a big enough difference between the scores, then one can say something significant occurred. If the scores are too close, then we can conclude that they are basically the same.

The actual formula for running a chi-square is as follows:

Test statistic

$$\chi^2{}_{\alpha,(r-1)(c-1)} = \sum_{i=1}^{r}\sum_{j=1}^{c}\left(\frac{O_{ij} - E_{ij}}{E_{ij}}\right)^2$$

Where O = observed frequency

E = expected frequency

(r-1)(c-1) = degree of freedom

α = level of significance

The expected (*e*) frequency is subtracted from the observed data, and then we find the square of the results are found, and thereafter it is divided by the expected data in all the categories.

To determine the significant value of an outcome, the **degrees of freedom** are referred, usually labeled as *df*, for short, and is defined for the chi-square as the number of categories minus 1. Due to the nature of the chi-square test, one usually uses the number of categories minus 1 to find the degrees of freedom. The reason for this is because, there is an assumption that the sample data is biased, and this helps shift the scores to allow for error. A chi-square distribution table is located, which is found in almost every statistical textbook printed. Using the degrees of freedom, then the *p*-value is located. Typically if the p-value is greater than 0.05, it means that the result is not significant.

4.8 The Pilot Study

As noted earlier, the questionnaire and interview for the study was guided by a pilot study. The researcher is of the opinion that in a study like this, it is pertinent to conduct preliminary investigations in order to explore and highlight the realities of the study area. This method facilitated a proper understanding of the target population and their socio-cultural norms and values.

The pilot research for the present study involved interviews with community leaders, traditional birth attendants (TBAs), orthodox health providers and discussion with various men and women within the study area (Ido/Osi Local Government Area in Ekiti State, Nigeria). From these findings, which have been discussed briefly in the course of this section reveal that some social, economic, demographic and cultural factors such as beliefs and practices have implications on maternal health seeking behaviour among the Yoruba sub-culture of Nigeria.

Using a qualitative approach for the pilot study, in-depth interviews were conducted among community and religious leaders, orthodox health care givers and traditional birth attendants in other to gain information on factors affecting maternal health seeking in the community which later serve as a guide for the design of the questionnaire for the study that was later

used as the instrument to generate quantitative data for the study. The individuals that were interviewed for the pilot study were randomly selected across the study area.

It was gathered from the pilot study conducted that pattern of marriage among the Yoruba people is a little bit complex. The researcher was informed that even those that claim to be monogamous actually have more than one partner in the real sense but only lay claim to the one living with them under same roof.

As regards the use of traditional medicine, the pilot study revealed that Yoruba people have strong belief in the usage of herbs and roots but the pattern of usage and the efficacy demands for further investigation in the main study. In addition, there was no clear-cut distinction or statistic as regards the particular group of individuals that patronise TBAs as against othordox facilities for maternal health care services. This also prompted the researcher to further investigation to elucidate the pattern of patronage and the reasons for choice making in seeking maternal health care services.

In the course of the interview for the pilot study, there are lots of new concepts that were discovered that needed further clarifications in the study proper. Some of these concepts are: “Asoro”, “Aseje”, “Oko l’olori aya” among others.

The pilot study exposed some of the traditional and cultural practices regarding maternal health seeking behaviour among the Yoruba people which necessitated further probing in order to gain an in-depth meaning and understanding of the scenario as it relates to the study. In addition, the pilot study showcases that there are some traditional attitude that are considered as either to promote maternal health or against the wellbeing of women of child bearing age. Among these attitudes are: Sleeping on bare floor or mat during pregnancy; restriction of pregnant women from eating certain foods, restricting the movement of pregnant women at a particular period and time; Avoidance of sexual intercourse at certain period of the day and lots more.

During the facility assessment by the researcher as part of the pilot study, it was discovered that a lot of the health facilities were in deplorable condition. Most of the facilities lacked water supply and electricity was not stable. None of the health facilities visited have ambulance for emergency. There are inadequate health workers. This position was supported by one of the interviewee during the pilot study at Basic Health Center, Aaye Ekiti.

"There is no water supply in the facility, we usually fetch water from the stream and the electricity is not regular. We don't have adequate equipment, we have made request to the government long time ago but, up till now we have not received a positive reaction in that respect. Also our salary is not regular at all"

4.9 Description of the Process Involved in Revising the Measuring Instrument in its Final Form

In order to arrive at the final version of the questionnaire used for the study, the following processes were involved:

(i) Correction of double barrel questions: double barrel questions are such questions that have two parts, but require a single response. The problem that arises from such question is that it confuses some respondents who agree with one aspect and disagree with the other. Thus, any single response could not be considered as accurate answer to each part of the composite question. An example of such question was asked in the first draft of the questionnaire thus:

"Did you attend antenatal at the hospital and gave birth there?" Yes or No.

A further examination of the question shows that there are two separate questions that are joined with the use of "and". The issue with the question of this nature was; how should the respondent answer if she did not attend antenatal programmes at the hospital but gave birth there or put differently, if she attended antenatal programmes at the hospital but delivers at a mission house or TBA's place. Such questions were identified in the course of the pilot study and corrected before the final form of the questionnaire for the survey.

(ii) Correction of vague and unclear questions: It was discovered that questions that are vague and unclear have the tendency to result in incorrect answers or no response at all. As part of the effort in correcting such questions, a great thought was given to the wording of the questions and the use of some technical jargons were replaced with words and phrases that are less technical and familiar to the level of the respondents. In addition, the researcher made effort in being as specific as possible in reframing the questions for the final form of the questionnaire.

(iii) Juxtaposition of relevant and irrelevant questions: According to Goode and Hatt (1952:135) every item in a questionnaire is expected to constitute a hypothesis or part of a hypothesis. In other words, there should be a justification for the inclusion of any item on the premise that its answer will be relevant or significant to the central problem. In this same vein, the exclusion of crucial questions may invalidate the entire research. It is imperative for researcher to have adequate knowledge of the subject matter before the construction of questionnaire (Goode and Hatt 1952:135).

As part of the measures put in place to ascertain a more reliable questionnaire for the study, the statement of the hypothesis to be tested has been made earlier (as in chapter one) before the construction of the questionnaire. The logical relationships between those hypotheses and the type of data to be gathered thereby specifying those items that are relevant and those that are not. With this as a background, it provides an avenue for the questions being drawn up to be of relevance to the study.

However, the researcher considered it as a matter of importance, in spite of the prior knowledge of the problem of the study, to draw up questions that are distantly related to the factors affecting maternal health seeking in Yoruba community of Nigeria. Such seemingly irrelevant or harmless questions are usually necessary at the beginning of the questionnaire. For instance the first question after the socio-demographic section of the questionnaire is- "which health facility do you use in this community?" This strategy was discovered in the course of the pilot study and was very helpful because it is more difficult for a respondent to break up an interview than to refuse to begin it at all. There is every tendency for many people to refuse to participate in the survey if the questionnaire begins with controversial questions than would be the case if the controversial issue occurred later in the questionnaire. Such question like "how many children do you have" sounds controversial as some people believe that it is a taboo in Yoruba sub-culture to be counting the number of children a person have while still alive.

(iv) Detecting biased questions: questions are considered to be biased if they are designed in such a way to favour one alternative answer to a research question. It was discovered during the test of the questionnaire that there were some omission of possible alternatives in the close ended questions. This was promptly corrected and provisions were made for "other specify" such that respondents will not be limited to alternatives provided. In addition, in situations where the researcher was not sure that all the logical possible alternatives could be covered, open ended questions were used in such instances.

(v) Removal of leading question: Leading questions are questions phrased in such manner as to be suggestive of the response intended of the researcher. The danger in leading questions is that respondents generally answers the questions in line with the language of the questions and not in accordance with the issues raised. All the spotted leading questions in the initial draft of the questionnaire were reframed and avoided entirely in order not to lead to distortions of the study.

(vi) Modification of Threatening Questions: threatening questions are questions that inquire about some aspect of the respondent's behaviour, which she would rather not discuss. For example, questions that inquired about respondent's sexual behaviour. Respondents in most cases are not comfortable disclosing such information. Due to the nature of the study, it is obvious that such question cannot be entirely avoided, the researcher tried to reduce the extent of the tension by asking such questions in an open-ended manner.

Adjustment in Timing: the initial form of the questionnaire was too voluminous to the extent that it takes about thirty minutes to be completed. Looking at the condition of the respondents being entirely nursing mothers and pregnant women it pose a serious challenge to commit themselves to such a long drawn out questionnaire. Hence the number of questions in the questionnaire was reduced and some reformulated.

4.10 Testing of the Reliability and Validity of the Questionnaire

Reliability is defined as the consistency between independent measurements of the same phenomenon. It is the stability, dependability and predictability of a measuring instrument. It has to do with the accuracy or precision of measuring instruments. Validity is the degree to which a measuring instrument measures what it is designed to measure. In testing for the reliability and validity of the questionnaire as the quantitative method for gathering data for the study, the researcher paid keen attention to the definitions of the seemingly complex concept and broke it down in such a way that questions asked were simple, direct and stated in a general language and manner that is acceptable to the generality of the respondents. In other words, ambiguous questions that could mislead the respondents were completely avoided. The questionnaire was tested repeatedly and amendments were made where necessary to ascertain that it actually captured the intended objectives of the study. Twenty questionnaires were administered during the pre-test of the survey questionnaire.

4.11 Conclusion

The hallmark of every social research methodology is to explore the principles, procedures and strategies of the research. The reliability of the conclusions drawn from the data gathered from the study owe largely to the methods of investigation that were used to obtain from them.

To this end, a cross section of women of childbearing age that were either pregnant or have child(ren) of not more than 24 months old as at the time of the study were selected as respondents using a multi-stage sampling technique. In all, 200 questionnaires were administered out of which 198 were finally returned for analysis. However, only 196 questionnaires were in good condition for use, representing a return rate of 98 percent, which may be considered adequate for the analysis. Also, 8 key informants were purposively selected for the in-depth interviews which formed the qualitative approach of the study. Ethical issues in research on human subjects were given due consideration throughout the process of this study and the data analysis procedure was clearly spelt out. The next chapter deals extensively with the presentation, analysis and discussion of the results of the study.

CHAPTER FIVE

PRESENTATION AND ANALYSIS OF DATA

This chapter utilizes representative data from Ido/Osi Local Government Area of Ekiti State in analysing socio-cultural beliefs and practices in order to examine the factors affecting maternal health seeking in a Yoruba community of Nigeria. The qualitative data that was generated via In-Depth Interviews (IDI) from the fieldwork were presented using content analysis method. Each interview recorded in a tape was transferred verbatim for thorough reading and annotation of topics, themes and issues with a view to examining associations between identified socio-cultural beliefs and practices variables and maternal health seeking. The researcher also made sure that, explicit rules otherwise known as criteria of selection which was formally established before the actual analysis of data was strictly and consistently adhered to.

The data are displayed in tabular and graphical forms and the analysis revolves around frequency distribution, cross tabulation and inferential statistics using chi-square. Both the qualitative and quantitative results are discussed together, where necessary.

5.1 Socio-Demographic Characteristics of Respondents

Table 1: Percentage Distribution of Respondents by Selected Socio-Demographic Characteristics

Characteristics	Category	Frequency	Percent
Age	15-19	06	3.1
	20-24	12	6.1
	25-29	57	29.1
	30-34	51	26.0
	35-39	34	17.3
	40-Above	30	15.3
	45+	06	3.1
	Total	**196**	**100.0**
Marital Status	Single	16	8.2
	Married	140	71.4
	Separated	12	6.1
	Divorced	13	6.6
	Widowed	15	7.7
	Total	**196**	**100.0**
Education	No School	17	8.7
	Primary	16	8.1
	Secondary	69	35.2
	Tertiary	94	48.0
	Total	**196**	**100.0**
Occupation	Student/ unemployed	20	10.2
	Farming	22	11.2
	Trading	30	15.3
	Civil services	80	40.8
	Artisan	44	22.5
	Total	**196**	**100.0**
Occupation	Student/ unemployed	20	10.2
	Farming	22	11.2
	Trading	30	15.3
	Civil services	80	40.8
	Artisan	44	22.5
	Total	**196**	**100.0**
Religion	Christianity	147	75.0
	Islam	38	19.4
	Traditional	-	-
	No Response	11	5.6
	Total	**196**	**100.0**
Monthly Income in Naira	No, income	20	10.2
	20,000 or less	86	43.9
	21,000-40,000	29	14.8
	41,000-60,000	20	10.2
	61,000-80,000	23	11.7
	Above 80,000	18	9.2
	Total	**196**	**100.0**
Husband Monthly Income	No Income	18	9.2
	20,000 or less	34	17.3
	21,000-40,000	38	19.4
	41,000-60,000	26	13.3
	61,000-80,000	18	9.2
	Above 80,000	34	17.3
	No Response	28	14.3
	Total	**196**	**100.0**
No of Children	None	10	5.1
	One	32	16.3
	Two	50	25.5
	Three	56	28.6
	Four	35	17.9
	Five and Above	12	6.1
	No Response	01	0.5
	Total	**196**	**100.0**

Source: Field Survey, 2016.

Table 1 indicates that about 3.1 percent and 6.1 percent of the respondents were in the 15-19 and 20-24 age categories respectively. Also 29.1 percent and 26.0 percent were in the 25-29 and 30-34 age categories respectively. 17.3 percent of the respondents occupy the 35-39 age category and about 15.3 percent were between ages 40 to 44 while about 3.1 percent of the respondents belong to the age category of 45 years and above.

The modal class of the distribution, that is the age group with highest frequency, is 25-29. The reason why this age group have more respondents is that early marriage is not encouraged among the Yoruba sub-culture of Nigeria. Ladies below age 25 are expected to either be in school or undergoing skill acquisition training.

Looking at the marital status of the respondents, about 71.4 percent of the respondents are currently married and only 8.2 percent are single. About 6.1 and 6.6 percent of the respondents are separated and divorced respectively, a woman is considered separated if she is not living with the husband but in occasional contact with each other and continue to adopt the husband's name due to the stigma attached to divorce within the Yoruba culture. The survey also shows that about 7.7 percent of the respondents are widowed.

Of the entire population sampled, over 83 percent of the respondents fall within the category of people with secondary and tertiary education. This simply implies that Yoruba women particularly, in Ido/Osi LGA are obviously literate. Although, a critical observation based on the experience on the field shows a contrary view because many of the respondents that claimed to be school certificate holders for instance, could not read and understand the questionnaire. Hence, they sought for the assistance of the investigator in filling the questionnaire. This is not different as it points to the falling standard of education in most of the developing countries. Specifically, about 8.7 percent of the respondents have no formal education and 8.1 percent are with primary education while 35.2 and 48.0 percent of the respondents are with secondary and tertiary education respectively. A woman's level of education is considered to be a formidable factor in determining her maternal health seeking behaviour.

The occupational distribution of the respondents indicates that about 10.2 percent of the respondents are either students or unemployed. About 15.3 and 22.5 percent indicate to be traders and artisans respectively while 40.8 percent of the respondents are civil servants. The table also shows that only 11.2 percent are farmers. This figure could be misleading because, in Nigeria like some sub-Sahara African communities, occupation is notoriously a difficult

subject to study. Part of the reason lies in the differences that might exist between an investigator's perception and expectations of occupational distribution on one hand, and a respondent's self-identification on the other. A respondent may not consider herself to be one *per se*, since her farming activity may be a lesser separate economic activity than an entire way of life that is not primarily regulated by the modern market system and its price mechanisms. This is especially a true picture of women who bear the greater responsibility of farming practices in many Nigerian rural communities. Contextual variations like these may lead to under-reporting of that occupational group relative to others.

From table 1, it is observed that more than half (54.1 percent) of the respondents' have no-income and income less than Twenty Thousand Naira monthly which is equivalent to six hundred and sixty naira per day. Although this amount is a little bit above a dollar per day, (the exchange rate as of August 4, 2017 is N366 to 1 U.S Dollar) which places the respondents well above the national average, it will be highly misleading if this yardstick is applied to the Nigerian context. In reality, their income level is low relative to the cost of living in the country. Among civil servants, almost all of the respondents affirmed that the government owed them about seven-month salary as at the time of the interview for this research). The implication of this income situation is evident. Most of these women even with children less than one year old continue to engage in strenuous economic activities to augment the usually meager family income. Among the low-income earners, they rely on their husbands' financial support.

Specifically, about 10.2 percent and 43.9 percent of the respondents are within the categories of no income and income of N20,000 and below respectively. 14.8 percent of the respondents earn between N21,000 and N40,000 monthly while the monthly salary of about 10.2 percent of the respondents are between N41,000 and N60,000 per month. 11.7 percent and 9.2 percent of the respondents earn between N61,000 and N80,000 and above N80,000 respectively.

The Table shows that 75.0 percent of the respondents are Christians while 19.4 percent practice the Islamic religion and 5.6 percent did not reveal their religious affiliation. None of the respondents claimed to practice a traditional religion. However, one is inclined to question the commitment to traditional religion to Christianity and Islam going by the people's very strong attachment to traditional beliefs and practices. Thus, it is important to posit that most of the respondents exhibited "bandwagon bias" with regard to their religious affiliation. This submission is made with the claim that practicing Christians or Muslims are

significantly detached from traditional religion and practices. A majority of Yoruba people mix Christianity or Islam with tradition. Suffice to say therefore, that at the latent level, most of them respect and exhibit traditional beliefs and practices while at the manifest level they profess God and Allah.

From Table 1, it is observed that about 5.1 percent of the respondents were pregnant for the first time. At total of 16.3 percent and 25.5 percent of the respondents already had one and two children respectively, 28.6 percent had three children while another 17.9 percent had four children. Additionally 6.1 percent of the respondents had more than four children while one of the respondent representing about 0.5 percent did not respond. A closer examination shows that the sample has an average of three children per respondent.

5.2 Education and Occupation among Survey Respondents

Table 2: Distribution of Respondents by Educational Qualification and Occupation

Occupation	Educational Qualification									
	No Schooling		Primary		Secondary		Tertiary		Total	
	Number	%	Number	%	Number	%	Number	%	Number	%
Student/ Unemployed	1	5	0	0	13	65	6	30	20	100
Farming	13	59.1	5	22.7	4	18.2	-	-	22	100
Trading	2	6.7	2	6.7	20	66.6	6	20	30	100
Civil service	-	-	-	-	5	6.2	75	93.8	80	100
Artisan	1	2.3	9	20.5	28	63.6	6	13.6	44	100
Total	**17**	**8.7**	**16**	**8.2**	**70**	**35.7**	**93**	**47.4**	**196**	**100**

Source: Field Survey, 2016.

Table 2 shows that out of the seventy respondents with secondary school level of education, only five (6.2%) were engaged in civil service while others were either farmers, traders, artisans, students or unemployed. It is apparent from the Table that out of 196 respondents, 37.8 percent were either traders or artisans while about 11.2 percent were farmers. Specifically, 59 percent of those engage in farming activities are people with no formal education whilst another 22.73 percent were respondents with primary education while 18.18 percent of the farmers were respondents with secondary level education. This suggests that none of the farmers have an education beyond the secondary school level. It is also important to note that majority of this set of respondents are peasant farmers without other means of income which places them in the category of being relatively poor.

Looking at these distributions, the Yoruba people, particularly in Ekiti state, differ remarkably from most other communities in Nigeria, where the number of individuals at both extremes of educational attainment is more than those at the middle of the distribution. For example, as displayed in the Table, 8.7 percent and 47.4 percent represent respondents with "no schooling and tertiary education respectively (sum total of 56.1 percent of the entire respondents), while 8.2 percent are with primary education and 35.7 percent are with secondary education (sum total of 43.9 percent of the entire number of respondents).

In addition to the earlier submission, the reason for the seemingly low composition of farmers in the study area lies in the fact that although, 78.6 percent (154) of the respondents regarded themselves as civil servants, artisans or traders, the empirical norm is the combination of both with farming. It is usually common to observe many people who classify themselves as belonging to these occupational cohorts in reality have almost the same size of farm lands that they attend to as regularly as the people who classified themselves as farmers. Yoruba land is largely agricultural as indicated by the qualitative data from the field. For instance, one of the respondents in an interview conducted in Ayetoro Ekiti made it known that the community is known for production of gari (a whitish food item produce from cassava) and as the highest producer of okra in the state.

"……Some of them are civil servants but majority of them are farmers, they are the largest producer of okra in the state, other crops that they produce include yam and tomatoes some of the youth in addition to their farming commitment also engage in "okada" (cycling as means of commercial transportation) while majority of the women are traders." (Aiyetoro Ekiti Comprehensive Health Centre).

"Majority are farmers while others are into trading and civil service" (Ora Ekiti Basic Health Centre).

"mostly farming, even the civil servant also involve in farming as a supplement". (Orin Ekiti Basic Health Centre).

Usually, looking at the association between occupation and educational qualification, the ordinary expectation is for those that did not have any education to form the bulk of the unemployed category. However, Table 2 presents a contrary picture of that view. Apart from the primary column that present nobody in the unemployed status, (that is all respondents with only primary education level claimed to be employed), 65 and 30 percent of the

unemployed respondents, respectively have secondary and tertiary level education, although none of the respondents with primary education are unemployed. The fact that can also be deduced from the table is that none of the respondents with primary school level of education engaged in civil service and 31.5 percent of them are farmers.

In all, 10.2 percent of the respondents described themselves as unemployed during the survey, giving an unexpected low unemployment rate of 10.2 percent as against the nation's 25.2 percent as at the last quarter of 2016.

5.3 Educational Qualifications and Age of Respondents

Table 3: Distribution of Respondents by Educational Qualification and Age

Age	Educational Qualification									
	No Schooling		Primary		Secondary		Tertiary		Total	
	Number	%	Number	%	Number	%	Number	%	Number	%
15-19	-	-	1	6.7	5	83.3	-	-	6	100
20-24	-	-	1	8.3	7	58.4	4	33.3	12	100
25-29	5	8.6	3	5.2	24	41.4	26	44.8	58	100
30-34	2	3.9	6	11.8	24	47.0	19	37.3	51	100
35-39	3	8.8	3	8.8	8	23.6	20	58.8	34	100
40-44	5	17.3	2	6.9	1	3.4	21	72.4	29	100
45+	2	33.3	-	-	1	16.7	3	50.0	6	100
Total	**17**	**8.7**	**16**	**8.2**	**70**	**35.7**	**93**	**47.4**	**196**	**100**

Source: Field Survey, 2016.

Table 3 depicts the distribution of the survey sample by age and educational qualification. About 83.3 percent (5) of the respondents within age, 15-19 have secondary school education while the remaining 16.7 percent (1) have primary education as at the time of the survey. It can be deduced that early marriage discourages high level of education. Meanwhile, looking at the proportion of the respondents within age 15-19 (6) to the overall respondents (196) in the survey which is about 3 percent, one may hastily jump to the conclusion that pregnancy occurrence among this cohort is low among Yoruba subculture of Nigeria which is contrary to the results of the qualitative data. Whereas, part of the issues raised as the challenges facing maternal health by the participants in the various interviews conducted is that teenage pregnancy is rampant. In the words of a respondent

"…the major challenge is that teenage pregnancy is rampant now. This set of "teenage mothers" are not financially responsible, they don't have the money to pay for hospital bills. Many of them are even shy to come for antenatal. There is inadequate drug supply. Salary is not regular at all, we are in August and the last salary we were paid was in February." (Health Centre Orin).

A midwife from the Christ Apostolic Church (CAC) mission house responded by saying:

"You know like I said the other time, teenage pregnancy is too rampant here, how do you expect a fifteen year old girl probably a secondary school drop out to be financially responsible when she should normally still be under parental care". Another participant at the Basic Health Center Orin states that, "the major challenge is that teenage pregnancy is rampant now. This set of "teenage mothers" are not financially responsible, they don't have the money to pay for hospital bills. Many of them are even shy to come for antenatal".

It is very important to note that, the qualitative data above may actually be misleading as regards the true representation of the proportion of teenage mothers to the entire cohort of mothers in the survey area in that, some of the people within this cohort are actually shying away from participating in the survey despite persuasion, explanation of the research objectives and assurance of anonymity. This is one of the major challenges faced during the administration of questionnaires as the sole means of quantitative data gathering tool for the study. There is no gain saying the fact that teenage pregnancy or early marriage, to certain extent, affects a woman's education on sexuality and understanding of factors pertaining to reproductive health behaviour. It is a common phenomenon among the Yoruba people to delay sex education to their wards (if at all they do) to later period of adolescence and teenage pregnancy erode such advantage which will invariably result in little or no knowledge of the intricacies of maternal health.

The respondents with tertiary education fall within ages of 20 years and above, precisely 4.3 percent of the respondents with tertiary education are aged 20-24 while aged 25-29 and 30-34 are 27.9 and 20.4 percent respectively. About 21.5 percent of them fall within the 35-39 age cohort while 22.6 and 3.2 percent belong to the age category of 40-44 and above age 44 respectively. The impression of these trends is that involvement in higher education activities may probably result in delays in giving birth or child rearing.

At the same time, a closer look at the Table shows that only half (3) of the respondents age 45+ have tertiary education and about 33.3 percent (2) never had formal education. This

pattern suggests that education does not really show a consistent pattern with the age of the respondents. It therefore depends on individuals and other circumstances outside this variable.

5.4 Educational Qualification and Income of the Respondents

Table 4: Distribution of Respondents by Educational Qualification and Income (Monthly)

Income (Monthly)	Educational Qualification									
	No Schooling		Primary		Secondary		Tertiary		Total	
	Number	%	Number	%	Number	%	Number	%	Number	%
No Income	1	5.8	-	-	11	15.7	8	8.6	20	10.2
20,000 or less	15	88.2	16	100	49	70.0	6	6.5	86	43.9
21,000-40,000	-	-	-	-	5	7.1	24	25.8	29	14.8
41,000-60,000	1	5.8	-	-	3	4.3	16	17.2	20	10.2
61,000-80,000	-	-	-	-	2	2.9	21	22.5	23	11.7
Above 80,000	-	-	-	-	-	-	18	19.4	18	9.2
Total	**17**	**100**	**16**	**100**	**70**	**100**	**93**	**100**	**196**	**100**

Source: Field Survey, 2016.

Table 4 represents the distribution of respondents by educational qualification and monthly income. It shows that out of 93 respondents that have tertiary education 18(19.4%) of them earn between N80,000 and above as monthly salary while 22.5 percent fall between a monthly salary of N61,000 and N80,000. About 17.2 and 25.8 percent of this same cohort earn monthly salary of 41,000-60,000 and 21,000-40,000 respectively. Only 6.5 percent of the respondents who have tertiary education earn less than N20,000 per month while 8.6 percent have no income. Looking at the respondents with secondary school education, the majority of them (70%**,** i.e. 49 out of 70) earn less than N20,000 per month while very few but significant (11.4 percent) earn between N21,000 and N60,000. 15.7 percent of them have no income. In addition, all respondents with primary school level of education fall within monthly income of less than N20,000 while among the respondents with no formal education, majority of them (88.2 percent) fall within monthly income of less than N20,000 and 5.8 percent earn between N41,000 and N60,000 and no income respectively.

5.5 Educational Qualification and Who Decides Facility Usage

Table 5: Distribution of Respondents by Educational Qualification and Who Decides Facility Usage

Who Decides Facility Usage	Educational Qualification									
	No Schooling		Primary		Secondary		Tertiary		Total	
	Number	%	Number	%	Number	%	Number	%	Number	%
Husband	16	94.1	06	37.5	19	26.1	53	56.4	93	100
Self	01	5.9	08	50	34	48.6	28	30.1	72	100
Parent/Relatives	-	-	02	12	17	24.6	04	4.3	23	100
Friends	-	-	-	-	-	-	01	1.1	01	100
Health Workers	-	-	-	-	-	-	06	6.4	06	100
Others	-	-	-	-	-	-	01	1.1	01	100
Total	**17**	**8.7**	**16**	**8.2**	**70**	**35.2**	**93**	**47.9**	**196**	**100**

Source: Field Survey, 2016.

The above Table distributes the survey respondents by educational qualification and "who decides facility usage". The Table illustrates that women without education are more likely to receive instruction regarding access to a health care facility from their husband as compared to their learned counterparts. Specifically, only one out of the seventeen respondents with no formal education decided for herself as to where to receive health care whilst for the overwhelming majority (94.1 percent) it was the husband that decided. Even among the respondents with tertiary education, the decision on which facility to be used suggests that 56 percent of them are made by their husbands.

There is also a clear indication from the Table that health workers has no impact in deciding access and use of maternal health care facility for respondents with less than tertiary education. One could be tempted to infer that it may be difficult for health care workers to interact freely with people with little or no formal education. In addition, it is also illustrated in the Table that parents/relatives and friends are also sources of decision making on the health care facility to be patronized by women of child bearing age. In all, 23 percent of the respondents indicated that their parents/relatives made the choice of place for seeking health care service.

5.6 Income and Who Decides Facility Usage

Table 6: Distribution of Respondents by Income and Who Decides Facility Usage

Who Decides Facility Usage	Income													
	No Income		20,000 or less		21,000-40,000		41,000-60,000		61,000-80,000		Above 80,000		Total	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Husband	09	45	34	39.5	22	75.9	13	65	05	21.7	11	61.1	94	48
Self	03	15	41	47.7	02	6.9	05	25	15	65.2	05	27.8	71	36.2
Parent/Relatives	07	35	11	12.8	03	10.3	01	5	-	-	01	5.6	23	11.7
Friends	-	-	-	-	-	-	-	-	01	4.4	-	-	01	0.5
Health Workers	01	5	-	-	02	6.9	-	-	02	8.7	01	5.6	06	3.1
Others	-	-	-	-	-	-	01	5	-	-	-	-	01	0.5
Total	**20**	**100**	**86**	**100**	**29**	**100**	**20**	**100**	**23**	**100**	**100**	**100**	**196**	**100**

Source: Field Survey, 2016

Ordinarily, one will believe that the more a woman is financially buoyant, the higher her decision making power should be but, the data for relationship between respondents' income and decision for facility usage in Table 6 shows a divergent view of that position. It is obvious from the table that majority of the respondents' husband decide the facility to patronize regardless of the wives' financial status. Specifically 61.1 and 65.0 percent of the respondents with income of above eighty thousand Naira and income between forty one to sixty thousand Naira respectively indicates that their husbands decide where to seek health care.

A closer observation of the Table shows that less than fifty percent (09) of the respondents with no income received a directive from their spouse on where to seek health care. Summarily, it is clear that largely, patriarchy plays a huge role in the decision leading to maternal health seeking. Results from the qualitative data for the study corroborate this claim. In reacting to a question on the effects of cultural beliefs and practices in an interview with one of the Traditional Birth Attendants (TBAs) from Orin Ekiti, the respondent states thus:

"…yes, for instance the husband is the lord of the wife (oko lolori aya) and as such he directs the wife to the extent of dictating for her the facility to receive care. You know men are naturally jealous, they don't like the wife to visit male practitioners for the fear of the wife being snatched……."

There is a similar response from another TBA from Ilogbo Ekiti stating that:

"oko l'olori aya (the husband is the lord over the wife). The husband as the head of the family, to a great extent does influence maternal health in terms of choice of facility for prenatal, natal and post natal care".

5.7 Educational Qualification and Who Pays for Maternal Health Care Services

In the Table below, an analysis of the influence of respondents' educational qualifications and who pays for their maternal health care services is made. The results of this procedure (Table 7) provide some fascinating reflections on the role of men in maternal health seeking. It is significant that majority (73.4%) of the respondents' spouses are responsible for the payment of health care services rendered to their wives. Among respondents with tertiary education, about 80 percent of them indicate that their husband is responsible for the payment of health care bills they incur. In spite of their level of education, they seem to hold tenaciously to the traditional belief that, it is the role of men (the husbands) to take financial responsibility of the health of their spouse. As discussed earlier in this chapter, about 25 of the entire respondents indicate that they are either divorced or separated, therefore, one may conclude that these cohorts are part of those that either pay for the health care services themselves or through parents/relatives or in-laws.

A negligible but significant number (2) of the respondents indicated that they have not been paying for the health care services received. This few respondents could be regarded as part of those who were unable to pay health care bills due to poverty or deliberate act as pointed out by a participant during the interview for this study. Responding to an interview in Orin Ekiti, a TBA lamented that:

"……many people are not even willing to pay bills. The patient are not even encouraging, for example, a woman that I delivered of a set of twins of which one of them is Ige (a child that comes out of her mother's womb with the leg first); if this kind of delivery were to be done in the hospital, she will spend fortune but yet, she did not even deem it fit to come back and say thank you. The work I am doing should be enough to take care of me without engaging in farming provided I am being adequately paid".

Table 7: Distribution of Respondents by Educational Qualification and Who Pays for Maternal Health Care Services

Who Pays for Health Care Services	Educational Qualification									
	No Schooling		Primary		Secondary		Tertiary		Total	
	Number	%	Number	%	Number	%	Number	%	Number	%
Husband	16	94.1	6	37.5	42	60.0	74	79.5	138	100
Self	-	-	4	25	08	11.4	15	16.1	27	100
Parent	01	5.9	4	25	11	15.8	02	2.2	18	100
Inlaw	-	-	-	-	01	1.4	02	2.2	03	100
No payment	-	-	02	12.5	-	-	-	-	02	100
No response	-	-	-	-	08	11.4	-	-	08	100
Total	**17**	**8.7**	**16**	**8.2**	**70**	**35.2**	**93**	**47.9**	**196**	**100**

Source: Field Survey, 2016.

5.8 Income and Who Pays for Maternal Health Care Services

Table 8: Distribution of Respondents by Income and Who Pays for Maternal Health Care Services

Who Decides Facility Usage	Income													
	No Income		20,000 or less		21,000-40,000		41,000-60,000		61,000-80,000		Above 80,000		Total	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Husband	12	60	55	64	21	72.5	17	85	17	73.9	16	88.9	138	100
Self	02	10	12	14	05	17.2	02	10	06	26.1	-	-	27	100
Parent/Relatives	01	5	16	18.5	-	-	01	5	-	-	-	-	18	100
Inlaw	02	10	01	1.2	-	-	-	-	-	-	-	-	03	100
No Payment	-	-	02	2.3	-	-	-	-	-	-	-	-	02	100
No Response	03	15	-	-	03	10.3	-	-	-	-	02	11.1	08	100
Total	**20**	**100**	**86**	**100**	**29**	**100**	**20**	**100**	**23**	**100**	**18**	**100**	**196**	**100**

Source: Field Survey, 2016.

Table 8 illustrates the distribution of respondents by monthly income and who pays for health care services that they receive. It is important to note that 88.9 percent of the respondents within the highest monthly income strata still depend on their husbands to pay the bill for

their health care services. Looking at the respondents with no income, 60 percent of them (that is 12 out of 20) rely on their spouse for payment for their health care services. It is also important to note that in some instances, in-laws do pay for the cost of health services. Although, for those respondents that indicated that their in-laws paid for their bill earned no income except one that earned less than twenty thousand Naira monthly. However, it is not enough to argue that their seemingly poor status is responsible for not being able to pay by themselves because, even those that receive hefty salary still depend on their husbands for payment.

Rather, it can be sufficiently argue that Yoruba women believe that it is part of the cultural responsibility of the husband to take care of the cost of health care services for them. Specifically, out of 27 respondents that pay for the cost of health care service by themselves, none of them earn above eighty thousand Naira per month, two of them have no income while 14.0 percent (12) and 17.2 percent (5) earn income less than twenty thousand and between twenty one to forty thousand Naira respectively. It is also worthy of note that this attitude of women's financial dependence on their husband as encouraged by the culture of the land further strengthen the influence of patriarchal practices on maternal health seeking.

5.9 Place of Receiving Maternal Health Care and Educational Qualification

Table 9 below distributes the survey respondents by educational qualification and place of receiving maternal health care. Although, the Table shows that the majority of the respondents patronize TBAs for maternal health care, but a closer look at the table presents that women's level of education is also a key factor in maternal health seeking. As evident from the data, none of the respondents with tertiary education relies solely on receiving care from TBAs. Interestingly, also on the other hand, none of the respondents with no education relied absolutely on their husband to receive health care from the hospital. Looking at the cohort of respondents that combines the patronage of TBAs and hospitals for prenatal, natal and post natal care, one could simply draw a conclusion that the higher the level of educational qualification of a woman, the lesser the tendency to combine the two said facilities for maternal health care services.

In all, 60.2% percent (118) of the survey respondents believe that maternal health care is incomplete without the combination of traditional and orthodox health care services. One can arguably say that this cohort did not see the two sources of care as alternative or in

opposition, but rather as complimenting each other to ensure better health care. Put differently, they might have been so acculturated to the cultural beliefs and practices of their society regarding maternal health, as being transmitted from generation to generation to a level; that they find it difficult to depart totally from traditional way of maternal health seeking, in spite of the seemingly improvement, recorded by orthodox or westernized health care.

Table 9: Distributions of Respondents Based on Place of Receiving Maternal Health Care and Educational Qualification

Place of Maternal Health Care services	Educational Qualification									
	No Schooling		Primary		Secondary		Tertiary		Total	
	Number	%	Number	%	Number	%	Number	%	Number	%
Hospital (Only)	-	-	01	6.2	23	32.9	45	48.4	69	35.2
TBA/Mission(Only)	02	11.8	03	18.8	04	5.7	-	-	09	4.6
Combination of Both	15	88.2	12	75	43	61.4	48	51.6	118	60.2
Total	17	8.7	16	8.2	70	35.7	93	47.4	196	100

Source: Field Survey, 2016.

5.10 Place of Receiving Maternal Health Care and Income

Table 10 below depicts the relationship between income and place of receiving maternal health care among the Yoruba people of Nigeria. The Table indicates that the place of receiving maternal health care shows a consistent pattern between income and respondents that solely patronize TBAs. Looking vividly at the table, one will discover that of all the respondents that solely patronize TBAs, 15 percent (three out of twenty) of the respondents with no income solely patronize TBAs compare with 7 percent (six out of eighty six) of the respondents with income less than twenty thousand Naira per month. It is also observed from the Table that none of the respondents with income above twenty thousand Naira per month access only TBAs as source of their health care. Instead, they combine the two services (TBAs and orthodox) or solely patronize an orthodox facility.

Specifically, 30 percent (six out of twenty) of the respondents with no income access solely orthodox facility while a significant proportion of 55 percent (eleven out of twenty) of this cohort seek health care from the two sources simultaneously. For respondents with monthly income less than twenty thousand Naira, about 27.9 percent (twenty four out of eighty six) and 7.0 percent (six out of eighty six) access orthodox facility and TBAs respectively while about 65.1 percent (fifty six out of eighty six) make use of the two sources for maternal health care services.

Among respondents with monthly income between twenty one thousand and forty thousand Naira, 20.7 percent (six out of twenty nine) strictly patronize orthodox facilities while 79.3 percent (twenty three out of twenty nine) access both sources of health care. From the survey participants with monthly income between forty one thousand and sixty thousand Naira, 65 percent (thirteen out of twenty) and 35 percent (seven out of twenty) visit solely orthodox facility and both sources of health care respectively. In addition, the table shows that 56.5 percent (thirteen out of twenty three) of the respondents with monthly income between sixty one thousand and eighty thousand naira strictly make use of orthodox facility while the remaining 43.5 percent (ten out of twenty three) patronize both TBAs and orthodox centers simultaneously for care.

It is also observed from Table 10 that a significant number (61.1 percent) of respondents with income of eighty one thousand and above access both TBAs and orthodox facility for health care while only 38.9 percent of them strictly attend orthodox facility.

From the foregoing, it can be deduced that the number of women that solely patronize orthodox facilities outnumbered those that patronize TBAs, but in all, findings from the studies shows that a verse majority of the respondents combined the two sources for maternal health care services. In other words, they do so with a strong belief that the two facilities serves as complementing each other rather than being considered as alternative source of maternal health care services.

Table 10: Distributions of Respondents Based on Income and Place of Receiving Maternal Health Care Services

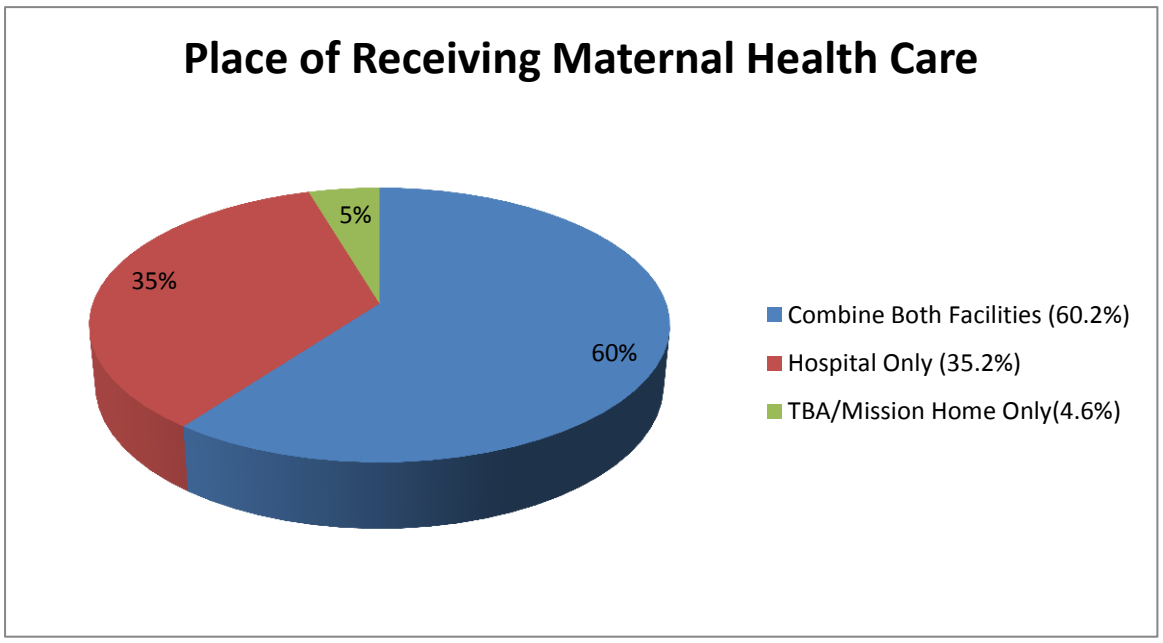
Place of Receiving Maternal Health Care	Income													
	No Income		20,000 or less		21,000-40,000		41,000-60,000		61,000-80,000		Above 80,000		Total	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Hospital (Only)	06	30	24	27.9	06	20.7	13	65	13	56.5	07	38.9	69	35.2
TBA/Mission Home (Only)	03	15	06	7	-	-	-	-	-	-	-	-	09	4.6
Combination of Both	11	55	56	65.1	23	79.3	07	35	10	43.5	11	61.1	118	60.2
Total	**20**	**10.2**	**86**	**43.9**	**29**	**14.8**	**20**	**10.2**	**23**	**11.7**	**18**	**9.2**	**196**	**100**

Source: Field Survey, 2016.

5.11 Summary of Respondents' Place of Receiving Maternal Health Care

The pie chart below presents the summary of the respondents' choice as regards place of receiving maternal health care.

Figure 5.1: Summary of Respondents' Place of Receiving Maternal Health Care



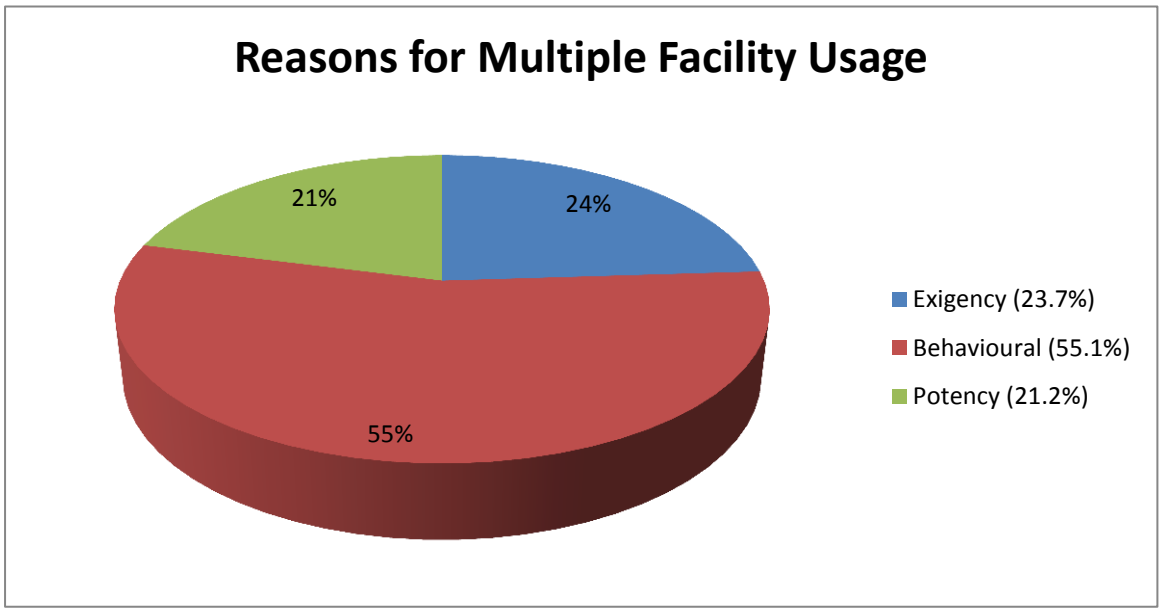
Source: Field Survey, 2016.

The pie chart above shows maternal health care facilities used by respondents. Summarily, out of the 196 respondents sampled for the study, approximately 60 percent of them combine the usage of both hospital and TBA facilities simultaneously in seeking for maternal health care services. About 35 percent of the respondents strictly seek pre-natal, natal and post-natal health care services at the hospital while a small but significant proportion (approximately 5 percent) of the entire respondents solely patronize TBAs for maternal health care services. The implication of this is that Yoruba women of Nigeria, regardless of their educational and socio-economic status have strong belief in the efficacy of traditional medicine not as alternative but as complement to orthodox facility. The reason for this position is analyzed in the subsequent section.

5.12 Reasons for Multiple Facility Usage

The chart below shows the respondents' reasons for making use of multiple facilities in seeking for maternal health care services. These reasons; are subsumed under three basic groupings: behavioural; exigency and; potency. The behavioural reason is dictated by norms and values of the people in the community, it is on the premise that a woman's maternal health seeking behaviour is being influenced by the health seeking behaviour or common practices of the (majority) others in the community (i.e. imitating the actions and inactions of others regarding maternal health seeking behaviour). The second category, which is tagged "exigency", is associated with desperate and essential need for desired health outcome or result (just as if a drowning man will stick to a straw). This cohort of respondents utilizes multiple facilities out of fear of the unknown. For instance a woman who is suffering from infertility (primary or secondary) or other life threatening health related issues will succumb virtually to all kinds of options at her disposal for possible remedy or relief. The last category for reason for multiple facility usage is labeled "potency". This rests on the principle of adequate knowledge of efficacy based on experience and strong understanding of the limits or, strength and weaknesses of both sources of health care services. The respondents that fall within this cohort display a convincing knowledge of the possible outcome of their actions (health seeking behaviour) without necessarily being influenced by others. The subsequent paragraphs will provide an extensive explanation and illustration of these three serendipitous concepts as they relate to reasons given by respondents for the usage of multiple facilities regarding maternal health seeking behaviour.

Figure 5.2: Reasons for Multiple Facility Usage



Source: Field Survey, 2016.

From the chart, it is observed that more than half (55.1%) of the respondents with dual facility usage for maternal health care services indicate that they do so in accordance with the expected norms (culture) in their community. Some say it is their custom, while others reported that; it is the usual/normal practice. In other words, this cohort believes that it will be abnormal for them to deviate from the usual practices of majority of the women in the community. Besides, it could be argued that the respondents under this cohort are being influenced by the behaviour of other people or the popular cultural practices in the society without adequate knowledge or understanding of the intricacies and consequences of their actions and inactions. Hence, the maternal health seeking behaviour of women that based their reasons for multiple facility usage on the influence of common practice or norms in the community could be described as being behavioural.

The second group pertains to the cohort of women who provided reasons for accessing multiple facilities due to exigency of their need for maternal health care services. Some of the reasons gathered from the quantitative data include: search for proper care; for adequate care; to ascertain safe delivery; not to take chances; to avoid miscarriage and; for the sound health of mother and child. According to the above chart, 23.7 percent of the respondents with mixed facility usage fall within this cohort (exigency). Largely, the maternal health seeking

behaviour of women regarding health care facility usage in this cohort is influenced by their personal predicament.

The data for facility usage shows that about 21.2 percent of the respondents with mixed facility usage are of the opinion that each of the facilities have its individual inherent strengths and weaknesses. Therefore, they indicate that one complements the other (it works for me, it is the best practice). It could be argued that they prefer mixed facility usage in order to explore the unique advantages of the two services. This category is what the researcher regarded as "potency". This is in agreement with the qualitative data that asserts:

"….there are different types and procedure depending on the circumstance, for instance, some baby will come out with leg first during delivery, this kind of baby is popularly refers to as "Ige" in Yoruba culture. Owing to this, I always instruct and request for the pregnancy scan from those that attend my clinic to determine the position of the baby because this will to a large extent assist me in preparation of the needed herbs for safe delivery. The Doctors in the orthodox facility will always recommend caesarean section for delivery cases like Ige whereas with herbs and root, we do deliver it safely." (Orin Ekiti TBA)

*"….we are different practitioners and our methods are quite different, it is like the functions of locust beans (iru) and salt (iyo) in the soup, though they differ but each compliment the other. We the traditional practitioners mostly have edge over them due to the fact that we also take care of the spiritual aspect of maternal health." (*Ilogbo Ekiti TBA*)*

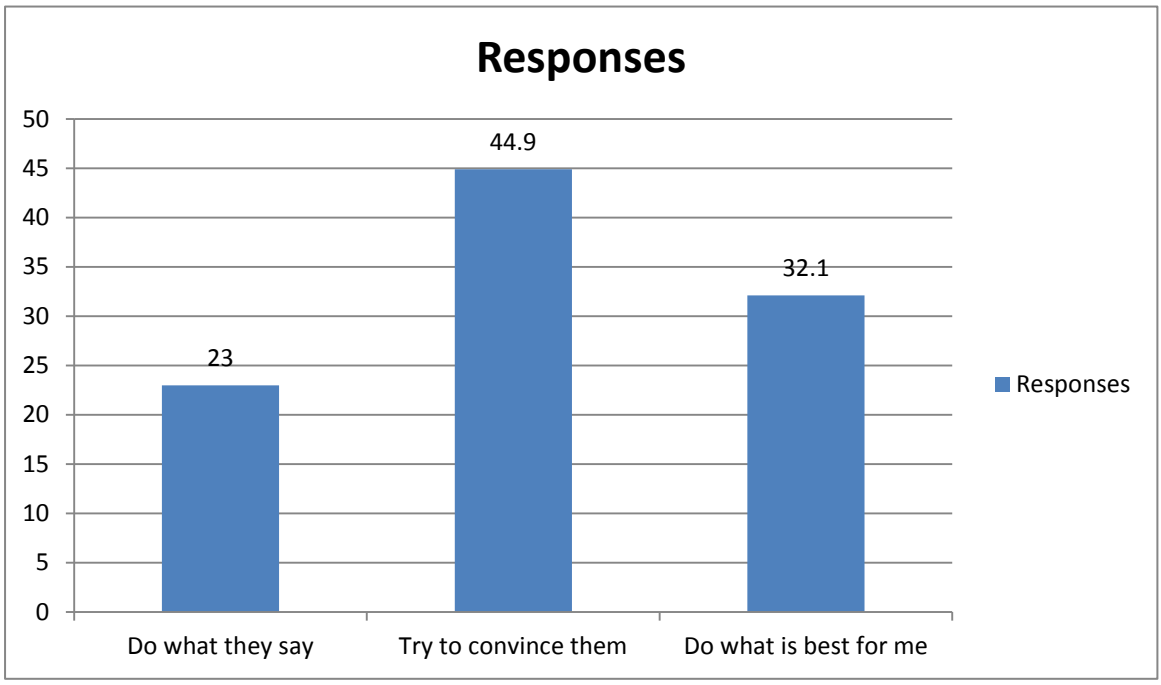
"……they are many, many pregnancy are being attacked by evil men thereby making delivery almost impossible, many times that Doctor insist on operation (cesarean section) on the women in this condition often lead to loss of life of either the woman or the baby if not both. If they bring such patient to us by the grace of Orunmila, the woman will be delivered of her baby safe and sound; this is the edge we have over the orthodox facilities."….. "care for pregnancy start from the first month of conception through the ninth month, which is why women that seek care from us have safer and easier delivery. For instance, a woman that is suffering from infertility (either primary or secondary) will first of all be examined to determine the cause and administer appropriate treatment before conception and she will be monitored throughout the period of pregnancy to delivery. Even in cases of fibroid there is a traditional way of treating it without going through cesarean section as usually recommended by the orthodox facility, there are different types of fibroid some can be medically treated while the other that is spiritually inflicted can be treated by (spiritual) traditional practitioners." (Igbole Ekiti TBA)

These assertions hold important clues to the mixed facility patronage rate recorded from the survey instrument. The researcher notes that, the serendipitous categorization of reasons for combined usage of alternative facilities needs further expansion and modeling.

5.13 Women and Decision Making

The bars chart below shows the distribution of respondent's decision in a situation whereby her opinion differs from that of her family members on issues of her maternal health. The chart indicates that about 45 percent (eighty-eight) of the respondents prefer to convince the family members in order to see reasons for her position while about 32 percent (sixty-three) declare that they will do whatever they consider the best for them. The smallest but significant cohort of 23 percent (forty-five) of the respondents indicates that they will obey their relatives. The implication of this is that the opinion of family members is a factor in making decisions regarding the health of women of reproductive age.

Figure 5.3: Distributions of Respondents Opinion Relating to Maternal Health



Source: Field Survey, 2016.

In a related development, on whether a woman can visit a maternal health care facility without her husband's permission, it is noted that majority of the respondents with educational qualifications of secondary school and below indicated that they cannot visit health facility without the permission of their spouse. In contrast, seventy-three percent of

respondents with tertiary education were of the opinion that they could visit maternal health care facilities without their husbands' permission. Considering this data (in Figure 3) one can arguably say that education has a role to play in influencing women's decision making power. But looking at Figure 5 (as presented later in this this chapter), which displays the various reasons for respondents saying yes to visit health care facility without their spouse's permission, none of them claimed that their exposure based on their acquired educational training influenced their decision.

Rather, forty-one (out of one hundred and ten) of this cohort who have no husbands (i.e. as a result of being single, separated, divorced or widowed) reported that they did not have to seek permission. Among respondents with tertiary education, twenty-nine believed that they have the privilege to decide unilaterally on visiting health care facilities while twenty-six of them submitted that it is only during emergency (situation) that they could visit a health care facility without seeking permission from their husbands.

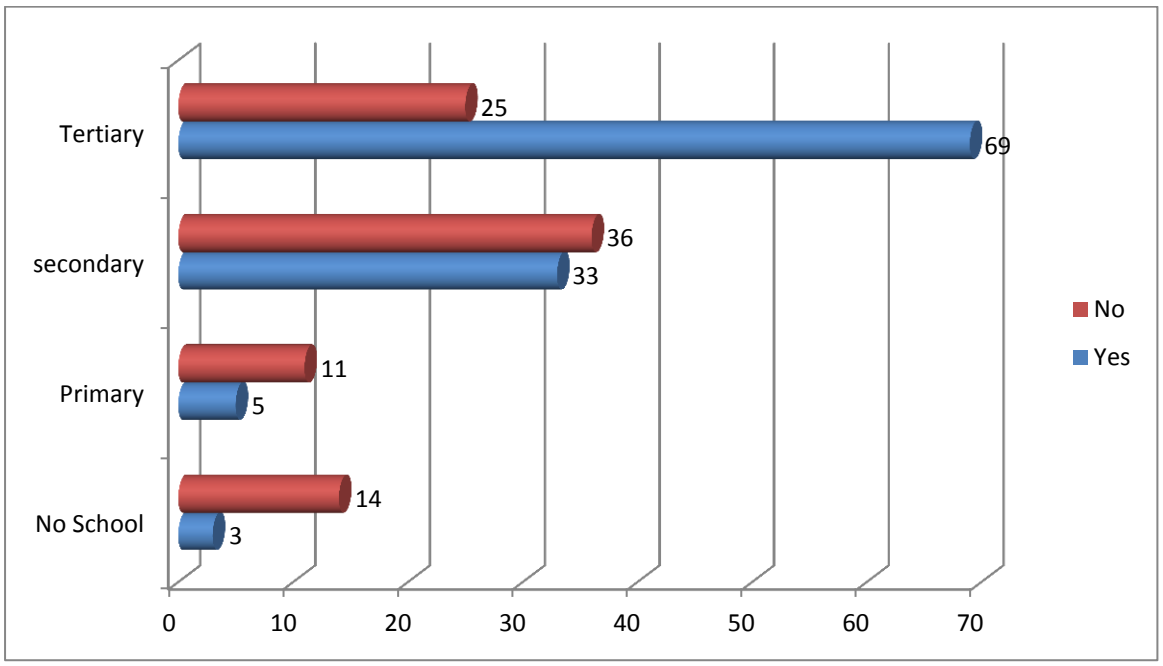
Of those with secondary education, only six stated that they had the privilege to take unilateral decisions on visiting health care facilities while five reported that it was only in a state of emergency that seeking permission from their spouse was not necessary. Two out of three respondents with no formal education equally were of the opinion that they could solely decide to visit a health care facility while only one person indicated her husband was not responsible. To buttress the discussion, a health worker in an interview at Basic Health Center Usi Ekiti had this to say:

".....you know oko l'olowo ori aya (the husband is the lord over the woman), so if a woman unilaterally takes a decision and something went wrong, the husband will claim that he was not aware of her attending the facility. Ideally, the woman needs to seek her husband's permission especially on issues regarding her health. Even when the husband was not around he would have provided instruction on which health care facility to attend at least prior to the time the woman going into labour". (Usi Basic Health Centre)

This scenario is a reflection of a typical rural community where attitude and practices are still largely defined by patriarchy. This is obvious in the women's lack of decision-making power within the family at the micro level. So far, the family is a microcosm of the larger society hence a replica of this system or arrangement is not uncommon at the macro level of Yoruba society.

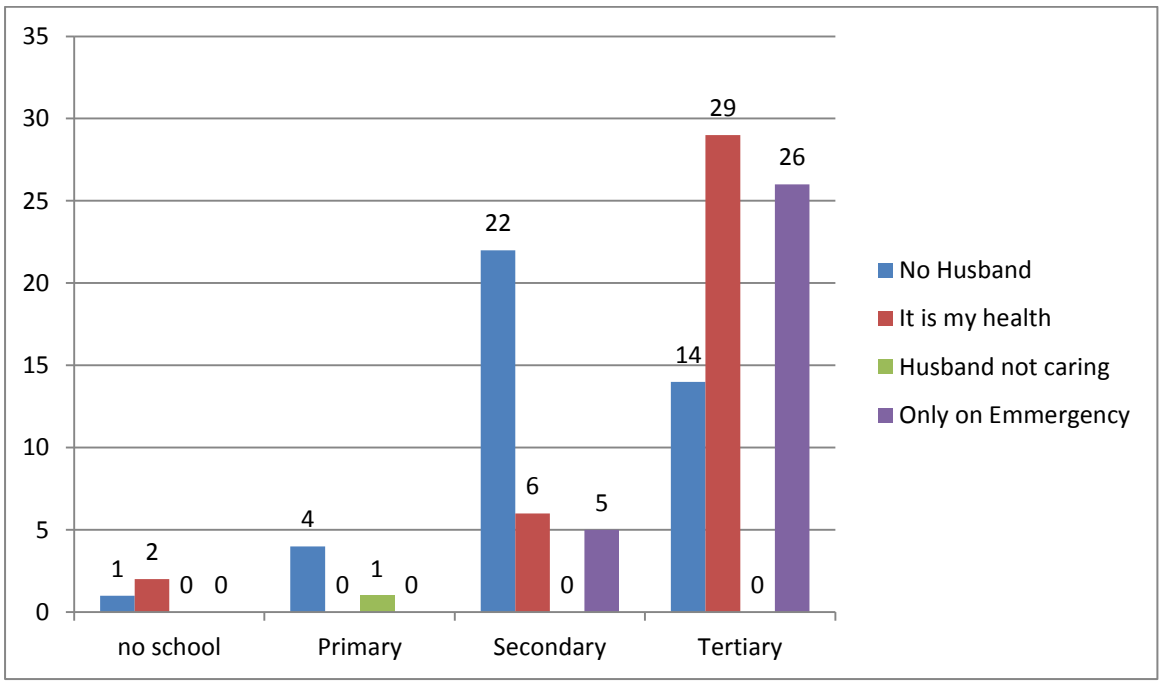
Summarily, it is obvious from the above discussion that the decision making power among Yoruba women in Nigeria is very weak regardless of their educational status and exposure to modern way of life. Patriarchy is culturally and practically dominant in all facets of Yoruba subculture to the extent that it determined most of the decisions regarding maternal health care seeking and the health and wellbeing of women of child bearing age in general.

Figure 5.4: Distribution of Respondents by Educational Qualifications and Whether they Can Visit Health Care Facility Without their Husband's Permission



Source: Field Survey, 2016.

Figure 5.5: Distributions of Respondents Based on Reasons for Attending Health Care Facility Without their Husband's Permission



Source: Field Survey, 2016.

5.14 Response to Effects of Cultural Beliefs and Practices on Family Planning

Table 11 illustrates that 99.4 percent of the respondents have heard about family planning programmes before and 57.1 percent of this category heard it through media (mostly radio and television) while another 40.8 percent of them got informed at various health care facilities, and a negligible percentage (2.1) heard it through other sources such as village meetings. The Table also reveals that 79.1 percent of the respondents had been using contraceptives while 29.9 percent claimed not to have used at all. A closer examination of the table shows a slight consistence or direct relationship between being informed about family planning and its adoption or usage.

Table 11: Distribution of Responses Related to Family Planning in Percent

Variables	Responses	Frequency	%
1a Have you heard about family planning programme	(a) Yes	195	99.4
	(b) No	-	-
	(c) No Response	1	0.6
1b If yes, state source of information	(a) Media	112	57.1
	(c) Hospital	80	40.8
	(d) Others	4	2.1
2a. Do you ever-used contraceptives	(a) Yes	155	79.1
	(b) No	41	20.9
2b. If yes, which method are you currently using	(a) Billing /calendar	18	11.6
	(b) Condom	62	40.0
	(c) Withdrawal	14	9.0
	(d) Intra uterine devices	1	0.6
	(e) Norplant implant	2	1.3
	(f) Pill	34	21.9
	(g) Injectables	3	1.9
	(h) Others	5	3.2
	(i) No response	16	10.3
3a. What are the traditional methods of family planning you know	(a) External use (beeds, ring, Asoro)	85	43.4
	(b) Orally administer (herbs, Aseje, Lime and Efirin	8	4.1
	(c) Natural (calendar/billing, withdrawal	39	19.9
	(d) Combination of oral & external use	29	14.8
	(e) Combination of natural & external use	4	2.0
	(f) Combination of oral & natural use	1	0.5
	(g) All	1	0.5
	(h) No response	29	14.8
3b. which one have you used	(a) External use (beeds, ring, Asoro)	32	16.3
	(b) Orally administer (herbs, Aseje, Lime and Efirin	11	5.6
	(c) Natural (calendar/billing, withdrawal	40	20.4
	(d) Combination of oral & external use	8	4.1
	(e) Never use	105	53.6

Source: Field Survey, 2016.

Data gathered from in-depth interviews reveals that most of the facilities do not have family planning facilities readily available at the time of the fieldwork. Of the 195 respondents that have ever used contraceptives, 11.6 percent declared practicing billing/calendar method and 40 percent indicated that they were currently using condom while 21.9 percent used the pill. 1.3 percent and 9 percent of this cohort were using Norplant Implant and withdrawal method respectively while 1.9 percent and only one (0.6%) respondent indicated using injectable and intra uterine devices (IUD) respectively.

Pertaining to knowledge of traditional methods of family planning, 43.4 percent of the respondents were aware only of the use of such traditional methods as "asoro", waist beads and rings: all these are categorized as methods that are for external use only. 19.9 percent of the respondents indicated that they were aware of only the natural method. Classified under this method are abstinence, billing/calendar and withdrawal.

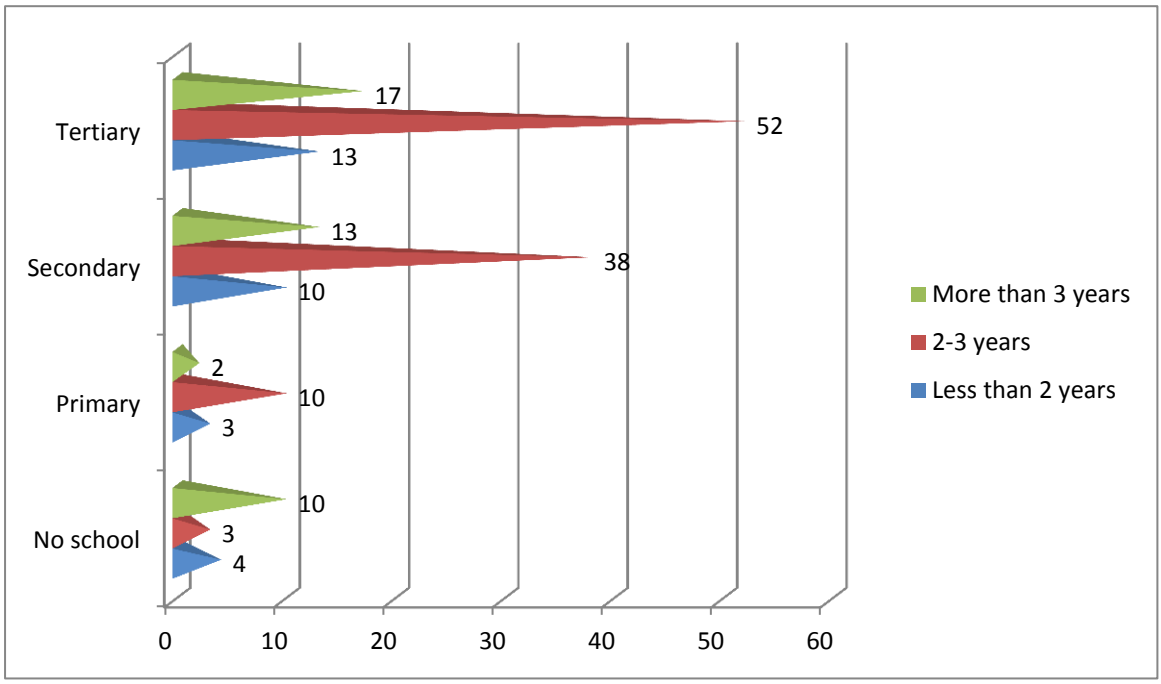
Worthy of note is the fact that, it is a common cultural practice among the Yoruba people of Nigeria that a husband should abstain from sexual intercourse with his breastfeeding wife for a certain period. The third group under this cohort is 4.1 percent of the respondents that claimed they were aware of only those methods that are orally administered (like, aseje, lime, efirin, salt and water, other herbs, and gbere (incision on the body). In all, about 48 percent of the respondents were aware of both external and oral traditional methods of family planning while 2 percent of the respondents were aware of both external and natural methods. Only one respondent (0.5%) indicated awareness of both oral and natural methods and the same was applicable to the set of respondents that claimed awareness for all three categories.

Table 11 also displays the usage of traditional methods of family planning by the respondents. Respondents use rates of more than 20 percent are recorded for only periodic abstinence and withdrawal while 16.3 percent use solely beads, ring and asoro. 5.6 percent of the respondents used only herbs while 4.1 percent represent the number of respondents that combine both oral (herbs) and external use. The overall picture shows a significant relationship between awareness and use of traditional family planning methods. In-depth interviews suggest that most Yoruba women in Nigeria have little access to family planning and reproductive health services.

"……..they are aware because we do enlighten them; we do refer those that request for family planning to health centre because it is not within our jurisdiction. Some of them have got about six

kids already and the current economy of the nation does not even support having too many children like fowl hence there is need to have the very few that you will be able to cater for. In lieu of this we do advise them to go for family planning at the hospital as we do not have the facility here." (CAC Mission Home, Ayetoro)

Figure 5.6: Distribution of Respondents by Educational Qualification and Child Spacing Period



Source: Field Survey, 2016.

From the above chart, seventeen (20.7%) out of the entire eighty two responses related to child spacing among respondents with tertiary education shows a waiting period of more than three years between births while a significant proportion of fifty-two (63.5%) indicates child spacing period of between two to three years while thirteen (15.8%) of the cohort practice child spacing period of less than two years. Among respondents with secondary education, ten (16.4%) of them waited between births for less than two years and about 62.3 percent (38) observed a child spacing period of between two to three years while about 21.3 percent (13) waited between births for more than three years.

From the cohort with primary education, 20 percent indicated that they observed child spacing period of less than two years while 66.7 percent and 13.3 percent of the group waited between births for two to three years and more than three years respectively. Regarding respondents with no formal education, 23.6 percent of them waited between births for less

than two year while 17.6 percent of the respondents practiced child spacing of between two to three years and a significant proportion of 58.8 percent were involved in child spacing of more than three years.

Table 12: Distributions of Respondents by Child Spacing Period and Reasons

Reasons	Child Spacing									
	Less than 2 Years		2-3 Years		More than 3 Years		No Response		Total	
	Number	%	Number	%	Number	%	Number	%	Number	%
Tradition/Culture	16	59.3	85	82.5	10	23.8	-	-	111	56.6
Medical	06	22.2	17	16.5	27	64.3	-	-	50	25.5
Finance	-	-	01	1.0	05	11.9	-	-	06	3.1
Personal Intention	05	18.5	-	-	-	-	-	-	05	2.6
No Response	-	-	-	-	-	-	24	100	24	12.2
Total	**27**	**13.8**	**103**	**52.6**	**42**	**21.4**	**24**	**12.2**	**196**	**100**

Source: Field Survey, 2016.

Looking at the various reasons given by the respondents for child spacing period, Table 12 suggests that the majority (56.6 percent) of the respondents attributed it to cultural belief systems while 25.5 percent provided medical reasons, 3.1 percent indicated finance as a reason while as few as 2.6 percent attributed their reasons to personal intention. 12.2 percent (24) of the entire respondents did not respond to the question on child spacing simply because some of the respondents were having either their first pregnancy or child at the time of the survey.

5.15 Test of Significant Relationship Using Chi-Square for Basic Survey Questions Related to Beliefs and Practices

This section attempts an analysis of some identified variables and their impacts or influence on maternal health seeking among the Yoruba people of Nigeria. The different variables that were analysed include: attitude of health workers; availability of drugs in the health care facilities; cost of drugs and services; some practices in the hospital that are not against culture and religion; proximity of health facility; Traditional Birth Attendants health care; choice of place to receive health care and; education amongst others.

Decision rule: Reject Ho if P-value is less than the level of significance, otherwise accept.

Hypothesis 1

Ho: Health workers attitude does not discourage (not affect) women attendance to hospital

H_I: Health workers attitude affect women attendance to hospital

Table 13: Discouraging Attitude of the Health Care Workers

Opinion	Observed N	Expected N	Residual
Strongly Agree	20	39.2	-19.2
Agree	65	39.2	25.8
Undecided	31	39.2	-8.2
Disagree	75	39.2	35.8
Strongly Disagree	5	39.2	-34.2
Total	196		

Test Statistics

	Discouraging attitude of the health workers
Chi-Square	90.633
Df	4
P-value	0.003

Observation

From Table 13, it is observed that, 20 people strongly agreed that the attitude of health workers has significant relationship on maternal health seeking, 65 agreed, 31 undecided, 75 disagreed, and 5 strongly disagreed with the opinion. The expected value for each row is equal to the sum of the observed frequencies divided by the number of rows in the Table. In this survey, there were 196 observed responses, resulting in approximately 39 responses per each opinion using the Likert scale.

Finally, the residual is equal to the observed frequency minus the expected value. The table shows the disparities between the observed and expected frequencies.

Since the p-value is 0.003 which is less than the level of significance (0.05), the null hypothesis is rejected. This means that the respondents' opinions are statistically significant at 5% level and not just by chance. In other words, the attitudes of health care workers have a significant relationship on maternal health seeking.

Hypothesis 2

Ho: Lack of drugs does not discourage (not affect) women attendance to hospital.

H_I: Lack of drugs affects women attendance to hospital.

Table 14: Discouragement from Lack of Drugs

Opinion	Observed N	Expected N	Residual
Strongly Agree	25	39.2	-14.2
Agree	138	39.2	98.8
Undecided	10	39.2	-29.2
Disagree	18	39.2	-21.2
Strongly Disagree	5	39.2	-34.2
Total	**196**		

Test Statistics

	Discouragement from lack of drugs
Chi-Square	317.214
Df	4
P-value	0.001

Observation

The null hypothesis is rejected in the above Table. The result shows that constant lack of drugs is another strong factor that can discourage women from attending health care facilities. In other words, this may be another reason for the high patronage of TBAs, since traditional medicines are almost readily available. The response below from one of the respondents in the study, attests to this assertion.

"…….the major challenge is that teenage pregnancy is rampant now. This set of "teenage mothers" are not financially responsible, they don't have the money to pay for hospital bills. Many of them are even shy to come for antenatal. There is inadequate drug supply. Salary is not regular at all, we are in August and the last salary we were paid was in February." (Orin Ekiti BHC)

Hypothesis 3

Ho: Cost of drugs and services does not discourage (not affect) women attendance to hospital.

$H_{I:}$ Cost of drugs and services discourage (affect) women attendance to hospital.

Table 15: Discouragement from Cost of Drug

Opinion	Observed N	Expected N	Residual
Strongly Agree	24	39.2	-15.2
Agree	103	39.2	63.8
Undecided	32	39.2	-7.2
Disagree	34	39.2	-5.2
Strongly Disagree	3	39.2	-36.2
Total	**196**		

Test Statistics

	Discouragement from the cost of drugs and services
Chi-Square	145.173
Df	4
P-value	0.004

Observation

The null hypothesis is rejected in Table 16 above. This suggests that the cost of drugs is a very significant factor as regards women attendance to hospitals. The respondents invariably show that many women could delay or even forego maternal health care if the cost of drugs and services are not affordable. The following assertions made during the interview supports this position.

"…….the main problem is finance; most of the mothers find it difficult to pay for their bills after treatment or delivery. We cannot bill them before treatment because, this is a primary health care facility, if it were to be tertiary health care facility, patient must have made at least part of the payment before treatment commence. The distance to cover to the facility is a barrier, poor funding due to the terrible state of the economy in the country. Our salary is not regular; the last salary paid was November last year" (seven months ago) (Basic Health Centre Usi Ekiti).

"……..other challenges are from the patients, some of them cannot even provide the basic material to take care of them and the expected baby, a time I wonder why a woman will carry pregnancy for good nine months without making necessary preparation for the delivery, some will not even buy common pad or cloth for the expected baby. Most of the women are very poor, we wish the government can provide delivery kits for them because most of them do come with empty handed to the extent that we are the one providing the kits and even beverages in most cases. We do have most of these materials in our facility. You know like I said the other time, teenage pregnancy is too rampant here, how do you expect a fifteen year old girl probably a secondary school drop out to be financially responsible when she should normally still be under parental care" (CAC Ayetoro Ekiti).

Hypothesis 4

Ho: Some practices in the hospital are not against culture and religion.

$H_{I:}$ Some practices in the hospital are against culture and religion.

Table 16: Some Practices in the Hospital are Against Culture and Religion

Opinion	Observed N	Expected N	Residual
Strongly Agree	3	39.2	-36.2
Agree	16	39.2	-23.2
Undecided	84	39.2	44.8
Disagree	80	39.2	40.8
Strongly Disagree	13	39.2	-26.2
Total	**196**		

Test Statistics

	Some practices in the hospital are against culture and religion
Chi-Square	158.337
Df	4
P-value	0.001

Observation

Since the p-value is less than the level of significance (0.05), the null hypothesis is rejected in the Table 16. This means that some practices in the hospital are against the religion and cultural practices of the respondents; which in the long run contributes to factors affecting maternal health seeking among the Yoruba women of Nigeria. Suffice to say therefore, that this is one of the major cultural factors that had hitherto hindered

maternal health seeking at the orthodox facility and still have persistent traces on women's attitudes towards health seeking.

Hypothesis 5

Ho: Proximity of health care facility does not affect women attendance to hospital.

$H_{I:}$ Proximity of health care facility affects women attendance to hospital.

Table 17: Proximity of Health Care Facility

Opinion	Observed N	Expected N	Residual
Strongly Agree	24	39.2	-15.2
Agree	130	39.2	90.8
Undecided	17	39.2	-22.2
Disagree	15	39.2	-24.2
Strongly disagree	10	39.2	-29.2
Total	**196**		

Test Statistics

	Proximity of health facility
Chi-Square	265.480
Df	4
P-value	0.002

Observation

Since the p-value is less than the level of significance 0.05, the null hypothesis in Table 17 is rejected. This means that the proximity of health care facility has an effect on women's attendance to health care centres. This position can also be corroborated by the qualitative data. In an interview at a comprehensive Health Centre in Aiyetoro Ekiti, the respondent reported that:

"…….apart from the distance to cover, no ambulance; for instance if we have a stable ambulance with driver, patients will be able to call us even in the midnight, in case of emergency and we will be able to come to their aid because this place is too far from the community people".

In other words, data from this study established that, there is a strong relationship between access and use of maternal health care facilities among the Yoruba women of Nigeria.

Hypothesis 6

Ho: Traditional centers are not better places to receive care than orthodox health care centres.

$H_{I:}$ Traditional centers are better place to receive care than orthodox health care centres.

Table 18: Traditional Women are Better Place to Receive Care than Orthodox Health Care Centres

Opinion	Observed N	Expected N	Residual
Strongly Agree	5	39.2	-34.2
Agree	29	39.2	-10.2
Undecided	69	39.2	29.8
Disagree	57	39.2	17.8
Strongly disagree	36	39.2	-3.2
Total	**196**		

Test Statistics

	Traditional women are better place to receive care than orthodox health care centres.
Chi-Square	63.490
Df	4
P-value	0.003

Observation

Looking at the p-value (0.003) in the Table above, which is less than the significance (0.05) level, the null hypothesis is rejected. This indicates that Traditional Health Care Centres have a very strong influence regarding place of receiving maternal health care among the Yoruba women of childbearing age. The result is evident in the data which indicates the place of receiving maternal health care (see the chart in Figure 2). There are results from the qualitative data, which also confirm this fact. Almost all of the respondents in the interview session with the TBAs assert that there are certain health conditions that are beyond the conventional medical practices, which can only be dealt with by traditional practitioners.

According to one of the TBA respondents (from Ilogbo Ekiti) in an interview, she said *"…….one is infertility (primary and secondary), there are ways of curing these two types of infertility, and we first ask her (the patient) eleda (destiny) by consulting the oracle to find*

out the cause or source of her infertility. It could be as a result of spiritual attack, abortion or sickness. If it is as a result of sickness or malfunction in the body system then, we treat the ailment with herbs and roots, thereafter she will conceive and deliver but, if it is as a result of spiritual attack which is beyond medicine, we equally know what to do and her testimony will change for better…… awo lo ye o gberi o mo (only the initiates can understand the intricacies)".

From the above evidence, we can therefore argue that seeking maternal health care from orthodox facilities and traditional practitioners results in maternal health care services transcending the boundaries of either of these sources and that a comprehensive maternal health care entails the collaboration of both.

Hypothesis 7

Ho: The church is not a better place to receive care than orthodox health care centres.

$H_{I:}$ The church is a better place to receive care than orthodox health care centres.

Table 19: The Church is a Better Place to Receive Care than Orthodox Health Care Centres

Opinion	Observed N	Expected N	Residual
Strongly Agree	13	39.2	-26.2
Agree	31	39.2	-8.2
Undecided	73	39.2	33.8
Disagree	51	39.2	11.8
Strongly Disagree	28	39.2	-11.2
Total	**196**		

Test Statistics

	The church is a better place to receive care than health care
Chi-Square	55.122
Df	4
P-value	0.002

Observation

Since the p-value (0.002) is less than the level of significance (0.05), the null hypothesis is rejected in the above Table. This means that the church as a place to receive care has a strong influence on maternal health seeking behaviour. Responses such as the ones below support the finding.

"…….it is the husband that decides for most patients to come here for care because of their belief in the power of prayer. Today is even our antenatal day during which we observe prayers for two hours (9-11am). We cannot rule out the fact that some women do come here as against their husband choice."

"……..our clients have strong beliefs in the efficacy of our job, for instance now, I have been here for almost four years and I have recorded several women that have made use of our facility twice meaning that if their first experience is not palatable they won't come back, that shows trials have convince them. Many a times pregnant women who have been slated for cesarean section (CS) at the hospital do come here and have safe delivery because the power of God of Ayo Babalola is still performing miracle like that of 1930".In addition we don't charge money for delivery, even there are cases where our clients would not be able to by the necessary kits for the unborn baby, in such cases we do supply the needed kits, it is our belief that whatever we do for them, we are doing it to serve God which is the ultimate reason for our existence"

"……as against some people opinion, we do give health talks relating to family planning and importance of maternal health care in our mission house. Because of the believe that our people have in our faith (CAC), they do follow our advice and instruction regarding how and where to seek health care services at appropriate time. We do refer some cases to orthodox practitioners and once we give then instructions they follow it strictly because they have the belief that we cannot mislead them as servants of the "most high" God. And to God be the glory He has never failed His people. (Ayetoro CAC)

Hypothesis 8

Ho: Care during pregnancy is independent of outcome of delivery.

$H_{I:}$ Care during pregnancy affects outcome of delivery.

Table 20: Care During Pregnancy Affect Outcome of Delivery

Opinion	Observed N	Expected N	Residual
Strongly Agree	35	39.2	-4.2
Agree	133	39.2	93.8
Undecided	9	39.2	-30.2
Disagree	11	39.2	-28.2
Strongly Disagree	8	39.2	-31.2
Total	**196**		

Test Statistics

	Care during pregnancy affect outcome of delivery
Chi-Square	293.286
Df	4
P-value	0.003

Observation

Since the p-value (0.003) is less than the level of significance (0.05), the null hypothesis is rejected in the above Table. This simply implies that there is a strong correlation between ante natal care and pregnancy outcome. The survey data revealed that an overwhelming number of the respondents sought care during pregnancy but their adherence to required and routine visits to the facility could not be readily established by this study. Nevertheless, we can assume that many Yoruba women believe in the fact that, care during pregnancy is a key factor in the equation of maternal health.

Hypothesis 9

Ho: Lack of drugs in the facility does not prevent women from attending maternity centres.

$H_{I:}$ Lack of drugs in the facility prevents women from attending maternity centres.

Table 21: Lack of Drugs Prevents Women from Attending Maternity

Opinion	Observed N	Expected N	Residual
Strongly Agree	11	39.2	-28.2
Agree	145	39.2	105.8
Undecided	22	39.2	-17.2
Disagree	14	39.2	-25.2
Strongly Disagree	4	39.2	-35.2
Total	**196**		

Test Statistics

	Lack of drugs prevents women from attending maternity centres
Chi-Square	361.194
Df	4
P-value	0.006

Observation

Since the p-value is less than the level of significance 0.05, the null hypothesis is rejected in the above Table; this means that lack of drugs prevents women from attending the maternity center. In other words, there is a strong link between availability of drugs and maternal health care seeking. This issue is largely hinged on the lackadaisical approach of the government (at every tier) to health related needs. In a situation whereby the government cannot adequately provide for the basic health needs of her citizenry like availability of drugs at health care facilities then, achieving goal 5 of the MDGs (for example) becomes a mirage.

As at the time of gathering qualitative data for this survey, it was revealed that the Nigerian health care system particularly, in Ekiti State where the study was conducted was besieged with deteriorating facilities, incessant lack of drugs and inadequate competent health care professionals owing largely to the economic recession in the country and corruption; which is a major bane to economic development in most of the developing countries. In responding to questions dealing with challenges facing maternal health in the community, a respondent from the Basic Health Center Usi Ekiti lamented that the challenges include,

"……poor funding due to the terrible state of the economy in the country, our salary is not regular; the last salary paid was November last year (seven months ago). Summarily, availability of drugs in

terms of being accessible and affordable to women of child bearing age will to a large extent improve maternal health seeking and the health of women in particular" (USI BHC).

Hypothesis 10

Ho: Frightening equipment in the labour room does not prevent women from attending maternity centres.

$H_{I:}$ Frightening equipment in the labour room prevents women from attending maternity centres.

Table 22: Effect of Frightening Equipment on Maternity Attendance

Opinion	Observed N	Expected N	Residual
Strongly Agree	9	39.2	-30.2
Agree	49	39.2	9.8
Undecided	66	39.2	26.8
Disagree	50	39.2	10.8
Strongly Disagree	22	39.2	-17.2
Total	**196**		

Test Statistics

	Frightening equipment in the labour room
Chi-Square	54.561
Df	4
P-value	0.008

Observation

Table 22 above shows a p-value of 0.008 which is less than the level of significance (0.05). Therefore, the null hypothesis is rejected. This implies that frightening equipment in the labour room have an impact in preventing women from attending the maternity center. The data presented above reveals that majority of the respondents are of the opinion that there are some frightening equipment in maternity centers compare to TBA and mission homes. This belief indirectly affects maternal health seeking behaviour among Yoruba women of child bearing age.

Hypothesis 11

Ho: Devotion of health workers to duty does not prevent women from attending maternity centres.

$H_{I:}$ Devotion of health workers to duty prevents women from attending maternity centres.

Table 23: Effect of Health Workers' Devotion to Duty and Attendance at Maternity Centre

Opinion	Observed N	Expected N	Residual
Strongly Agree	26	39.2	-13.2
Agree	99	39.2	59.8
Undecided	53	39.2	13.8
Disagree	14	39.2	-25.2
Strongly Disagree	4	39.2	-35.2
Total	**196**		

Test Statistics

	Devotion to duty
Chi-Square	148.337
Df	4
P-value	0.004

Observation

Looking at the Table above, the p-value is less than the level of significance (0.05) hence, the null hypothesis is rejected in the above Table. This means that devotion of health workers to duty have a strong impact on maternal health seeking behaviour. Probing beyond the ordinary, it is commonsensical to note that, workers devotion to duty varies from individual to individual which is greatly determined by factors such as: the working environment (environmental determinism); nature or condition of the job and; remunerations/motivation (economic determinism). Looking critically at this issue of health workers' attitude in terms of devotion to their job, the ordinary expectation is that an average health worker in Ekiti State of Nigeria (the study site) will not be devoted to work. The reason for this assumption is that virtually all health care workers interviewed lamented that they have not received salary for almost seven months. An adage says; a hungry man is an angry man. They also went further to indicate that most of the facilities are in a state of disrepair. These observations could be generalized that most health care personnel are not devoted to their work due to non-payment of salary and poor funding of the health care facilities. This position can be qualified by the qualitative data from the field as presented below:

"……..we needs a lot of things. We don't have enough staff. The facility here is in poor state and apart from that, the location is very far from the people and this has really affected the patronage adversely. No doctor because just a doctor is assigned to the whole LGA, he only comes here on request. Since I have started my career that has been the tradition, we have sixteen doctors assigned to the sixteen local government areas in the state. (Deputy OIC Basic Health Centre, Usi Ekiti).

"……..funding is a barrier apart from the distance to cover, no ambulance; for instance if we have a stable ambulance with driver, patients will be able to call us even in the midnight in case of emergency and will be able to come to their aid. There is shortage of staffs including gardeners. This is the reason why you see that our environment is bushy. There have been several incidences of snakes coming into the facility, our patients do complain a lot. These have been reported severally but the government has not yielded to complains, worst still embargo has been placed on employment. It is a pathetic condition when there is bag locks of unpaid salary of people in service. I must confess, with all these problems, how do you want us to be really committed to our duty? No salary and the government is not willing to procure and supply the needed equipment, drugs and conducive working environment, you cannot expect the hungry workers to put in their best. We are all human beings"

"…….the government is not really doing anything except for the supply of drugs which is not even regular. Regarding non-governmental organization, I want to commend this Ayetoro people, they have good ambassadors (products); Ayetoro Progressive Union. This union have done a lot for the community and the facility in particular, part of what the union did are; provision of well water, bought rechargeable lamps (when we have electricity problem), renovate part of the facility (change the leaking roof), gave us bed sheets, and mosquito nets. Most especially, malaria drugs are being supplied free of charge but our people are under-utilising this opportunity, most people will not come for care until they are severely ill or under a serious complications. Some people belief that it is "Olokunrun" (a stigmatized name for person that often fall sick) that visit hospital at a frequent interval" (Assistant OIC and Officer in charge of Drug Revolving Fund, Comprehensive Health Centre, Ayetoro).

Hypothesis 12

Ho: Discrimination in services rendered to literate/illiterates does not affect women in attending health care

$H_{I:}$ Discrimination in services rendered to literate/illiterates affect women in attending health care

Table 24: Discrimination in Services Rendered to Literate/Illiterates

Opinion	Observed N	Expected N	Residual
Strongly Agree	15	39.2	-24.2
Agree	72	39.2	32.8
Undecided	40	39.2	.8
Disagree	64	39.2	24.8
Strongly Disagree	5	39.2	-34.2
Total	**196**		

Test Statistics

	Discrimination in services rendered to literate/illiterates
Chi-Square	87.929
Df	4
P-value	0.002

Observation

The p-value (0.002) in the above table is less than the significant level (0.05), therefore, the null hypothesis is rejected; this means that discrimination in services rendered to women based on literacy or otherwise have an effect on maternal health seeking behaviour. This position holds essential clue to the importance of education in the health of women of child bearing age in particular. It is assumed that a more literate patient will be able to discuss freely with health care workers regarding her health conditions and the health workers in return will be able to comprehend better unlike the non-literate patients. In other words, there is a likelihood of non-literates exhibiting subservient behaviour resulting in the tendency for health workers displaying certain acts of discrimination on the other hand.

Hypothesis 13

Ho: There's no need to come back for checkup after delivery

$H_{I:}$ There's need to come back for checkup after delivery

Table 25: There's Need to Come Back for Checkup after Delivery

Opinion	Observed N	Expected N	Residual
Strongly Agree	27	49.0	-22.0
Agree	100	49.0	51.0
Undecided	41	49.0	-8.0
Disagree	28	49.0	-21.0
Total	**196**		

Test Statistics

	There's need to come back for checkup after delivery
Chi-Square	73.265
Df	3
P-value	0.008

Observation

Since the p-value is less than the level of significance 0.05, the null hypothesis is rejected in the above table. The implication of this is that medical checkup after delivery is very essential to the health of mothers and the new baby born. An in-depth analysis of the various interviews conducted corroborates the fact that some TBAs do refer their patients to orthodox facilities for immunization after delivery. They do this because not only they don't have access to the health care kits and technical expertise in administering such services but also for the belief they have in the efficacy of the exercise. To support this claim, for instance, a birth attendant at CAC mission house in Aiyetoro stressed thus: "our relationship is cordial, we do refer some cases to them (orthodox health workers) and, many of their patients also come here for care. They usually bring immunization kits to our center to immunize our patients and in some cases when they do not come on time we do refer our client to the hospital for immunization".

Hypothesis 14

Ho: There are no special foods for pregnant women/nursing mothers.

$H_{I:}$ There are special foods for pregnant women/nursing mothers.

Table 26: There are Special Foods for Pregnant Women/Nursing Mothers

Opinion	Observed N	Expected N	Residual
Strongly Agree	100	39.2	60.8
Agree	68	39.2	28.8
Undecided	17	39.2	-22.2
Disagree	6	39.2	-33.2
Strongly Disagree	5	39.2	-34.2
Total	196		

Test Statistics

	There are special food for pregnant women/nursing mothers
Chi-Square	185.990
Df	4
P-value	0.007

Observation

Looking at the relationship between some culturally determined (special) foods for pregnant women and nursing mothers, Table 26 presents a p-value that is less than the level of significance (0.05) in the above stated hypothesis. Therefore, the null hypothesis is rejected; this connotes the assumption that there are special foods for pregnant women and nursing mothers is significant. Both quantitative and qualitative survey results reveal that Yoruba people of Nigeria have strong belief in the prohibition of certain food for pregnant women and nursing mothers. It is widely believed that eating asala (wall-nut) during pregnancy could cause esuke (gasping) which could invariably cause delay or complications during labour. There is also a belief that when a woman eats plantain or banana during pregnancy it will cause eka ori (rashes) for the on-born child. In addition, it is widely believed that the intake of osan wewe (lime) could lead to abortion. Besides, majority of Yoruba people sees eating snakes during pregnancy as a taboo lest the unborn baby start crawling on its chest. In addition, there is a belief among the Yoruba people that when a woman eats snails during pregnancy, the on-born child will persistently (irritatingly) be salivating. A succinct breakdown of this scenario established that apart from asala (wall-nut) which have direct potential implication on the health of mothers, other food prohibitions are kept to secure the health and wellbeing of the on-born child. In other words, one can arguably say that, either overt or unconscious safety precautions

exhibited by women during pregnancy is largely to the interest of the on-born child due to deep cultural values attached to child bearing. This argument can be supported by the following assertions derived from one of the interview:

"……..for example it is popular beliefs among the Yoruba people that if a pregnant woman eats wall nut (Asala) there will be complication; she will be belching (gunfe) during labour, as a matter of fact belching during delivery usually result in prolong labour which is not healthy for both the mother and the unborn child. For us we do encourage them to take nutricious food like beans, vegetables, fish and cray-fish among other foods that will generally promote their health and that of the on-born child, even snail produce calcium which is essential for both mother and the baby. Though, in spite of our teaching, many women have the belief that certain foods are prohibited for pregnant women and nursing mothers as informed by their culture, such foods are not limited to wall nut but also include: snails, snake, and banana among others" (Usi Basic Health Center).

"……We really bless God for civilization. In terms of taboos and folk laws , there some families or most of the women have the belief that when they give birth they will have to eat foods that doesn't contain palm oil, salt, maggi and so on for probably seven or fourteen days. This culture have adverse effect on them; I have seen a lot of patient about five to ten of them that after this period they fall sick, don't forget that they were breastfeeding even during that period yet, they were denied the opportunity of taking balance diet" (Comprehensive Health Centre, Ayetoro).

"……we do enlighten our patient during health talk on the type of diet (food) that is good for them either as pregnant women or as nursing mothers. As a matter of fact there are some foods that pregnant women are prohibited from according to the dictate of their culture and tradition. I could remember during one of the health talks that a woman posited that it is not good for pregnant women to eat snails but I tried to re-orientate her on the calcium value of snails to the mother and the unborn baby" (Basic Health Centre Ora Ekiti).

"…We normally advise the patient to eat balance diet though traditionally there are some food items that are prohibited for pregnant women and nursing mothers. It is our duty to enlighten them that balance diet will help the health of the mothers and at the same times assists the healthy growth of the baby. In my own opinion, most of the women are poor hence they cannot afford balance diet, that is why they stick to the tradition of don't eat this don't eat that, if they were able to marry rich husband they will be able to afford food items like snails and the likes" (Orin BHC).

CONCLUSION

The present chapter has presented a survey that was conducted between March and December 2016. The chapter was organized around the three distinctive study objectives and fourteen

hypotheses, and the analyses centered on them. This approach helped enhance the cohesion of the work from the view point of targets set early in the investigation.

The presentation involved the display of data in tabular and graphical forms and the analysis revolves around frequency distribution, cross tabulation and inferential statistics, using chi-square to elucidate the relationships among the various factors that affect maternal health care seeking behaviour in Ido/Osi LGA in Ekiti State of Nigeria.

The survey sampled a total of 196 women aged 15-45+ in the selected communities. The nature of the phenomenon under investigation subjected the sample to be sex specific. The socio-demographic characteristic of the respondents were presented in a frequency distribution table. This revealed that the respondents within age 25-29 represent the modal class of the distribution that is, the age group with highest frequency. The survey also showed that majority (71.4%) of the respondents are married while the occupational distribution of the respondents showed a contextual variation. In terms of education, the Yoruba women particularly, in Ido/Osi LGA are obviously literate looking at it from the angle of their level of educational attainment.

Cross tabulations of variables and test of hypotheses on factors affecting maternal health care seeking behaviour were thoroughly dealt with in the chapter.

Summarily, the chapter has indicated quite forcefully that the comprehensive study of maternal health care seeking behaviour in typical sub-Saharan African contexts is not feasible without a deliberate emphasis of the role of factors affecting it. The multivariate analysis served to demonstrate this by establishing the statistical interconnections among age, education, income, occupation, marital status, culture, tradition, gender and patriarchy among others as factors effecting maternal health care seeking behaviour.

CHAPTER SIX

SUMMARY, RECOMMENDATIONS AND CONCLUSSION

This study investigated the relationship between socio-cultural factors and maternal health seeking in a Yoruba community of Nigeria. The study was also predicated on the argument that maternal health seeking is principally a cultural event and should be studied within the socio-cultural contexts in which it occurs. The review of the existing literature reveals that the rate of maternal morbidity and mortality in Nigeria and many other developing countries is very high. Also by extension maternal health (and health seeking) is largely influenced by socio-cultural beliefs and practices. Sub-Saharan Africa, however, has been identified as the area where cultural beliefs and practices exert the highest influence on maternal health seeking. The quest for holistic understanding of maternal health seeking in a Yoruba community of Nigeria resulted in the convergence of Medical Sociology and Demography.

By combining these sub-fields, data collection was undertaken through the method of triangulation. The interdependence of Demography and Medical Sociology guided the designing of the study objectives, which sought to provide insights on the associations among socio-economic status of women, educational qualification of women, women's beliefs and practices towards maternal health seeking, women's perception of health workers and services, patriarchal influence on women decision making power and the assessment of the existing social structure.

The study employed the convergence of Model of Behavioural Change in Public Health, Rational Choice Theory, Location Theory and Feminist Theory to analyze the links between the dependent and independent variables. The combined influence of these theoretical perspective pinpoints some hidden socio-cultural factors affecting maternal health seeking behaviour in particular and the health of women of child bearing age in general.

Triangulation of qualitative and quantitative methods was adopted in gathering data for the study. The essence of triangulation is to enhance our ability to understand phenomena under investigation more holistically and that the use of multiple methods would compensate for the individual shortcomings or weaknesses inherent in each of them. The combination of these two methods resulted in the findings of this study.

6.1 Summary of Findings

The major findings of the study are summarised under corresponding objectives. As a prefatory, the research found that:

i. Women have limited control over their sexuality and reproductive health and that there is power imbalance between men and women. Only 30.1% of the respondents decide on their own on where to seek maternal health care.
ii. Most women rely solely on their husband for the payment of maternal health care facilities received and indirectly strengthening the patriarchal tendency of the Yoruba men.
iii. Results from the qualitative data shows that TBAs are not adequately monitored, regularised and funded by government agency.
iv. Both qualitative and quantitative data reveal an inequitable distribution of amenities and trained health workers across the facilities.
v. There is low standard of education among women as many that claimed to be educated are not actually literate.

6.1.1 On the Association between Social Demographic Status of Women and Maternal Health Seeking

The study found the following:

i. That women in Ido/Osi that had below secondary school education visit TBAs' place more frequently than those with higher level of education and most women in Ido/Osi have secondary school and below education.
ii. That most women in Ido/Osi are situated within the low-income category and women within the high-income category prefer using orthodox facilities compared to traditional practitioners while the reverse is the case for women within the low-income category. There is also an association between women's level of education and monthly income just as the same association that exist between women's level of education and occupation.
iii. That income level of most women is low relative to the cost of living. Most women in Ido/Osi engage in trading, artisan and farming activities with an unemployment rate

of 10.2 percent as against the nation's 25.2 percent as at last quarter of 2016. Majority of the Yoruba women practice farming apart from their vocation to support their meagre salary. They rely ultimately on their husbands' finance to pay for medical bills.

iv. That there is a falling standard of education among Yoruba women of Nigeria.

v. That early marriage is not pronounced among Yoruba people and the Yoruba women attach strong stigma to divorce.

vi. That majority of Yoruba women profess God and Allah at manifest level while they respect and exhibit traditional beliefs and practices.

vii. That health workers salary is not paid regularly; the government owes them about seven months' salary arrears as at the time of this study.

6.1.2 On the Influence of Cultural Beliefs and Attitudes on Maternal Health Seeking

The study found the following:

i. That most women in Ido/Osi have dual registration at both TBAs' place and hospitals for antenatal and postnatal services. Women in Ido/Osi have a strong belief in the efficacy of care given at other centers apart from hospitals as complementary and that; there are some maternal health problems that cannot be solved by orthodox medicine.

ii. Patriarchy dominates the Yoruba culture. The decision making power among Yoruba women is very weak even in health matters that concern them regardless of their educational attainment and exposure. The husbands often make decisions on the choice of health care facilities they utilize. Parents and relatives have strong influence on women's choice of facility for health care services.

iii. Yoruba people believe that it is the cultural responsibilities of the husband to take care of the cost of health care services received by the wife.

iv. That the higher the level of educational qualification of a woman, the lesser her tendency to combine TBA and orthodox facilities for maternal health care.

v. Majority (60.2%) of the respondents believed that maternal health care is incomplete without the combination of traditional and orthodox health care services and about 61 percent of respondents within the highest income category combine TBA and orthodox facilities in respect of their maternal health care need.

vi. Yoruba women combine sources of receiving maternal health care services basically for three different reasons: behavioural; exigency and; potency.

vii. There is no consistency in women's educational qualification and decision making power.

6.1.3 On the Impact of Existing Social Structure on Maternal Health Seeking Behaviour

The study found the following:

i. There are inadequate health workers in the maternal health care facilities. Workers salary is not paid for over a period lasting seven months. There is incessant industrial strike action due to delays in the payment of health care workers salary. Only one medical doctor is assigned to cover all the facilities in the local government area as approved by the state ministry of health.

ii. The Yoruba cultural belief reinforces periodic postpartum abstinence and encourages child spacing

iii. There is a significant relationship between awareness of traditional family planning methods and the use of these methods.

iv. Attitude of health care workers towards maternal health care seekers have a significant relationship on maternal health seeking behaviour. Some practices in the hospital such as male health workers examining the private part of a female health care seeker are against the cultural beliefs of Yoruba people. There is a significant relationship between the belief of having frightening equipment in the health care facility and maternal health seeking behaviour.

v. Constant lack of drugs is identified as one of the factors that discourage women from attending health care facilities. There is a significant relationship between cost of drugs and maternal health seeking behaviour.

vi. There is a significant relationship between proximity of health care facility and maternal health seeking behaviour.

vii. The church has a strong influence on maternal health seeking behaviour.

viii. There is a strong correlation between antenatal care and pregnancy outcome.

ix. There is a strong belief in providing special food for pregnant women and nursing mothers.

x. There is a correlation between discrimination against illiterate mothers and maternal health seeking behaviour.

xi. Most of the health care facilities are in a state of disrepair. There is no stable water supply in most of the health care facilities. There is no stable power supply in most of the health care facilities. There is inadequate drug supply to the health care facilities. Some of the health care facilities are located a distance from the community. Roads leading to the facilities are not in good condition to facilitate easy movement to health care facilities. There is lack of ambulance service for emergency cases. Most of the facilities do not have family planning services readily available in the centers.

xii. There is no formal structure in place to evaluate and regulate the establishment and activities of the TBAs.

xiii. Immunization facilities are not available in most of the TBA places.

6.2 Recommendations

The study has been able to identify the factors that affect maternal health seeking behaviour and highlights that these factors cannot be separated from the environment in which they occur. This implies that the recommendations related to improving maternal health seeking behaviour should necessarily recognize the relative and specific demand of Yoruba people of Nigeria, as characterized by many rural areas in sub-Saharan Africa. The recommendations can be classified into three broad categories, which include: education and sensitization; public and private sector intervention, and academic contributions.

The study recommends the following:

i. Community education and mobilization is essential so that women and their family members learn about the need for special care during pregnancy and childbirth. Such education must include how to recognize obstetric complications and when and where to seek help. The goal of community mobilization should be to ensure that appropriate health-seeking behaviour becomes part of local social norms. Community education must address traditional beliefs about pregnancy-related complications that are often blamed on woman behaviour, fate, evil influences and other factors beyond the reach of the health care system. Due to the fact that Yoruba society is patriarchal in nature, men also should be educated on the need for family planning, contraceptive use, child spacing and moderate family size because they dominate family decision- making. In addition, dialogue among communities, policy-makers, and health system staff is essential to identify ways of overcoming barriers to women seeking maternal care.

There is need for educating the TBAs with the most current maternal health care techniques for effective management of varying maternal health situations in light of the fact that large majority of Yoruba women patronize them.

ii. In light of the socio-economic status of women in Ido/Osi are characterized by low-income and low literacy level, it is suggested that women's status and power be increased through awareness programmes. Governments, donors and international agencies can take steps to increase women's decision-making power within the family and community, particularly by investing in the education of women and girls, raise awareness of the critical importance of women's health to children and families and the need for women to have the power to make decisions about their own health and reduce women's disproportionate poverty, lack of economic power and lack of quality education, all of which constrain their ability to seek and receive the necessary maternal health care throughout the cycle of pregnancy and birth.

iii. Majority of women in Ido/Osi are poor, so based on this, targeting public sector subsidies to poor families and disadvantaged areas is essential. Poorer areas will need more financial and human resources to improved accessibility and improve quality of services. Introduction of community-financing schemes and making sure that public funds are used to finance transportation and care for the poor and needy.

iv. There is need to strengthen policies and capacity building, training health care providers for improved quality of care, availability of drugs, equipment and supplies and improve logistics. Ensure availability of emergency care services that also include Emergency Obstetric Care (EOC).

v. It is also recommended that effective "poor-friendly" referral systems should be developed. Communities and private sectors should be sensitized on their roles. There is need to strengthen partnerships between traditional birth attendants and skilled formal providers, build linkages with other reproductive health, nutrition, gender and adolescent health interventions.

vi. There should be a sensitization of communities and development of alternative outreach strategies that will take the MCH services to the poor women in their homes through community based skilled birth attendants, mobile teams for prenatal and EPI, community-based distribution of contraceptives, maternity waiting homes and rural midwifery programmes. Since it is established that TBAs meet a vital community need in supporting women throughout pregnancy, childbirth and the postpartum period, it is advised that they work with the healthcare team to act as community educators to lend support for accurate maternal and neonatal health messages.

vii. Lastly, it is recommended that sustained research on reproductive health should be encouraged particularly among the Yoruba people of Nigeria and among the rural communities of sub-Sahara Africa in order to proffer lasting solution to many health challenges which serves as a cog in the wheel of development of the developing nations.

6.3 Conclusion

This study has provided data that pinpoint the factors affecting maternal health seeking in a Yoruba community of Nigeria. By examining the separate and collective influences of the identified variables on maternal health seeking, the study contributes significantly to the methodological and theoretical aspect in the field of Demography and Medical sociology. In an attempt towards a comprehensive analysis of the relationship that exist between the dependent and independent variables, models of behavioural change, rational choice theory, location theory and feminist theory were employed in the study.

This theoretical triangulation employed in examining such a social phenomenon explains the serendipity of data collected for the study. The central concern has been that pre-industrial societies must naturally take considerable interest in maternal health care. To do this may exact a high level of re-socialization and re-thinking on the patriarchal nature of most sub-Saharan African societies. There are considerable constraints to the independence with which individuals can act, particularly as it concerns what may, in Parsonian terms, be described as the society's ultimate "functional prerequisite"

The conclusion to be drawn from this study is that the search for a holistic understanding of maternal health care seeking behaviour viz-a-viz maternal health transcend the linearistic nature of medical science rather, it calls for an interdisciplinary triangulation. This will invariably reduce the lacuna in knowledge and understanding of various issues in public health as a whole, which will invariably guarantee more valuable information for researchers and policy makers.

REFERENCES

Aarnio, P.,Chipeta, E., & Kulmala, T. (2013). Men's perceptions of delivery care in rural Malawi: Exploring community level barriers to improving maternal health. Health Care for Women Internatonal, 34(60, 419-439. Doi:10.1080/07399332.755982.

Abedin, S., Islam, R., & Hossain, T. (2008). Antenatal care during pregnancy: A study on Naogaon district of Bangladesh. Journal of the Social Sciences 3(8):537–41.

Abler, R., Adam, J. S., & Gould, P. (1977). "Spatial Organization: The geographer's view of the world", London: Prentice Hall.

Aboagye, E., & Agyemang, O. S. (2013). Maternal health-seeking behaviour: the role of financing and organization of health services in Ghana. Journal of Health Sciences, 5(5), 67-79. Doi:10.5539/gjhs.v5n5p67

Abor, P. A., Abekah-Nkrumah, G., & Sakyi, K. (2011). The Socio-economic determinants of maternal health care utilization in Ghana." International Journal of Social Economics 38 (7): 628–648. doi:10.1108/03068291111139258.

AbouZahr C., & Wardlaw, T. (2001). Maternal mortality at the end of a decade: signs of progress? Bull World Health Organization 2001, 79(6):573–596.

Adamu, H. S. (2011). Utilization of maternal health care services in Nigeria: An analysis of regional differences in the patterns and determinants of maternal health care use. (MSc Thesis) The University of Liverpool.

Adamu, Y. M., & Salihu, H. M. (2002). Barriers to the use of antenatal and obstetric care services in rural Kano, Nigeria. Journal of Obstetrics and Gynaecology, 22(6), 600–603. doi:10.1080/0144361021000020349

Adanu, R. M. (2010). Utilization of obstetric services in Ghana between 1999 and 2003. African Journal of Reproductive Health, 14, 153–158.

Addai, I. (1998) Demographic and socio-cultural factors influencing use of maternal health services in Ghana. African Journal of Reproductive Health, **2**, 73-80.

Addai, I. (2000). Determinants of use of maternal-child health services in rural Ghana. Journal of Biosocial Science, 32, 1–15.

Adegbola, M.B. (2007). Social and behavioural contexts of infertility in Ibadan, Nigeria, Unpublished PhD thesis submitted to the Department of Sociology, University of Ibadan, Nigeria.

Adetunji, J.A. (1991). Response of parents to five killer diseases among children in a Yoruba community, Nigeria. Social Science and Medicine, 32, 1379-1387. http://dx.doi.org/10.1016/0277-9536(91)90198-L

Adewuyi, A. (1999). Understanding male involvement in maternal emergencies. Oke Gada,

Ede.

Afonja, S. (1986). Women power and authority in traditional Yoruba society. In: Dube, L., Leacock, E. and Ardener, S., Eds., Visibility and Power, Bergin and Garvey, South Hadley, 136-157.

African Health Monitor. (2003). Traditional medicine: Our culture, our future. A Magazine of the WHO Regional Office for Africa; 4:1.

Ahmed, S., Creanga, A. A., Gillespie, D. G., & Tsui, A. O. (2010). Economic status, education and empowerment: Implications for maternal health service utilization in developing countries. PLoS ONE [Electronic Resource], 5, e11190.

Ajala, A.S. (2000). "Problems in maternal child health care". Unpublished Thesis, University of Ibadan, Nigeria.

Ajiboye, O. E., & Adebayo, K. A. (2012). Socio-cultural factors affecting pregnancy outcome among the Ogu speaking people of Badagry area of Lagos State, Nigeria. International Journal of Humanities & Social Science, 2, 133.

Akande, E. O. (2008). Affordable assisted reproductive technologies in developing countries: VG pros and cons. London: Oxford University Press.

Akazili, J., Doctor, H. V., Aboky, L., Hodgson, A., & Phillips, J. F. (2011). Is there any relationship between antenatal care and place of delivery? Findings from rural northern Ghana. African Journal of Health Sciences, 18, 62–73.

Akintan, O. A. (2001). The introduction of Christianity and its impact on traditional religion in Ijebuland: from 1892 to the present, Olubomehin, O.O. (Ed.), The Ijebu of Western Nigeria: a Historical and Socio-Cultural Study, Ibadan: College Press, 18-38.

Akunyili, D. (2004). Fake and counterfeit drugs in the health sector: The role of medical doctors. Annual Journal of Ibadan Postgraduate Medicine; 2(2):21-28.

Allman J, Parker, J., & Tongnaab, B. (2005). The history of a West African God. Indiana: Indiana University Press.

Allman, J. (1994). Making mothers: missionaries, medical officers and women's work in colonial Asante, 1924-1945. History Workshop 1994, 38:23–47. Oxford University Press.

Aluko, S.O. (2014). Perceived acceptability of assisted reproductive technology (ART) as treatment modality for infertility in Ijebu land, Ogun state, Nigeria Unpublished PhD thesis submitted to the Department of Sociology, University of Ibadan, Nigeria.

Aluko-Arowolo, S. O. (2010). Infertility diagnosis and treatment: Interpretation of sexism and patriarchal norms in Ijebu, South Western Nigeria: Being a paper presented at the 10th annual Africa conference on Women, Gender and Sexualities in Africa, University of Texas at Austin, March 26-28.

American Congress of Obstetricians and Gynaecologists (ACOG) and Committee on Obstetric Practice. (2002) "'Exercise during pregnancy and the postpartum period'. ACOG Committee Opinion Number 267," Obstetrics & Gynecology, vol. 99, no. 1, pp. 171–173.

Amooti-Kaguna, B., & Nuwaha, F. (2000). "Factors influencing choice of delivery sites in Rakai District of Uganda." Journal of Social Science & Medicine 50 (2): 203–213.

Ana, J. (2011). Are traditional birth attendants good for improving maternal and perinatal health? Yes. British Medical Journal, 2011; 342:d3310.

Asowa-Omorodion, F. I., (1997). Women's perceptions of the complications of pregnancy and childbirth in two Esan communities, Edo state, Nigeria. Social Science and Medicine 44 (12), 1817– 1824.

Awusi, V. O., Anyanwu, E. B. & Okeleke. V. (2009). Determinants of antenatal care services utilization in Emevor village, Nigeria. Benin Journal of Postgraduate Medicine 11:21–26.

Palaniappan, B. (1995). Role of antenatal care in safe motherhood. Journal of the Indian Medical Association, vol. 93, no. 2, pp. 53–54, 1995.

Babalola, S. (2009). Determinants of the uptake of the full dose of Diphtheria- Pertussis-Tetanus vaccines (DPT3) in Northern Nigeria: A multilevel analysis. Maternal and Child Health Journal, *13*, 550–558. doi:10.1007/s10995-008-0386- 5

Babalola, S., & Fatusi, A. (2009). Determinants of use of maternal health services in Nigeria—looking beyond individual and household factors. BioMed Central Journal of Pregnancy and Childbirth, 9, 43.

Babalola, S., & A. Fatusi. (2009). Determinants of use of maternal health services in Nigeria—Looking beyond individual and household factors. BioMed Central Journal of Pregnancy and Childbirth 9:43. doi:10.1186/1471-2393-9-43

Barakat, R., Pelaez M., Montejo, R., Luaces, M. & Zakynthinaki, M. (2011). "Exercise during pregnancy improves maternal health perception: a randomized controlled trial," American Journal of Obstetrics and Gynecology, vol. 204, no. 5, pp. 402.e1–402.e7.

Barclay L, & Kent D.(1998). Recent immigration and the misery of motherhood: a discussion of pertinent issues. Midwifery. 1998; 14:4–9.

Barker, D. J. P. (2004). Developmental origins of well-being. Philosophical transactions of the royal society: Biological Sciences, 359:1359-1366.

Bazzano, A. N., Kirkwood, B., Tawiah-Agyemang, C., Owusu- Agyei, S., & Adongo, P. (2008). Social costs of skilled attendance at birth in rural Ghana. International Journal of Gynaecology and Obstetrics, 102, 91–94.

Beegle K., Frankenberg E,. & Thomas D. (2001). Bargaining power within couple and use of prenatal and delivery care in Indonesia. Studies in Family Planning 2001; 32:130–146. Population Council.

Benintendi, L. (2004). The Sebei of Uganda. David D. Friedman's Homepage, May http://www.daviddfriedman.com/Academic/Course_Pages/legal_systems_very_different

Berry, N. S., (2006). Kaqchikel midwives, homebirths, and emergency obstetric referrals in Guatemala: contextualizing the choice to stay at home. Journal of Social Science and Medicine 62, 1958–1969.

Berry, N. S. (2008). Who's Judging the Quality of Care? Indigenous Maya and the Problem of "Not Being Attended". Medical Anthropology 27 (2): 164–189.

Bhutta, Z. A., Cabral, S., Chan, C., & Keenan, W. J. (2012). Reducing maternal new born and, and infant mortality globally: An integrated action agenda. International journal of gynecology and obstetrics, 1199(2012), S13-S17. Doi.10.1016/j.ijgo.2012.04.001.

Bina, R. (2008). The impact of cultural factors upon postpartum depression: a literature review. Health Care Women Int. 2008;29: 568–92.

Binet, C., Gastineau, B., & Rakotoson, L. (2009). Teenage pregnancy in Madagascar: impact on the health of mother and child. Notebooks for Study and Research French / Health 2009; Volume 19, Number 3:159-66.

Biratu, B. T., & Lindstrom, D. P. (2006). The influence of husbands' approval on women's use of prenatal care: Results from Yirgalem and Jimma Towns, South West Ethiopia. Ethiopian Journal of Health Development, 20, 84-92.

Birth (2010). Cultural and religious beliefs. Retrieved from birth.com.au from bellies to babies and beyond: http://www.birth.com.au/Factors-influencing-labour-pain-perceptions-and-choices-for-pain-relief/Culturaland- religious-beliefs

Blackwell, M. (1963). "The delay in seeking medical care for chronic illnesses". Health Education Monograph.16.

Bloom, S. S., Wypij, D., & Das Gupta, M. (2001). Dimensions of women's autonomy and the influence on maternal health care utilization in a North Indian City. Demography, 38, 67-78. http://dx.doi.org/10.1353/dem.2001.0001

Boyle, M. H., Racine, Y., Georgiades, K., Snelling, D., Hong, S., Omariba, W., Hurley, P., & Rao-Melacini, P. (2006). The influence of economic development level, household wealth and maternal education on child health in the developing world. Journal of Social Science and Medicine, 63, 2242-2254. http://dx.doi.org/10.1016/j.socscimed.2006.04.034

Bradby, B. (1999). "Will I return or not?: Migrant women in Bolivia negotiate hospital birth." Women's Studies International Forum 22 (3): 287–301.

Brown, H. L., & Small, M. J. (2012). Overview of maternal mortality. Uptodate. retrieved February 6, 2013, from http://www.uptodate.com/home/editorial

Brown, P., Lyson, M., & Jenkins, T. (2011). From diagnosis to social diagnosis. Journal of Social Science and Medicine, 73, 939–943.

Caldwell, J.C. (1977). Towards a restatement of demographic transition theory. In: John, C.C., Ed., The Persistence of High Fertility, Australian National University, Canberra, 25-119.

Caldwell, J.C. (1986). Routes to low mortality in poor countries. Population and Development Review, **12**, 171-220. http://dx.doi.org/10.2307/1973108

Centre for Reproductive Rights (CRR). (2008). Rights within marriage and the family: Government duties to ensure women's equality. Briefing paper: Marriage and Private life

Center for the Study of Religion and Culture (CSRC) (2005). Use of traditional versus orthodox medicine in help-seeking behaviour for psychiartric disorders in Nigeria. Summer Fellowship Report.

Chakraborty, N., Islam, M. A., Chowdhury, R. I., Bari, W., & Akhtar, H. H. (2003). Determinants of the use of maternal health services in rural Bangladesh. Health Promotion International 18(4):327–37.

Chapman, R. R. (2003). Endangering safe motherhood in Mozambique: prenatal care as pregnancy risk. Journal of Social Science and Medicine; 57: 355–374.

Chasan-Taber, L. (2012). Physical activity and dietary behaviors associated with weight gain and impaired glucose tolerance among pregnant Latinas," Advances in Nutrition, vol. 3, pp. 108–118.

Clapp, J. F. III. (1990). The course of labor after endurance exercise during pregnancy," American Journal of Obstetrics and Gynecology, vol. 163, no. 6, pp. 1799–1805, 1990.

Clapp, J. F. III., Kim, H., Burciu, B., & Lopez, B. (2000). Beginning regular exercise in early pregnancy: effect on fetoplacental growth," American Journal of Obstetrics and Gynecology, vol. 183, no. 6, pp. 1484–1488.

Clarke, P., & Gross, H. (2004). Women's behaviour, beliefs and information sources about physical exercise in pregnancy," Midwifery, vol. 20, no. 2, pp. 133–141.

Cohen, D. A., Finch, B. K., Bower, A., & Sastry, N. (2006). Collective efficacy and obesity: The potential influence of social factors on health. Social Science and Medicine, 62, 769–778.

Cohen, S. I., & Burger, M. (2000). Partnering: A new approach to sexual and reproductive health'', Technical Paper No. 3. United Nation Population Fund.

Conrad, P., & Barker, K. K. (2010). The social construction of illness: Key insights and policy implications. Journal of Health and Social Behavior, 51(Suppl), S67–S79.

Cosmimksy, S. (2001). "Midwifery across the generations: A modernising midwife in Guatemala." Medical Anthropology: Cross-Cultural Studies in Health and Illness 20 (4): 345–378.

Crissman, H. P., Crespo, K., Nimako, D., Domena, J., Engmann, C. M., & Adanu, R. M.. (2011). Intention to deliver in a healthcare facility and healthcare facility-based delivery rates among women in Akwatia, Ghana. International Journal of Gynaecology Obstetrics, 113, 161–162.

Crissman, H., Engmann, C. M., Adanu, R. M., Nimako, D., Crespo, K., & Moyer, C. A. (2013). Shifting norms: Pregnant women's perspectives on skilled birth attendance and facility based delivery in rural Ghana. African Journal of Reproductive Health (in press).

D'Ambruoso, L., Abbey, M., & Hussein, J. (2005). Please understand when I cry out in pain: Women's accounts of maternity services during labour and delivery in Ghana. Journal of BioMed Council. Public Health, 5, 140.

Dada, A. A. (2005). Access and use of maternal health facilities in Ido/Osi LGA, Ekiti State, Nigeria. Unpublished Thesis University of Ibadan.

Dairo, M. D., & Owoyokun, K. E. (2010). Factors affecting the utilization of antenatal care services in Ibadan, Nigeria. Benin Journal of Postgraduate Medicine, **12**, 3-13.

Dako-Gyeke, P., Snow R., & Yawson A. E. (2012). Who is utilizing anti-retroviral therapy in Ghana: an analysis of ART service utilization. International Journal of Equity & Health 2012, 11:62.

De Allegri, M., Ridde, V., Louis, V. R., Sarker, M., Tiendrebeogo, J., Ye, M., et al. (2011). Determinants of utilisation of maternal care services after the reduction of user fees: A case study from rural Burkina Faso. Health Policy, 99, 210–218.

Dennis, C. L, & Chung-Lee L. (2006). Postpartum depression help-seeking barriers and maternal treatment preference: a qualitative systematic review. Birth.;33:323–31.

Doctor, H. V. (2011). Intergenerational differences in antenatal care and supervised deliveries in Nigeria. Health Place 17:480–89.

Donald, D. M. (1994). Lower back pain during pregnancy," Nursing Journal of India, vol. 12, no. 15, pp. 43–49, 1994.

Donna V., & Barbara, K. (2005). Improving maternal health. e Journal USA*:* Economic Perspectives; 1- 7.

Duncombe, D., Wertheim, E. H., Skouteris, H., Paxton, S. J., & Kelly, L. (2009). "Factors related to exercise over the course of pregnancy including women's beliefs about the safety of exercise during pregnancy," Midwifery, vol. 25, no. 4, pp. 430–438, 2009.

Ekechi, C., Wolman, Y., & De Bernis, I. (2012). Maternal and new born health road maps: a review of progress in 33 sub-Saharan Africa countries, 2008-2009. Reproductive health matters, 20(39), 164-168. Doi:10.1016/s0968-8080(12)39630-4

Empowerment. (2001). Sexual and reproductive rights in Nigeria from legal and socio-cultural context. *Popline* Document Number: 187250. Oct-Dec; 9(7):20-22.

Erinosho O. (1982). Health planning in Nigeria. Nigerian Journal of Sociology and Anthropology 8: 34–49.

Erinosho, O.A. (1998). Health Sociology, Ibadan: Sam Bookman Educational Communication.

Erinosho, O.A. (2006). Health Sociology, Ibadan: Sam Bookman.

Essen, B., Johnsdotte, S., Hovelius, B., Gudmundsson, S., Sjoberg, N., Friedman, J., & Ostergren, P. (2000). Qualitative study of pregnancy and childbirth experiences in Somalian women residentin Sweden. British Journal of Obstetrics and Gynecology, *107*, 1507-1512.

Essendi, H., Mills, S., & Fotso, J. (2010). "Barriers to formal emergency obstetric care services' utilization." Journal of Urban Health: Bulletin of the New York Academy of Medicine 88 (2): s356–s369.

Estal, R. C., & R. D. Buchanan. (1968). "Industrial activity and economic geography"

London: Hutchinson.

Evenson, K. R., Moos, M., Carrier, K., & Siega-Riz, A. M. (2009). Perceived barriers to physical activity among pregnant women," Maternal and Child Health Journal, vol. 13, no. 3, pp. 364–375.

Ewa, E. E., Lasisi, C. J., Maduka, S.O., Ita, A.E., Ibor, U. W. & Anjorin, O. A. (2012). Perceived factors influencing the choice of antenatal care and delivery centres among childbearing women in Ibadan North South-Western, Nigeria. Ethiopian Journal of Environmental Studies and Management, **5**, 373-383. http://dx.doi.org/10.4314/ejesm.v5i4.6

Ezeonwu, M. C. (2011). Maternal birth outcomes: Processes and challenges in Anambra State, Nigeria. Health care for women international, 32(6), 492-514. Doi:10.1080/07399332.2011.555827

Falconer A. D. (2010). Millennium Goal 5. Journal of Obstetrics, Gynaecology and Reproductive Medicine (2010). 20(12):369– 371.

Faye, A., Niane, M., & Ba, I. (2011). Home birth in women who have given birth at least once in a health facility: Contributory factors in a developing country. Acta Obstetricia et Gynecologica Scandinavica, 90, 1239–1243.

Fayomi, O. O., & Igbokwe, N. (2009). Women's reproductive health—A question of human rights in the context of HIV/AIDS in Nigeria. *MP*: A Feminist Journal (Gender and Race), 2, 30.

Federal Ministry of Health and National Primary Health Care Development Agency (NPHCDA) Midwives Service Scheme (2009). Accelerating reduction in maternal, newborn and child mortality through improved access to skilled birth attendants. Retrieved from www.nphcda.gov.ng/.../MSS_HARMONIZED_CONCEPT_FINAL_AT-REIZ-HTL.doc

Freeman, M., & Motsei, M. (1992). Planning health care in South Africa--is there a role for traditional healers? Journal of Social Science and Medicine,; 34(11):1183-1190.

Friedman, & Hechter,. (1988). "The contribution of rational choice theory to macro Sociological research" Sociological Theory *6;201-218.*

Gabrysch, S., & Campbell, O.M.R. (2009). Still too far to walk: Literature review of the determinants of delivery service use. Journal of BioMed Council on Pregnancy and Childbirth, **9**, 34. http://dx.doi.org/10.1186/1471-2393-9-34

Gabrysch, S., Cousens, S., Cox, J., & Campbell, O. M. (2011). The influence of distance and level of care on delivery place in rural Zambia: A study of linked national data in a geographic information system. PLoS Medicine/Public Library of Science, 8, e1000394.

Galaa, S. Z., & Daare, K. (2008). Understanding barriers to maternal child health services utilization in northern Ghana. Journal of Social Development in Africa, 23, 127–155.

Geissler P. W., Prince R. J., Levene M., Poda C., Beckerleg, S. E., Mutemi W., & Shulman, C. E. (1999). Perceptions of soil-eating and anaemia among pregnant women on the Kenyan coast. Journal of Social Science and Medicine 1999, 48:1069–1079.

Geller, S.E. et al. (2006). Postpartum haemorrhage in resource-poor settings. International Journal of Gynecology and Obstetrics 92, 202–211.

Germov, John (ed) (2000). Challenges to medical dominance. In: Germov, J. (ed) Second opinion: An Introduction to Health Sociology. (Revised edition).Oxford: Oxford University Press, 230-248.

Geubbels, E. (2006). Epidemiology of maternal mortality in Malawi. Malawi Medical Journal 18(4) 206-225.

Gilmore, K., & Gebreyesus, T. A. (2012). What will it take to eliminate preventable maternal deaths? Lancent, 380, 87-88. Retrieved from http://dx.doi.org/10.1016/s0140-6736 (12)60982-9.

Gil-Gonza´ lez, D. et al. (2006). Knowledge gaps in scientific literature on maternal mortality: A systematic review. Bulletin of the World Health Organization 84(11), 903–909.

Glei, D. A., Noreen G., & Germa´n Rodriguez. (2003). "Utilisation of care during pregnancy in rural Guatemala: Does obstetrical need matter?" Journal of Social Science and Medicine 57 (12): 2447–2463.

Goodburn, E., & Campbell, O. (2001). "Reducing maternal mortality in the developing World: Sector-wide approaches may be the key." British Medical Journal 322 (7291): 917–920.

Goyal, D., Gay, C., & Lee K. A. (2010). How much does low socioeconomic status increase the risk of prenatal and postpartum depressive symptoms in first-time mothers? Women's Health Issues. 2010; 20:96–104.

Green E. C., & Makhubu L. (1984). Traditional healers in Swaziland: toward improved cooperation between the traditional and modern health sectors. Journal of Social Science and Medicine; 18(12):1071-1079.

Green, et. al (1974). "The research literature on why woman delay in seeking medical care for breast symptoms". Health Education Monograph. 2,2.

GSS/GHS: (2009). Ghana maternal health survey, 2007. Maryland: Ghana Statistical Service/Ghana Health Service/Macro international;.

Gulmezoglu, A. M. (2003). Promoting standards for quality of maternal health care. British Medical Bulletin 2003; 67:73-83.

Gyimah, S. O., Takyi, B. K., & Addai, I. (2006). Challenges to the reproductive-health needs of African women: On religion and maternal health utilization in Ghana. Journal of Social Science and Medicine, 62, 2930–2944.

Haque, M. N. (2009). Individual's characteristics affecting maternal health services utilization: Married adolescents and their uses of maternal health services in Bangladesh. International Journal of Health 8(2):1–15.

Harrison, K. A. (2003). Reproductive health struggles in Nigeria. Lancet. 362(9383), 582.

Hardy A. (2008). The integration of traditional and western medicine in Ngaoundéré, Cameroon. In: SIT Cameroon Fall 2008. Wesleyan University.

Hearn G, Iliff A, Jones I, Kirby A, Ormiston P, Parr P, et al. (1998). Postnatal depression in the community. British Journal of General Practices. 1998;48:1064–6.

HERFON, (2006). Nigerian health review. Publication of Health Reform Foundation of Nigeria

Herrel, N., Olevitch, L., Dubois, D., Terry, P., Throp, D., Kind, E., & Said, A. (2004). Somali refugee women speak out about their needs for care during pregnancy and delivery. Journal of Midwifery & Women's Health, *65*, 2-8.

Hill, K., Thomas, K., AbouZahr, C., Walker N., Lale, S., Inoue M., & Suzuki, E. (2007). Estimates of maternal mortality worldwide between 1990 and 2005: an assessment of available data. Lancet, 370:1311–1319.

Hindin, M. J. (2000). Women's power and anthropometric status in Zimbabwe. Journal of Social Science and Medicine, *51*, 1517–1528. doi:10.1016/s0277-9536(00)00051-4

Hinojosa, S. Z. (2004). "Authorizing Tradition: Vectors of Contention in Highland Maya Midwifery." Journal of Social Science and Medicine 59 (3): 637–651.

Hogan M. C., Foreman, K. J., Naghavi, M., Ahn, S. Y., Wang, M., Makela, S. M., et al. (2010). Maternal mortality for 181 countries, 1980–2008: a systematic analysis of progress towards millennium development goal 5. Lancet. ;375:1609–23.

Holopainen D. (2002). The experience of seeking help for postnatal depression. Australian Journal of Advance Nursing;19(3):39–44.

Holt-Lunstad, J., Smith, T. B., and Layton, J. B. (2010). Social relationships and mortality risk: A meta-analytic review. PLoS Medicine, 7, e1000316.

Honda A, Randaoharison PG, Matsui M.(2011). Affordability of emergency obstetric and neonatal care at public hospitals in Madagascar. Journal of Reproductive Health Matters 2011;19(37).

Hong, R., Ayad, M., and Ngabo, F. (2011). Being insured improves safe delivery practices in Rwanda. Journal of Community Health, 36, 779–784.

Hoope-Bender P, Liiljestrand J, MacDonagh S (2006). Human resources and access to maternal health care. International Journal of Gynaecology and Obstetrics 2006, 94:226–233.

Hoover, E.M. (1948). "The Location of Economic Activity", New York: McGraw-Hill.

Hounton, S., Byass, P., and Brahima, B. (2009). Towards reduction of maternal and perinatal mortality in rural Burkina Faso: Communities are not empty vessels. Global Health Action, 2(10). doi:10.3402/gha.v20.1947

Hounton, S., Chapman, G., Menten, J., De Brouwere, V., Ensor, T., and Sombie, I., (2008). Accessibility and utilisation of delivery care within a skilled care initiative in rural Burkina Faso. Tropical Medicine and International Health, 13(Suppl 1), 44–52.

Howson, C., Harrison, P., & Law, M. (Eds) (1996). In her lifetime: Female morbidity and mortality in sub-Saharan Africa. Washington, DC: National Academy Press; 1996.

Hunt, L. M., Glantz, N. M., & Halperin, D. C. (2002). Childbirth care-seeking behavior in Chiapas. Health Care Women International, 23(1):98–118.

Igun, V. (1962). "Models of health seeking behaviour". Nigerian perspective of medical Sociology. Ibadan: Colt. of William and Mercy.

Ikamari, L. D. E. (2004). Maternal health care utilization in Teso district. African Journal of Health Sciences 11:21–32.

Inhorn, M. C. (2002). The local confront the "global": infertile bodies and new reproductive technologies in Egypt. Eds Inhorn, M.C. and Van Balen, F. Infertility around the Globe. Berkeley: UCL 263-282.

INSTAT. (2010) Presentation des resultats de la cartographie numerique en preparation du troisieme recensement generale de la population et de l'habitation (Press release). 2010.

INSTAT. (2009) Region D'Anosy - enquête démographique et de santé Madagascar 2008-2009. Madagascar.

International Conference on Population & Development (ICPD). (1994): United Nations International Conference on Population and Development. 5- 13 September, 1994, Cairo , Egypt. Available at http://www.iisd.ca/cairo.html

International Forum on Globalization - IFG and Tebtebba. (2009). Implementing the United Nations declaration on the rights of indigenous peoples. San Francisco: IFG.

IRIN. (2011). Madagascar: a poor country gets poorer: IRIN humanitarian news and analysis - service of the UN Office for the Coordination of Humanitarian Affairs.

IRIN. (2012). Madagascar: a decaying health sector: IRIN humanitarian news and analysis - service of the UN Office for the Coordination of Humanitarian Affairs.

Isiugo-Abanihe, U. C. (2003). Male role and responsibility in fertility and reproductive health in Nigeria, Lagos: Ababa Press.

Issah, K., Nang-Beifubah, A., & Opoku C. F. (2011). Maternal and neonatal survival and mortality in the Upper West Region of Ghana. International Journal of Gynaecology Obstertric,; 113(3):208-210.

Iyaniwura, C. A., & Yussuf, Q. (2009). Utilization of antenatal care and delivery services in Sagamu, south western Nigeria. African Journal Reproductive Health/La Revue Africaine de la Santé Reproductive 13(3):111–22.

Jacob, A. B. (1977). A textbook of African traditional religions. Ibadan, Nigeria: Aromolaran Publishing Company

Jaffre, Y., & Prual, A. (1994). Midwives in Niger: an uncomfortable position between social behaviours and healthcare constraints. Journal of Social Science and Medicine 38 (8),1069–1073.

Jager, A. K. (2005). Is traditional medicine better off 25 years later? Journal of Ethnopharmacology; 100(12):3- 4.

Jansen, I. (2006). Decision making in childbirth: The influence of traditional structures in a Ghanaian village. International Nursing Review, 53, 41–46.

Jegede, A. S. (1998). African culture and health. Ibadan: Stirling Horden Publishers.

Jegede, A.O. (2007). Knowledge, opinion and attitude of household heads about reproductive health rights in Ibadan South West Local Government Area Oyo State Nigeria. University of Ibadan, Nigeria. P. 93

Jegede, A.S, & Fayemiwo, (2010). Cultural and ethical challenges of assisted reproductive technologies in the management of infertility among the Yoruba of South Western Nigeria. African Journal of Reproductive Health June 14(2): 115-127.

Jegede, A. S. (1989). Nurses perception of female physicians in Ile-ife, Nigeria. M.Sc.Dissertation, Obafemi Awolowo University, Ile-Ife, Nigeria.

Jejeebhoy, S. J. (2001). Women's autonomy in India and Pakistan: The influence of religion and Region. Population and Development Review, **27**, 687-712. http://dx.doi.org/10.1111/j.1728-4457.2001.00687.x

Jejeebhoy, S. J. (2002). Convergence and divergence in spouses' perspectives on women's autonomy in rural India. Studies in Family Planning, 33, 299-308. http://dx.doi.org/10.1111/j.1728-4465.2002.00299.x

Jenna, K., Muller, B., & Quiros, A. (2009). Women, men, and the changing role of gender in immigration. Student Research Series, **3**, 1-14.

Johnson, B., Reed, S., Hitti, J., & Batra, M. (2005). Increased risk of adverse pregnancy outcome among Somali immigrants in Washington State. American Journal of Obstetrics and Gynecology, *193*, 1-10.

Jose, L. A. (2010, April 21). Most maternal deaths in sub-Saharan Africa could be avoided'', Science Daily. Retrieved http://www.sciencedaily.com/releases/2010/02/100218092852.htm.

Kabir, M., Iluyasu, Z., Abubakar, I. S., & Sani, A. A. (2005). Determinants of utilization of antenatal care services in Kumbotso Village, Northern Nigeria. Tropical Doctor, 35, 110- 111. http://dx.doi.org/10.1258/0049475054036814

Kardel, K. R., & Kase, T. (1998). Training in pregnant women: effects on fetal development and birth," American Journal of Obstetrics and Gynecology, vol. 178, no. 2, pp. 280– 286.

Kasolo, J., & C. Ampaire. (2000). Knowledge, attitudes and practices of women and men towards safe motherhood in rural Settings. A Qualitative Study. Kampala: USAID.

Kistiana, S. (2009) Socio-economic and demographic determinants of maternal health care utilization in Indonesia. Unpublished Master's Thesis, The Flinders University of South Australia, Adelaide.

Kotecha, P., Patel, S., Shah, S., Katara, P., & Madan, G. (2012). Health seeking behaviour and utilization of health services by pregnant mothers in Vadodara slums. Healthline 2012, 3(1):30-32.

Krans, E. E., Gearhart, J. G., Dubbert, P. M., Klar, P. M., Miller, A. L., & Replogle, W. H. (2005). "Pregnant women's beliefs and influences regarding exercise during

pregnancy," Journal of the Mississippi State Medical Association, vol. 46, no. 3, pp. 67–73.

Kruk, M. E., Mbaruku, G., McCord, C. W., Moran, M., Rockers, P. C., & Galea, S. (2009). Bypassing primary care facilities for childbirth: A population-based study in rural Tanzania. Health Policy and Planning, 24(4), 279–288. doi:10.1093/heapol/czp011

Kruk, M. E., Mbaruku, G., Rockers, P. C., & Galea, S. (2008). User fee exemptions are not enough: Out-of-pocket payments for 'free' delivery services in rural Tanzania. Tropical Medicine and International Health, 13, 1442–1451.

Kruk, M. E., Rockers, P. C., Mbaruku, G., Paczkowski, M. M., & Galea, S. (2010). Community and health system factors associated with facility delivery in rural Tanzania: A multilevel analysis. Health Policy, 97(2–3), 209–216. doi:10.1016/j.healthpol.2010.05.002

Kyomuhendo, G. B. (2003). Low use of rural maternity services in Uganda: Impact of women' status, traditional beliefs and limited resources. Reproductive Health Matters, 11(21), 16–26. doi:10.1016/S0968-8080(03)02176-1

Lawoyin, T. O., Lawoyin, O. C. & Adewole, D. A. (2007). Men's perception of maternal mortality in Nigeria. Journal of Public Health Policy, 28, 299-318. http://dx.doi.org/10.1057/palgrave.jphp.3200143.

Leininger, M. (1996). Culture care theory, research, and practice. Nursing Science Quarterly 9(2),71-78.

Leslie, J., & Gupta, G. R. (1989). Utilization of formal services for maternal nutrition and health care. International Center for Research on Women, Washington DC.

Leutscher, P., Jensen, J. S., Hoffmann, S., Berthelsen, L., Ramarakoto, C. E, Ramaniraka, V., et al. (2005). Sexually transmitted infections in rural Madagascar at an early stage of the HIV epidemic: a 6-month community-based follow-up study. Sexually Transmitted Diseases 2005;32(3):150-55.

Levi, et al. (1990). "The limits of rationality." In K.S. Cook and M. Levi (eds), The Limits of rationality. Chicago: University of Chicago Press: 1-16.

Lieberman, E. S. (2007). Ethnic politics, risk, and policy-making: A cross-national statistical analysis of government responses to HIV/AIDS. Comparative Political Studies, 40, 1407-1432. http://dx.doi.org/10.1177/0010414007306862

Lindsey, A., Lubbock, L. A., & Stephenson, R. B. (2008). Utilization of maternal health care services in the department of Matagalpa, Nicaragua. American Journal of Public Health; 24:75–84.

Longwe, S. H. (2002). Assessment of the gender orientation of NEPAD. In: Nyong'o, P.A., Ed., New Partnership for Africa's Development NEPAD: A New Path, Heinrich Boll Foundation, Nairobi, 252-274.

Lori, J. R., & Boyle, J. S. (2011). Cultural childbirth practices, beliefs, and traditions in post-conflict Liberia. Health Care Women International; 32 (6):454-73.

Lozano, R., Wang, H., Foreman, K. J., Rajaratnam, J. K., Naghavi, M., Marcus, J. R., Dwyer-Lindgren, L., Lofgren, K. T., Phillips, D., Atkinson, C., et al (2011). Progress towards Millennium Development Goals 4 and 5 on maternal and child mortality updated systematic analysis. Lancet, 378(9797):1139–1165.

Lucas, O. J. (1978). The Religion of the Yoruba. Lagos: CMS Press

Lundberg, P. C., & Gerezgiher, (2008). "Experiences from pregnancy and childbirth related to female genital mutilation among Eritrean immigrant women in Sweden." Midwifery 24 (2): 214–225.

Mottola, M. F., & Ruchat, S. M. (2011). Exercise guidelines for women with gestational diabetes," in gestational diabetes by Miroslav Radenkovic, InTech, Rijeka, Croatia http://www.intechopen.com/books/gestational-diabetes/exercise-guidelines-for-women-with-gestationaldiabetes.

Riemann, M. K., & Hansen, I. K. (2000). Effects on the foetus of exercise in pregnancy," Scandinavian Journal of Medicine and Science in Sports, vol. 10, no. 1, pp. 12–19,

Mackian, S. (2003). A review of health seeking behaviour: problems and prospect. Working paper. Manchester: University of Manchester. Retrieved from http://r4d. dfid.gov.uk/PDF/Outputs/HealthSysDev_KP/05-03_health_seeking_behaviour. pdf.

Mafimiebi, T. E., Oguntade, A. E. & Mafimisebi, O. E. (2008). A Perspective of Patial Credit Guarantee Schemes in Developing Countries: A case Study of the Nigerian Agricultural Credit Guarantee Scheme Funds. A Paper Delivered at the World Bank Conference on Partial Credit Facility Schemes Held at the World Bank Main Building, Washington, D.C., USA.

Magoma, M., Requejo, J., Campbell, O. M. R., Cousens, S., & Filippi, V. (2010). "High ANC Coverage and Low Skilled Attendance in a Rural Tanzanian District: A case for Implementing a Birth Plan Intervention." BMC Pregnancy and Childbirth 10 (1): 13, http://www.biomedcentral. com/1471-2393/10/13

Maimbolwa, M.C., Yamba, B., Diwan, V., Ransj¨o-Arvidson, A., (2003). Cultural childbirth practices and beliefs in Zambia. Journal of Advanced Nursing 43 (3), 263–274.

Maine, D. (2002). Why aid maternal mortality decline in Materlab? Studies in Family Planning 27(4): 179-187.

Mama, A. (1996) Women's studies and studies of women in Africa during the 1990s Dakar, CODESRIA: Working Paper Series 5/96.

Marieke, Van Dijk, Marta Julia Ruiz, Diana Letona and Sandra G. Garcia (2013). Ensuring intercultural maternal health care for Mayan women in Guatemala: a qualitative assessment, Culture, Health and Sexuality, 15:sup3,S365-S382, DOI: 10.1080/13691058.2013.779026

Marmot, M. (2005). Social determinants of health inequalities. The Lancet, **365**, 1099-1104. http://dx.doi.org/10.1016/S0140-6736(05)74234-3

Martey, J. O. (1995). Utilization of maternal health services in Ejisu District. West African Journal of Medicine, 14, 24–28.

Martin, M. T., Mcnamara, M. J., Millot, A. S., Halleh, T., & Hair, E. C. (2007). The Effect of father involvement during pregnancy and receipt of prenatal care and maternal smoking'', Maternal and Child Journal 11, 595-602.

Mathole, T., Lindmark, G., Majoko, F., & Ahlberg, B. M. (2004). A qualitative study of women's perspectives of antenatal care in a rural area of Zimbabwe. Midwifery, 20(2):122–132.

Matsumura, M., & Gubhaju, B. (2001). Women's status, household structure and the utilization of maternal health service in Nepal. Asia Pacific Population Journal 16(1):23–44.

Maupin, Jonathan. (2008). Remaking the Guatemalan midwife: Health care reform and midwifery training programs in highland Guatemala." Medical Anthropology 27 (4): 353–382.

McCarthy, J. & Maine, D. (1992). A framework for analyzing the determinants of maternal mortality. Studies in Family Planning, 23, 23-33. http://dx.doi.org/10.2307/1966825

Mekonnen, Y. & Mekonnen, A. (2002). Utilization of maternal health care services in Ethiopia. ORC Marco, Maryland.

Metz, H. C. (1991). Nigeria: A country study. Washington: GPO for the Library of Congress.

Mignone, J., Jessica, H., Hugo, I., Carol, C., Garry, M., Me´lida, J., & Rosa, C. (2009). "Strengthening indigenous and intercultural midwifery: Evaluation of a collaboration between Guatemalan and Canadian aboriginal organizations." Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health 7 (1): 133–155.

Millennium Development Goals Report, (2014). United Nations.

Mills, S., & Bertrand, J. T. (2005). Use of health professionals for obstetric care in northern Ghana. Studies in Family Planning, 36(1), 45–56. doi:10.1111/j.1728-4465.2005.00040.x

Mills, S., Williams, J. E., Adjuik, M., & Hodgson, A. (2008). Use of health professionals for delivery following the availability of free obstetric care in northern Ghana. Maternal and Child Health Journal, 12(4), 509–518. doi:10.1007/s10995-007-0288-y

Ministry of Health (2011). Government of Ghana & United Nations Team: Ghana MDG Acceleration Framework and Country Action Plan for Maternal Health. Accra: MoH/GoG;.

Ministry of Health. (2010). Health sector strategic plan iii 2010/11-2014/15. Kampala: Ministry of Health.

Montagu, D., Yamey, G., Visconti, A., Harding, A., & Yoong, J. (2011). Where do poor women in developing countries give birth? A multi-country analysis of demographic and health survey data. PLoS ONE, 6(2), e17155. doi:10.1371/journal.pone.0017155.s002

Moran, C. F., Holt, V. L. & Martin, D. P. (1997). What do women want to know after childbirth?" Birth, vol. 24, no. 1, pp. 27–34.

Moronkola O. A., Omonu J. B., Iyayi D. A., & Tiamiyu M. A. (2007). Perceived determinants of the utilization of maternal health-care services by rural women in Kogi State, Nigeria. Tropical Doctor ; 37: 94-96.

Morrow M, Smith J. E., Lai Y., & Jaswal S. (2008). Shifting landscapes: immigrant women and postpartum depression. Health Care Women Int.;29:593–617.

Mosley, W. H. (1984). Child survival: Research and policy. Population and Development Review, 10, 3-23. http://dx.doi.org/10.2307/2807953

Mosley, W. H., & Lincoln, C. C. (1984). An analytical framework for the study of child survival in developing countries. Population and Development Review, 10, 25-45. http://dx.doi.org/10.2307/2807954

Mrisho, M., Obrist, B., Schellenberg, J., Haws, R., Mushi, A., Mshinda, H., & Schellenberg, D. (2009). The use of antenatal and postnatal care: Perspectives and experiences of women and health care providers in rural southern Tanzania. BMC Pregnancy and Childbirth, 9(10). doi:10.1186/1471-2393-9-10

Mrisho, M., Schellenberg, J. A., Mushi, A. K., Obrist, B., Mshinda, H., Tanner, M., & Schellenberg, D. (2007). Factors affecting home delivery in rural Tanzania. Tropical Medicine and International Health, 12(7), 862–872. doi:10.1111/j.1365-3156.2007.01855.x

Muchabaiwa, L., Mazambani, D., Chigusiwa, L., Bindu, S.& Mudavanhu, V. (2012). Determinants of maternal healthcare utilization in Zimbabwe. International Journal of Economic Sciences and Applied Research, **5**, 145-162.

Mullay, B. C., Hindin, M. J., & Becker, S. (2005). Can women's autonomy impede male involvement in pregnancy health in Kathmandu, Nepal?'', Journal of Social Science and Medicine. 61(9):1993- 2006.

Mumtaz Z, & Salway S. M (2007). Gender, pregnancy and the uptake of antenatal care services in Pakistan. Sociology of Health and Illness 2007, 29(1):1–26.

Mushi, D., Mpembenji, R., & Jahn, A. (2010). Effectiveness of community based safe motherhood promoters in improving the utilization of obstetric care. The case of Mtwara rural district in Tanzania. BMC Pregnancy and Childbirth, 10(14). doi:10.1186/1471-2393-10-14

Nanjala, M. & Wamalwa, D. (2012). Determinants of male partner involvement in promoting deliveries by skilled attendants in Busia'', Kenya. Global Journal of Health Science, 4(2): 60-67. [Online] Available: www.ccsenet.org/gjhs (April 21st, 2014)

National Population Commission & ICF Macro. (2009). Nigeria 2008 Demographic and health survey. Abuja, Nigeria: National Population Commission and ICF Macro, Calverton, Maryland, USA.

Navaneetham, K. & Dharmalingam, A.(2000). Utilization of maternal healthcare services in South India. Faculty seminar at the Centre for Development Studies, Thiruvananthapuram, 31 March 2000, 1-40.

Neema, S. (1994). "Mother and Midwives: Maternity care options in Ankole Southwest Uganda." PhD thesis, University of Copenhagen.

Nelms L.W & Gorski J. (2006). The role of the African traditional healer in women's health. Journal of Transcultural Nursing; 17(2):184-189.

Nigeria Demographic & Health Survey (NDHS) (2000). Nigeria: DHS, 1999—Final Report. Measure DHS, Calverton.

Nuraini, E. & Parker, E. (2005). ‘‘Improving knowledge of antenatal care (ANC) among pregnant women: a Field trial in Central Java, Indonesia’’, Asia Pacific Journal of Public Health, 17(1):3-8.

Nwakoby B. A. N. (1994). Use of obstetric services in rural Nigeria. Journal of Reproductive & Social Health; 114:132-136.

Nwokocha, E. E. (2004). “Socio-cultural factors affecting pregnancy outcomes among the Ibani of Rivers State”. A Ph.D Thesis submitted to University of Ibadan.

Oates, M. R., Cox, J. L., & Neema, S. (2004). Post-natal depression across countries and cultures: a qualitative study. British Journal of Psychiatry; 184(suppl.46):10S–6S.

Obermeyer, C. M. (1993). Culture, maternal health care, and women’s status: A comparison of Morocco and Tunisia. Studies in Family Planning, **24**, 354-365. http://dx.doi.org/10.2307/2939245

Obionu, C. N. (2007). Primary health care for developing countries. Second edition. Institute for Development Studies UNEC. Enugu. p 217- 240.

Ochako, R., Fotso, J. C., Ikamari, L., & Khasakhala, A. (2011). Utilization of maternal health services among young women in Kenya: Insights from the Kenya Demographic and Health Survey, 2003. Journal of BioMed Council on Pregnancy & Childbirth, 11, 1.

Odemerho, B. I., & Baier, M. (2012). “Female genital cutting and the need for culturally competent communication.” The Journal for Nurse Practitioners 8 (6): 452–457.

Odoi-Agyarko, Dallimorre, & Owusu-Argye (1993). “Risk Factors in maternal mortality: A community- based study in Kassena Nankani District”. Paper presented at the national consultative meeting on safe motherhood, Accra, Ghana, January 1993.

Ogbuile, J. N., Ogueke, C. C. & Nwanebu, F. C. (2007). Antibacteria properties of *uvaria chamae, gongronema latifolium, garcinia kola, vernonia amygdalina and aframomum melegueta*. Africa Journal of Biotech; 6(13):159-1553.

Ogundele, S. O. (2007). Aspect of indegenous medicine in South Western Nigeria. Ethno-Med; 1(2): 127-133.

Okafor, C. B., (2000). Folklore linked to pregnancy and birth in Nigeria. Western Journal of Nursing Research 22 (2) , 189–202.

Okafor, C. B., & Rizzuto, R. R. (1994). Women’s and health-care providers’ views of maternal practices and services in rural Nigeria. Studies in Family Planning 25 (6), 353–361.

Okeshola, F. B., & Ismail, T. S. (2013). Determinants of home delivery among Hausa in Kaduna South Local Governmen Area of Kaduna State, Nigeria. American International Journal of Contemporary Research, **3**, 78.

Okonofua, F., Harris, D., Odebiyi, A., Kane, T., & Snow, R. C. (1997). The social meaning of infertility in south-west Nigeria. The cultural, social and behavioural determinants of health. Health Transition Review: 7.2:205-220.

Olagunju, O. S. (2012). The traditional healing system among the Yoruba. Archeological Science Journal; 1(2): 6-14.

Olson, J. & Nkiwane, S. (2006). Integrate for efficiency: Traditional Yoruba medicine in Nigeria, GS 218 Introduction to Africa, Colorado College.

Olusanya, B. O., Alakija, O. P., & Inem, V. A. (2010). Non-uptake of facility-based maternity services in an inner-city community in Lagos, Nigeria: An observational study. Journal of Biosocial Science, 42, 341–358.

Omenyo, C. (2006). Pentecost outside pentecostalism: a study of the development of charismatic renewal in the mainline churches in Ghana. Netherlands: Boekencentrum Publishing;

Omideyi, A. (1987). Status, cultural beliefs and fertility behavior among Yoruba women. In: Ebigbola, J. & Van de Walle, E., Eds., The cultural roots of African fertility Regimes: Proceedings of the Ife Conferences, Obafemi Awolowo University, Ile-Ife and University of Pennsylavania, Philadelphia, 151-165.

Omoruyi, G. (2008) Causes of maternal mortality in Nigeria. Sunday Observer.

Onah, H. E., Ikeako, L. C., & Iloabachine, G. C. (2006). Factors associated with the use of maternity service in Enugu south eastern Nigeria. Journal of Social Science & Medicine 63:1870–8.

Onasoga, O.A., Afolayan, J.A. & Oladimeij, B.D. (2012). Factors Influencing Utilization of Antenatal Care Services among Pregnant Women in Ife Central Lga, Osun State, Nigeria. Advances in Applied Science Research, **3**, 1309-1315.

Osakue, G. & Martin-Hilber, A. (1998). "Women's sexuality and fertility in nigeria: breaking the culture of silence" in: Petchesky, R.P. and Judd, K (eds) Negotiating reproductive rights: women's perspective across countries and cultures. London: ZED. 180 - 216.

Osubor K. M., Fatusi, A. O., & Chiwuzie, J. C. (2006). Maternal health-seeking behaviour and associated factors in a rural Nigerian community. Maternal Child Health Journal; 10:159-169.

Otchere, S. A., & Kayo, A. (2007). The challenges of improving emergency obstetric care in two rural districts in Mali. International Journal of Gynecology and Obstetrics, 99(2), 173–182. doi:10.1016/j.ijgo.2007.07.004

Owumi, B., & Raji, S. O. (2013). Socio-cultural determinants of maternal health care seeking behavior in Seme side of Benin Republic. African Journal of Social Sciences, **3**, 145-158.

Parpart, J., Connelly, M., & Barriteu, V. (2000). Theoretical perspectives on gender and development. International Development Research Centre, Ottawa.

Paula, G., & Rob, S. (2001). Understanding users' perspectives of barriers to maternal health care use in Maharashtra India. Journal of Biosocial Science 2001, 33(03):339–359.

Penfold, S., Harrison, E., Bell, J., & Fitzmaurice, A. (2007). Evaluation of the delivery fee exemption policy in Ghana: Population estimates of changes in delivery service utilization in two regions. Ghana Medical Journal, 41, 100–109.

Pfeiffer, C., & Rosemarie, M. (2013). Delivering at home or in a health facility? Health seeking behaviour of women and the role of traditional birth attendants in Tanzania. Journal of BioMed Council on Pregnancy & Childbirth 2013, 13(55):1–10.

Piane, G. M. (2009). Evidence-based practices to reduce maternal mortality: A systematic review. Journal of Public Health 31 (1), 26–31.

Pivarnik, J. M., Chambliss, H. O. Clapp J. F. et al., (2006). Impact of physical activity during pregnancy and postpartum on chronic disease risk," Medicine and Science in Sports and Exercise, vol. 38, no. 5, pp. 989–1006.

Ploch L.,& Cook N.(2012). Madagascar's political crisis: Congressional Research Service.

Population Council. (2010). Sistematizacio´n de servicios de salud con pertinencia cultural. Guatemala City: Population Council Guatemala.

Population Reference Bureau. (2011). The world's women and girls 2011 (data sheet): Population Reference Bureau.

Preston, S. H., & Haines, M. R. (1991). Fatal years: Child mortality in late nineteenth century America. Princeton University Press, Princeton. http://dx.doi.org/10.1515/9781400861897

Rahman, S. A. (2000). Utilization of primary health care services in rural Bangladesh: the population and provider perspectives. Unpublished PhD Thesis, London School of Hygiene and Tropical Medicine, University of London.

Rai, R. K., Singh, L. (2012). Utilization of maternal health care services among married adolescent women: insights from the Nigerian demographic and health Survey, 2008. Women's health issues, 22(4), e407-414. Doi:10.1016/j.whi.2012.05.001.

Renne, E. P. (1993). Gender ideology and fertility strategies in an Ekiti Yoruba Village. Studies in Family Planning, **24**, 343-353. http://dx.doi.org/10.2307/2939244

Repogle, Jill. (2007). "Training traditional birth attendants in Guatemala." Lancet 369 (9557): 177–178.

Ribeiro, C. P., & Milanez, H. (2011). Knowledge, attitude and practice of women in Campinas, S˜ao Paulo, Brazil with respect to physical exercise in pregnancy: a descriptive study," Journal of Reproductive Health, vol. 8, no. 1, p. 31, 2011.

Ridde, V., & Diarra, A. (2009). A process evaluation of user fees abolition for pregnant women and children under-five Years in Niger (West Africa). Journal of BioMed Council Health Services Research 9: 89.

Ritzer, G. (1996). "Sociological Theory" (4th ed.) New York: The McGraw-Hill Companies, Inc.

Roost, M., Sara J., Jerker, L., & Birgitta, E. (2004). A qualitative study of conceptions and attitudes regarding maternal mortality among traditional birth attendants in Rural Guatemala. BJOG: An International Journal of Obstetrics and Gynecology 111 (12): 1372–1377.

Rockers, P. C., Wilson, M. L., Mbaruku, G., & Kruk, M. E. (2009). Source of antenatal care influences facility delivery in rural Tanzania: A population-based study. Maternal and Child Health Journal, 13(6), 879–885. doi:10.1007/s10995-008-0412-7

Rodrigues M., Patel, V., Jaswal, S., & DeSouza, N. (2003). Listening to mothers: qualitative studies on motherhood and depression from Goa, India. Journal of Social Science and Medicine. 2003;57:1797–806.

Rogo, K. O., Oucho, J., & Mwalali, P. (2006). Maternal mortality. In D. T. Dean, T. Jamison, R., G. Feachem, M. W. Makgoba, E. R. Bos, F. K. Baingana,…K. O. Rogo (Eds.), Disease and mortality in sub-Saharan Africa (2nd ed., pp. 223–236). Washington, DC: World Bank.

Ronsmans, C. & Graham, W. J. (2006). Maternal mortality: who, when, where, and why. Lancet 2006, 368(9542):1189–1200.

Roost, M., Johnsdotter, S., Liljestrand, J., & Essen, B., (2004). A qualitative study of conceptions and attitudes regarding maternal mortality among traditional birth attendants in rural Guatemala. British Journal of Obstetrics and Gynecology: An International Journal of Obstetrics and Gynaecology 111, 1372–1377.

Rosenstock, I. M. (1966). "Why people use health services". Milbank Memorial Fund Quarterly. 44:94-127.

Ruiz, M. J., Van Dijk, M. G., Berdichevsky, K., Munguı´a, A., Burks, C., & Garcı´a. S. G. (2013). Barriers to the use of maternity waiting homes in indigenous regions of Guatemala: A study of users' and community members' perceptions." Culture, Health and Sexuality 15 (2): 205–218.

Morkved, S., Bo, K., Schei, B., & Salvesen, K. A. (2003). Pelvic floor muscle training during pregnancy to prevent urinary incontinence: a single-blind randomized controlled trial," Obstetrics and Gynecology, vol. 101, no. 2, pp. 313–319, 2003.

Sackey, B. (2002). Faith healing and women's reproductive health. Research Review 2002, 18(1):5–12.

Sargent, C. (1984). "Between death and shame: Dimensions of pain in Bariba culture." Journal of Social Science and Medicine 19 (12): 1299–1304.

Schim S. M., Doorenbos A., Benkert, R., & Miller J. (2007). Culturally congruent care: putting the puzzle together. Journal of Transcultural Nursing *2007*;18(2):103-10.

Schouten, B. C., & Meeuwesen, L. (2006). Cultural differences in medical communication: A review of the literature. Patient Education and Counseling, 64, 21–34.

Schram, R. (1966). Development of Nigerian health services, 1940-1966. MD Thesis accepted by the Cambridge University, UK under the Title " A Breif History of Public Health in

Nigeria", 1966. Published by the University of Ibadan Press in 1971 under the title, "A History of Nigerian Health Services.

Secka, E. (2010). Men's involvement in care and support during pregnancy and childbirth'', A thesis submitted to the Department of General Practice and Community Medicine, Institute of Health and Society, Oslo University.

Seljeskog, L., Sundby, J., & Chimango, J. (2006). Factors influencing women's choice of place of delivery in rural Malawi–an explorative study. African Journal of Reproductive Health, 10 (3):66–75.

Shah, I. H. & Say, L. (2007). Maternal mortality and maternity care from 1990-2005: Uneven but important gains. Reproductive Health Matters, **15**, 17-27. http://dx.doi.org/10.1016/S0968-8080(07)30339-X

Shaikh, B. T., Haran, D., & Hatcher, J. (2008). Women's social position and health seeking behaviours: Is the health care system accessible and responsive in Pakistan? Health Care Women International 29(8):945–56. doi:10.1080/07399330802380506.

Sharp, M., & Kruse, I. (2011) Health, nutrition and population in Madagascar 2000–09. World Bank working paper 2011;Africa Human Development Series (216).

Shiferaw, S., Spigt, M., Godefrooij, M., Melkamu, Y., & Tekie, M. (2013). Why do women prefer home births in Ethiopia? BMC Pregnancy Childbirth 2013, 13:5. doi:10.1186/1471-2393-13-5

Sibley, L. M. et al., (2009). Cultural theories of postpartum bleeding in Matlab, Bangladesh: Implications for community health intervention. Journal of Health Population and Nutrition 27 (3), 379–390.

Simkhada B, Teijlingen E. R, Porter M., & Simkhada P (2008). Factors affecting the utilization of antenatal care in developing countries: systematic review of the literature. J Adv Nurs 2008, 61(3):244–260.

Singh, K., Bloom, S., Haney, E., Olorunsaiye, C., & Brodish, P. (2012). Gender factors and facility delivery: Nigeria and MDG5. African Journal of Reproductive Health, 16, 122–128.

Singh, K., Haney, E., & Olorunsaiye, C. (2013). Maternal autonomy and attitudes towards gender norms: Associations with childhood immunizations in Nigeria. Maternal and Child Health Journal, 17, 837–841. doi:10.1007/s10995-012- 1060-5

Singh, S., Darroh, J., Vlassoff, M., & Nadeau, J. (2006). The benefits of maternal health care. Sexual and Reproductive Health Care'', New York.

Small, R., Gagnon, A., Gissler, M., Zeitlin, J., Bennis, M., Glaziner, R. H.,Vangen, S., Stoltenberg, C., Johansen, R., Sundby, J., & Stray- Pedersen, B. (2002). Perinatal complications among ethnic Somalis in Norway. Acta Obstetricia et Gynecologica Scandinavica, *81*, 317-322.

Smith, K. V., and Sulzbach, S. (2008). Community-based health insurance and access to maternal health services: Evidence from three West African countries. Journal of Social Science and Medicine, 66, 2460–2473.

Soares, R. R. (2005). Mortality reductions, educational attainment, and fertility choice. American Economic Review, 95, 580-601. http://dx.doi.org/10.1257/0002828054201486

Sofowora, A. (2008). Medicinal plants and traditional medicine in Africa. Edition 3, Spectrum Books Ltd, Ibadan, Nigeria.

Spangler, S. A., & Bloom, S. S. (2010). Use of biomedical obstetric care in rural Tanzania: The role of social and material inequalities. Journal of Social Science and Medicine, 71, 760–768.

Steenkamp, V., Stewart, M. J. & Zuckerman, M. (2000). Clinical and analytical aspects of pyrrolizidine poisoning caused by South African traditional medicines. The Drug Monitor, 2000; 22(3):302-306.

Stephens, C., Porter, J., Nettleton, C., & Willis, R. (2006). "Disappearing, displaced, and undervalued: A call to action for indigenous health worldwide." The Lancet 367 (9527): 2019–2028.

Stephenson, R., & O'Connor, L. (2000) Obstetric and gynaecologic care in physical therapy, Charles B. Slack, Thorofare, NJ, USA, 2ndn edition.

Stephenson, R., Baschieri, A., Clements, S., Hennink, M., & Madise, N. (2006). Contextual influences on the use of health facilities for childbirth in Africa. American Journal of Public Health, 96, 84-93. http://dx.doi.org/10.2105/AJPH.2004.057422

Stokols, D. (1996). Translating social ecological theory into guidelines for community health promotion. American Journal of Health Promotion 10(4):282–98.

Stycos, J. M. (1996). Men, couples and family planning: A retrospective look'', Working paper No. 96- 12. Cornell University Population and Development Program, Ithaca, New York.

Subramanian, S. V., Belli, P., & Kawachi, I. (2002). The macroeconomic determinants of health. Annual Review of Public Health, **23**, 287-302. http://dx.doi.org/10.1146/annurev.publhealth.23.100901.140540

Wang, T. W., & Apgar, B. S. (1998). "Exercise during pregnancy," American Family Physician, vol. 57, no. 8, pp. 1846–1852, 1998.

Tabi M. M., Powell, M., & Hodnicki, D. (2006). Use of traditional healers and modern medicine in Ghana. International Nursing Review, 2006; 53(1):52-58.

Tann, C. J., Kizza, M., Morison, L., Mabey, D., Muwanga, M., Grosskurth, H., et al. (2007). Use of antenatal services and delivery care in Entebbe, Uganda: A community survey. Journal of BioMed Council on Pregnancy & Childbirth, 7, 23.

Telfer, M. L., Rowley, J. T., & Walraven, G. E. (2002). Experiences of mothers with antenatal, delivery and postpartum care in rural Gambia. African Journal of Reproductive Health, 6, 74–83.

Teng, L., Robertson, Blackmore, E., & Stewart, D. (2007). Healthcare workers perceptions of barriers to care by immigrant women with postpartum depression: an exploratory qualitative study. Arch Womens Mental Health. 2007;10:93–101.

Thaddeus, S & Maine, D. (1994). "Too far to walk: Maternal mortality in context". Journal of Social Science and Medicine 38 (8),1091-1110.

Thaddeus, S., & Nangalia, R., (2004). Perceptions matter: barriers to treatment of postpartum hemorrhage. Journal of Midwifery and Women's Health 49 (4), 293–297.

Theuring, S. et al., (2009). ''Male Involvement in PMTCT services in Mbeya Region, Tanzania'', AIDS and Behaviour, 13: 92–102.

Thornton, P. L., Kieffer, E. C., Salabarr´ıa-Pe˜na Y. et al., (2006) "Weight, diet, and physical activity-related beliefs and practices among pregnant and postpartum latino women: the role of social support," Maternal and Child Health Journal, vol. 10, no. 1, pp. 95–104.

Thwala, S. B., Jones L. K, & Holroyd E. (2011) Swaziland rural maternal care: ethnography of the interface of custom and biomedicine. International Journal for Nurse Practitioners 2011;17(1):93-101.

Tunde, S. (2007). Factors enabling and constraining the use of maternal and new-born health services in Northern Nigeria: Formative research findings and implications. A paper presented at the 135th Annual Meeting and Exposition on (November 3-7, 2007) of American Public Health Association (APHA).

Uganda Bureau of Statistics (UBOS) and ICF International. (2012). Uganda Demographic and Health Survey 2011. Kampala, Uganda: UBOS and ICF International.

Ugarriza, D. N. (2004). Group therapy and its barriers for women suffering from postpartum depression. Arch Psychiatric Nursing. 2004;18: 39–48.

Uguru, N. P., Uzochukwu B. S. C., Onwujekwe, O. E., Obikeze, E. .N., & Onoka, C. (2003). Inequality in utilization of maternal health services in South-East Nigeria: Implications for reducing maternal mortality. Journal of Community Medicine and PHC 2003; 15:10-16.

Ukwuomah, B. & Da Coaster, K. (1997). Government may soon formulate crude drugs herbal policy. In the Guardian Newspaper (Nigeria):3,4.

UN Department of Economic and Social Affairs. (2013). The Millennium Development Goals report 2013. New York: UN Department of Economic and Social Affairs. http://www.un.org/millenniumgoals/pdf/report-2013/mdg-report-2013- english.pdf.

UNFPA. (2010). Reducing maternal mortality: the contribution of the right to the highest attainable standard of health. University of Essex, Essex, UK: Human Rights Centre.

UNFPA, (2010). The maternal health thematic fund. Annual Report 2010. New York: United Nations Population Fund.

UNFPA.(2011). The state of the world's midwifery: delivering health, saving lives UNFP.

UNICEF.(2013). At a glance: Ghana. Unicef.org. Retrieved March 2, 2013, from [http://www.unicef.org/ infobycountry/ghana_statistics.html#93]

United Nations Department of Economic and Social Affairs. (2011). World urbanization prospects, the 2011 revision: Data on urban and rural populations. Retrieved from http://esa.un.org/unpd/wup/CD-ROM/Urban-Rural-Population.htm

United Nations Population Fund. (2012). Sub-Saharan Africa's maternal death rate down 41 percent. Retrieved January 29, 2013, from http://africa.unfpa.org/ public/cache/offence/news/pid/10767

United Nations (2012). The Millenium Development Goals Report 2011. New York: United Nations.

Van der Geest S. (1997). Is there a role for traditional medicine in basic health services in Africa? A plea for a community perspective. Tropical Medicine & International Health, 1997; 2(9):903-911.

Van Dijk R. A. (1997). From camp to encompassment: discourses of trans subjectivity in the Ghanaian pentecostal diaspora. Journal of Religion in Africa 1997, 27(2):135–159.

Wadsworth, P. (2007) "The benefits of exercise in pregnancy," Journal for Nurse Practitioners, vol. 3, no. 5, pp. 333–339.

Waiswa, P., M. Kemigisa, J. Kiguli, S. Naikoba, G. W. Pariyo, & S. Peterson. (2008). Acceptability of evidence-based neonatal care practices in rural Uganda – Implications for programming. Journal of BioMed Council on Pregnancy and Childbirth 8 (1): 21, http://www.biomedcentral.com/1471-2393/8/21

Waiswa, P., S. Peterson, G. Tomson, and G. W. Pariyo. (2010). "Poor newborn care practices – A population based survey in Eastern Uganda." BioMed Council on pregnancy and childbirth 10 (1): 9, http://www.biomedcentral.com/1471-2393/10/9

Wall, L.L. (1998). Dead mothers and injured wives: The social context of maternal morbidity and mortality among the Hausa of Northern Nigeria. Studies in Family Planning, 29, 341-359. http://dx.doi.org/10.2307/172248

Wang, W., Alva, S., Wang, S., & Fort, A. (2011). Levels and trends in the use of maternal health services in developing countries. DHS comparative reports no. 26. Calverton, Maryland: ICF Macro.

Warren, D. M., Bova, G. S., Tregoning, M. A., & Kliewer, M. (1982). Ghanaian national policy toward indigenous healers. The case of the primary health training for indigenous healers PRHETIH) program. Journal of Social Science & Medicine, 1982; 16(21):1873-1881.

Welaga, P., Moyer, C. A., Aborigo, R., Adongo, P., Williams, J., Hodgson, A., Oduro, A., & Engmann, C. (2013).Why are babies dying in the first month after birth? A 7-year study of neonatal mortality in northern Ghana. PLoS One, 2013; 8(3):e58924.

White, D., Dynes, M., Rubardt, M., Sissoko, K., & Stephenson, R. (2013). The influence of intra-familial power on maternal health care in Mali: Perspectives of women, men and mothers-in-law. International Perspectives on Sexual and Reproductive Health, 39, 58-68.

World Bank, 2004. "A new agenda for women's health and nutrition". Washington, DC: World Bank.

World Bank. (2013). Trends in maternal mortality: *1990–2010*. Estimates developed by WHO, UNICEF, UNFPA and The World Bank. Retrieved February 6, 2013, from http://data.worldbank.org/indicator/SH.STA.MMRT

World Bank. (2012). Madagascar overview: The World Bank Group, 2012.

World Bank. (2013) Madagascar: Measuring the impact of the political crisis: The World Bank Group, 2013.

World Bank. (2011). Reproductive health at a glance. Madagascar, April 2011.

World Bank, (2012). Madagascar overview: The World Bank Group. 2012

WHO, UNICEF, UNFPA, & the World Bank. (2010a). Trends in maternal mortality: 1990 to 2008.

WHO, UNICEF, UNFPA, World Bank. (2012). Trends in maternal mortality, 1990–2010. Geneva: World Health Organization.

World Health Organization. (1996). Final report of the seminar on the use of medicinal plants in health care. WHO WPRO Publication, Tokyo

World Health Organization. (2014). Maternal Health: WHO.

World Health Organization. (1978) Primary health care. Report of the international conference on primary health care, Alma-Ata, USSR, World Health Organization, Geneva. 1978:63.

World Health Organization, (2002). "Reducing the risk, promoting healthy life". WHO. Geneva

Wissink, L., Jones-Webb, R., Dubois, D., Krinke, B., & Ibrahim, Q. (2005). Improving healthcare provision to Somali refugee women. Minnesota Medicine, *88*, 1-9.

Woldemicael, G. (2010). Do women with higher autonomy seek more maternal health care? Evidence from Eritrea and Ethiopia. Health Care for Women International, 31, 599– 620.

Wolfe L. A. and Davies, G. A. L. (2003). "Canadian guidelines for exercise in pregnancy," Clinical Obstetrics and Gynecology, vol. 46, no. 2, pp. 488–495.

World Health Organization. (1978). "primary health care" Report on the international conference on primary health care. Alma Ata, USSR 6-12 September. WHO. Geneva.

World Health Organization (1998). Improved access to maternal health service. WHO. Geneva.

World Health Organization (2005). The world health report 2005. WHO. Geneva.

World Health Organization. (2003). Integration of the human rights of women and the gender perspective. Statement by WHO on 10 April, 2003: UN Commission on Human Rights. Agenda item.12. p2

World Health Organization, (1999). "Making a difference". WHO. Geneva.

World Health Organization, (2002). "Reducing the risk, promoting healthy life". WHO. Geneva.

World Health Organization. (2012, April 21). Male involvement in the preparation of mother-to-child transmission. Retrieved from www.who.int/reproductivehealth.

World Health Organization. (2008). Improve the quality of maternal health services. Geneva, Switzerland,

World Health Organization. (1998). Division of reproductive health (technical support), 4 (World Health Day– 7April: Safe motherhood / WHO 98.8) accessed 14th August 2008.

Wu, G., Bazer, F. W., Wallace, J. M., & Spencer, T. E. (2006*).* Intrauterine growth retardation: Implications for the animal sciences. Journal of Animal Science, 84:2316-2337.

Zere, E., M. Kirigia, J., Duale, S., & Akazili, J. (2012). "Inequities in maternal and child health outcomes and interventions in Ghana." BioMed Council on Public Health 12: 252.

Zere, E., Oluwole, D., Kirigia, J. M., Mwikisa, C. N., & Mbeeli, T. (2011). Inequities in skilled attendance at birth in Namibia: A decomposition analysis. Journal of BioMed Council on Pregnancy Childbirth, 11, 34.

Zere, E., Tumusiime, P., Walker, O., Kirigia, J., Mwikisa, C., & Mbeeli, T. (2010). "Inequities in utilization of maternal health interventions in Namibia: Implications for progress towards MDG 5 targets." International Journal for Equity in Health 9: 16.

Zola, I. K. (1964). "Illness behaviour of the working class: Implications and recommendations". Shostak, A. et al. (eds) Blue Collar World. Englewoods Cliffs: N.J. Prentice Hall Inc.

APPENDIX A: Ethical Clearance

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

21 July 2016

Mr Ayoola A Dada 214584018
School of Social Sciences
Howard College Campus

Dear Mr Dada

Protocol reference number: HSS/0289/016D
Project title: Factors Affecting Maternal Health Seeking in a Yoruba Community of Nigeria: An Analysis of Socio-Cultural Beliefs and Practices.

Expedited Approval

In response to your application dated 16 March 2016, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. Please note: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

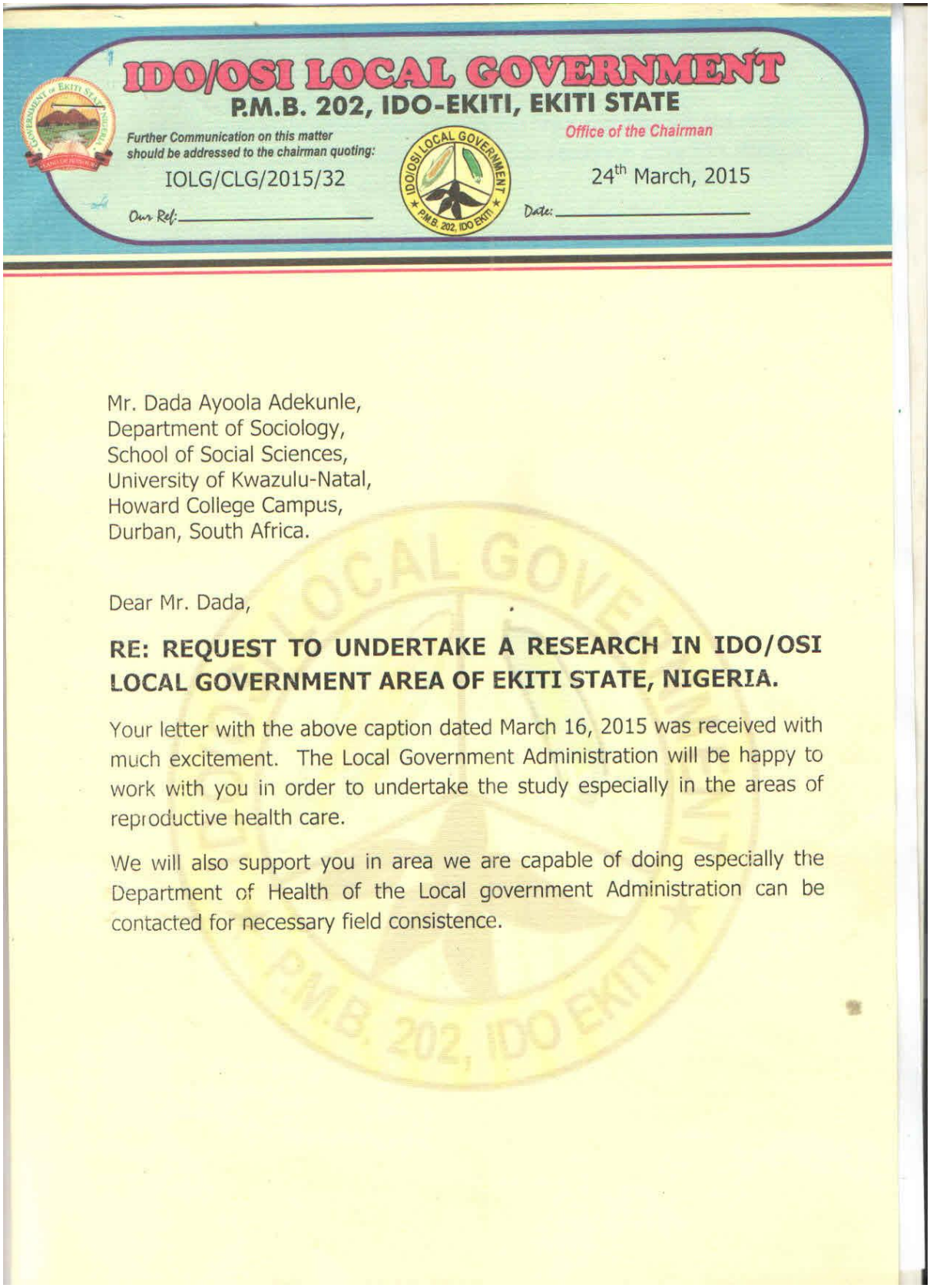
.....
Dr Shamila Naidoo (Deputy Chair)

/px

cc Supervisor: Professor Sultan Khan & Dr Lubna Nadvi
cc Academic Leader Research:
cc School Administrator: Ms N Ntuli & Ms N Radebe

Humanities & Social Sciences Research Ethics Committee
Dr Shenuka Singh (Chair)
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Telephone: +27 (0) 31 260 3587/8350/4557 **Facsimile:** +27 (0) 31 260 4609 **Email:** ximbap@ukzn.ac.za / snymanm@ukzn.ac.za / mohunp@ukzn.ac.za
Website: www.ukzn.ac.za

APPENDIX B: Gate keeper's Letter from Chairman Ido/Osi LGA



IDO/OSI LOCAL GOVERNMENT
P.M.B. 202, IDO-EKITI, EKITI STATE

Further Communication on this matter should be addressed to the chairman quoting:

IOLG/CLG/2015/32

Our Ref:

Office of the Chairman

24th March, 2015

Date:

Mr. Dada Ayoola Adekunle,
Department of Sociology,
School of Social Sciences,
University of Kwazulu-Natal,
Howard College Campus,
Durban, South Africa.

Dear Mr. Dada,

RE: REQUEST TO UNDERTAKE A RESEARCH IN IDO/OSI LOCAL GOVERNMENT AREA OF EKITI STATE, NIGERIA.

Your letter with the above caption dated March 16, 2015 was received with much excitement. The Local Government Administration will be happy to work with you in order to undertake the study especially in the areas of reproductive health care.

We will also support you in area we are capable of doing especially the Department of Health of the Local government Administration can be contacted for necessary field consistence.

Kindly inform us when you arrive in the area and also we will request that you provide the Administration with your feedback after the study in order to assist the Governments.

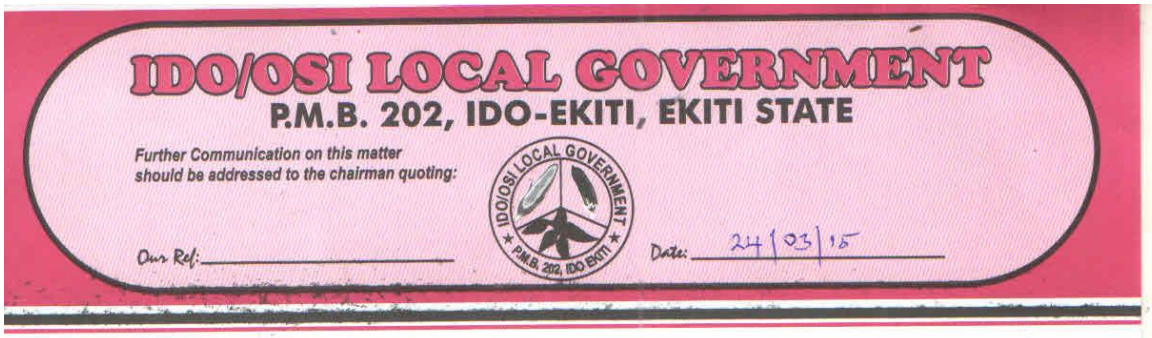
Accept our warmest regards.

Yours,

24/03/15

Hon. Ayodeji Odutola
Caretaker Chairman,
Ido/Osi Local Government.

APPENDIX C: Gate keeper's Letter from Ido/Osi LGA Medical Officer



IDO/OSI LOCAL GOVERNMENT
P.M.B. 202, IDO-EKITI, EKITI STATE

Further Communication on this matter should be addressed to the chairman quoting:

Our Ref:_____ Date: 24/03/15

Mr. DADA AyoolaAdekunle,
Department of Sociology,
School of Social Sciences,
University of Kwazulu – Natal,
Howard College Campus,
Durban, South Africa.

Dear Mr. Dada,

RE: REQUEST TO UNDERTAKE A RESEARCH IN IDO – OSI LOCAL GOVERNMENT AREA OF EKITI STATE, NIGERIA

Your letter dated March 16, 2015 was received. We will like to congratulate you for the academic progress and also happy that you chose our Local Government Area as study area. We have been providing supports for previous academic and development research and projects in the past and we assure you that the Local Government and her people will also cooperate with you.

However, we require that you carry our Health Officer at your sampled communities along in the field work. Also make available copies of your research instruments and procedure for our proper documentation.

Be assured of our cooperation.

Yours faithfully,

24/03/15.

Medical Officer for Health,
Ido – Osi Local Government

APPENDIX D: Participants Informed Consent Form

Appendices

Dear Participant,

My name is DADA Ayoola Adekunle (214584018). I am a PhD candidate studying at the University of KwaZulu-Natal, Howard College Campus. The title of my research is: Factors Affecting Maternal Health Seeking in a Yoruba Community of Nigeria: An Analysis of Socio-Cultural Beliefs and Practices. The aim of the study is to ascertain a comprehensive understanding of socio-cultural beliefs and practices on maternal health seeking by examining the proximate factors within the content in which they occur. I am interested in interviewing you so as to share your experiences and observations on the subject matter.

Please note that:

- The information that you provide will be used for scholarly research only.
- Your participation is entirely voluntary. You have a choice to participate, not to participate or stop participating in the research. You will not be penalized for taking such an action.
- Your views in this interview will be presented anonymously. Neither your name nor identity will be disclosed in any form in the study.
- The interview will take about (*30 minutes*).
- The record as well as other items associated with the interview will be held in a password-protected file accessible only to me and my supervisors. After a period of 5 years, in line with the rules of the university, it will be disposed by shredding and burning.
- If you agree to participate please sign the declaration attached to this statement (a separate sheet will be provided for signatures)

I can be contacted at: School of Social Sciences, University of KwaZulu-Natal, Howard College Campus, Durban. Email: dadaayoola@yahoo.com ; 214584018@stu.ukzn.ac.za
Cell: +27603430248; +234 8035774639
My supervisor is Professor Sultan Khan who is located at the Department of Sociology, School of Social Sciences, Howard College Campus, University of KwaZulu-Natal, Durban, South Africa. Contact details: email: khans@ukzn.ac.za Phone number: +27 312607240
My co-supervisor is Dr. Lubna Nadvi who is located at the Political Science Programme, School of Social Sciences, Howard College Campus of the University of KwaZulu-Natal. Contact details: email nadvis@ukzn.ac.za Phone number: +27 837864918

The Humanities and Social Sciences Research Ethics Committee contact details are as follows: Ms Phumelele Ximba, University of KwaZulu-Natal, Research Office, Email: ximbap@ukzn.ac.za,Phone number +27312603587.

Thank you for your contribution to this research.

DECLARATION

I…… *(full names of participant*) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire. I understand the intention of the research. I hereby agree to participate.

I consent / do not consent to have this interview recorded (if applicable)

SIGNATURE OF PARTICIPANT DATE

……

APPENDIX E: Interview Schedule

Interview Schedule on Factors Affecting Maternal Health Seeking Behaviour in a Yoruba Community of Nigeria: An Analysis of Socio-Cultural Beliefs and Practices.

Dada Ayoola Adekunle (214584018)

1. General Information:

   a) May I please know your name and what you do to earn a living?
   b) How old are you now?
   c) Sir/Ma can you please tell me the Position you occupy in this community?

2. Community Setting:

   a) Please can you tell us briefly, the history of this community?
   b) What can you say about the condition of sanitation in this community?
   c) What is your comment on the state of Infrastructures i.e. water supply, electricity, school, road etc.?
   d) What forms of marriage and family type are practiced here?
   e) What are the major economic activities of our people here?

3. Factors Affecting Maternal Health Seeking:

   a) What is your assessment of prevailing maternal healthcare provision (adequate or not, private or public, orthodox or traditional)?
   b) Please tell us the relationship between orthodox and traditional facilities in this community?
   c) What can you say about people's perception of health workers and services in this area?
   d) What are the things you can consider as barriers to maternal health facilities in this our community?
   e) What is your observation as regards people's awareness (information and communication) of maternal health programme like family planning etc.?
   f) How does our cultural beliefs and practices affects the decision making power of mothers?
   g) What is your assessment of impact of government and non-governmental agencies on maternal health of our people?
   h) What is the possible way out from barriers/problems associated with maternal health?
   i) What can you say about the level of awareness of mothers on diseases like HIV/AIDS and hepatitis?

APPENDIX F: Questionnaire

Q(ID)	

QUESTIONNAIRE

DEPARTMENT OF SOCIOLOGY
SCHOOL OF SOCIAL SCIENCES
HOWARD COLLEGE CAMPUS,
UNIVERSITY OF KWAZULU-NATAL,
DURBAN, SOUTH AFRICA.

Dear Madam,

This questionnaire seeks your perception of the factors affecting maternal health in the Yoruba Community.

Your responses are purely for academic purpose; hence, your name and address are not required. Please, be assured that any information provided will be treated as strictly confidential.

Thanking you for your co-operation.

Yours faithfully,

Dada A.A.

INSTRUCTION: Please tick the appropriate response and supply information where necessary.

SECTION A: SOCIO-DEMOGRAPHIC DATA

1. Age:……..

2. Marital Status: single [ ]1; married [ ]2; separated [ ]3; divorced [ ]4; widowed [ ]5; other (specify)6……

3. Educational Qualification:

4. Occupation: unemployed

5. Religion: Christianity [ ]1 Islam [ ]2 Traditional [ ]3

6. Your income (monthly)……

7. Husband's income(monthly)……

8. Number of children:……

SECTION B: HEALTH SEEKING BEHAVIOUR

1. Which health facilities do you use in this community?

2. How far is your house from the nearest health facility?

3. How often do you use maternal health facilities? Daily [ ]1; weekly [ ]2;
   i. Monthly[ ]3; any time needed [ ]4; not at all [ ]5;
   ii. other (specify)6……

4. Reason(s) for the response……

5. Who decides on the type of facilities you visit? Self [ ]1; husband [ ]2;
   1. in-laws [ ]3; parent/relatives [ ]4; friends [ ]5;
   2. Health workers [ ]6; other (specify)7……

6. Have you ever registered for Antenatal care at a Health Institution? Yes [ ]1; No [ ]2

7. If 'No' please state reasons……

8. Did you use Antenatal service during your last pregnancy? Yes [ ]1 No [ ]2

9. If yes, where did you receive care during pregnancy? Hospital [ ]1; maternity center [ ]2; dispensary [ ]3; TBA [ ]4; church/mosque [ ]5; herbalist center [ ]6; other (specify)7……

10. How old was the pregnancy before you went for Antenatal care?……

11. Have you ever used more than one facility at the same time? Yes [ ]1 No [ ]2

12. If yes, state the types and reason (s)……

13. Which of the center do you prefer most for care during pregnancy, childbirth and post-natal?

	(i) Pregnancy	(ii) Childbirth	(iii) Post-natal
Hospital	[ ]	[ ]	[ ]1
T.B.A	[ ]	[ ]	[ ]2
Church	[ ]	[ ]	[ ]3
Mosque	[ ]	[ ]	[ ]4
Herbalist	[ ]	[ ]	[ ]5
Home	[ ]	[ ]	[ ]6

Other (specify)7……

14. Where did you deliver your first child? ……

15. Where did you deliver your last child? ……

16. If your answer to question 15 is different from that of 14, please state reason(s)…… ……

17. Who pays for the service? Self [ ]1; husband [ ]2; In-law [ ]3; Parent/relatives [ ]4 other (specify)5…… ……

18. Where do you intend to deliver your next …….…… ……

19. What is the mode of payment in prefered center?…… ……

20. If you attend any center different from the maternity center to receive care during pregnancy, child birth and post-natal please state reason(s) it is our custom/normal [ ]1; to obtain proper care [ ]2; for traditional medicine or herbs, and prayer [ ]3; other reason (specify)4……

21. What other types of medicine are you given at this center, which are not given at the maternity center? Aseje [ ]1; Asoro [ ]2; awebi [ ]3; holy water [ ]4; other (specify)5…… ……

22. you have strong believe in the efficacy of this medicine? Strongly agree[ ] agree [ ] undecided [ ] disagree strongly disagree[ ]

23. reason(s) for your response …… …

24. If your family's opinion is different from your own on issue relating to your health, what will you do: do whatever they say [ ]1; try to convince them [ ]2; do what I know is best for me [ ]3; other (specify)4……

25. Can you go to hospital if need arises without your husband's permission? Yes [ ]1; No [ ]2

26. If yes, please state reason(s)…….
….

27. Where do most women in your community receive care during pregnancy and childbirth? Maternity center [ ]1; hospital [ ]2; church [ ]3; herbalist center [ ]4 home from family members [ ]5; other (specify)6……

28. Which of these facilities would you like to continue attending for antenatal and post-natal cares? Hospital [ ]1; mission house [ ]2; TBA [ ]3; Herbalist center [ ]4; mission house [ ]5; other (specify)……

29. What are your reasons for this choice? Close to my house [ ]1; services are affordable [ ]2; services are adequate [ ]3; spiritual reasons [ ]4; saves time [ ]5; cultural reasons [ ]6; other (specify)7……

30. Did you go back to the facility for check-up after childbirth? Yes [ ]1; No [ ]2

31. If 'Yes' please state reason(s)…….
…

32. Have you heard about family planning programme? Yes [ ]1; No [ ]2

33. 36b. If 'Yes' state source of information…….

34. When was the last time you gave birth? less than 1 year [ ]1; two years ago [ ]2; more than 2; years ago [ ]3; other(specify)4……

35. How long did you wait before the birth of the child? Less than 2 year [ ]1; 2-3 years [ ]2; more than 3 years [ ]4; other (specify)5……

36. Please state reason(s): It is tradition/normal [ ]1; medical reason [ ]2; other (specify)3……
……

37. Do you ever-used contraceptives? Yes [ ]1; No [ ]2

38. If 'Yes' which contraceptives method have you used before? Abstinence [ ]1; condom [ ]2; withdrawal [ ]3; intra uterine devices [ ]4; Norplant important [ ]5; pill [ ]6 injectables [ ]7 other (specify)8……

39. Which one are you currently using? Abstinence [ ]1; condom [ ]2; withdrawal [ ]3; intra uterine devices [ ]4; Norplant important [ ]5; pill [ ]6; injectable [ ]7; other (specify)8……
…….

40. Why do you think women should use contraceptives? Prevent Pregnancy [ ]1 Prevent Disease[ ]2 others (specify)3……..

41. Do you know of any other incurable sexually transmitted disease apart from HIV? Yes[ ]1 No[ ]2

42. If Yes, name them.

43. what are the traditional methods of family planning that you know and their usage?……
……
……
……
……
……
……

44. Which one have you used?…….

45. Does the tradition prohibit you from eating certain foods during pregnancy and breast feeding? Yes…….No……

46. if Yes, what are they and reasons for the prohibition?.....
.....
.....
.....
.....
.....

47. what are the local traditions and practices that you considered to promote maternal health in this community……
……
……
……
……
……
……

48. What are the traditional practices that you considered as detrimental to maternal health in this community?
……
……
……
……
……..

49. Is there any implication of male child preference on maternal health? Yes……..No……..

50. Give reasons for your response.

……
……
……
…..

SECTION C: RESPONDENT' S PERCEPTION OF HEALTH WORKERS AND SERVICES

	STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE
1. The attitude of the health care workers discourages people from using the service					
2. Lack of drugs can discourage people from using the facilities					
3. The cost of item to buy and pay for discourages people from using the service					
4. Some practices in the hospitals are against my culture/religion					
5. Proximity of the health facilities affects the use of the services					
6. Traditional women are better place to receive care than health center					
7. The church is a better place to receive care than health center					
8. Care during pregnancy affect outcome of delivery					
9. Constant lack of drugs prevents people from attending maternity center					
10. There are frightening					

equipment used in the labour room of the maternity centers, which are not found in the other alternative centers					
11. The health workers in government maternity centers are not as devoted to duties as their counterparts in private hospitals					
12. There is discrimination in terms of services that health workers render to literate and non-literate women that attend maternity centers					
13. There is need to come back to hospital for check-up after delivery					
14. In this community it is believed that there are some special food that pregnant women/nursing mother should be eating					

Is there any other information you want to add to assist this study?……
…….……
…….

APPENDIX G: Turnitin Plagiarism Report

FACTORS AFFECTING MATERNAL HEALTH

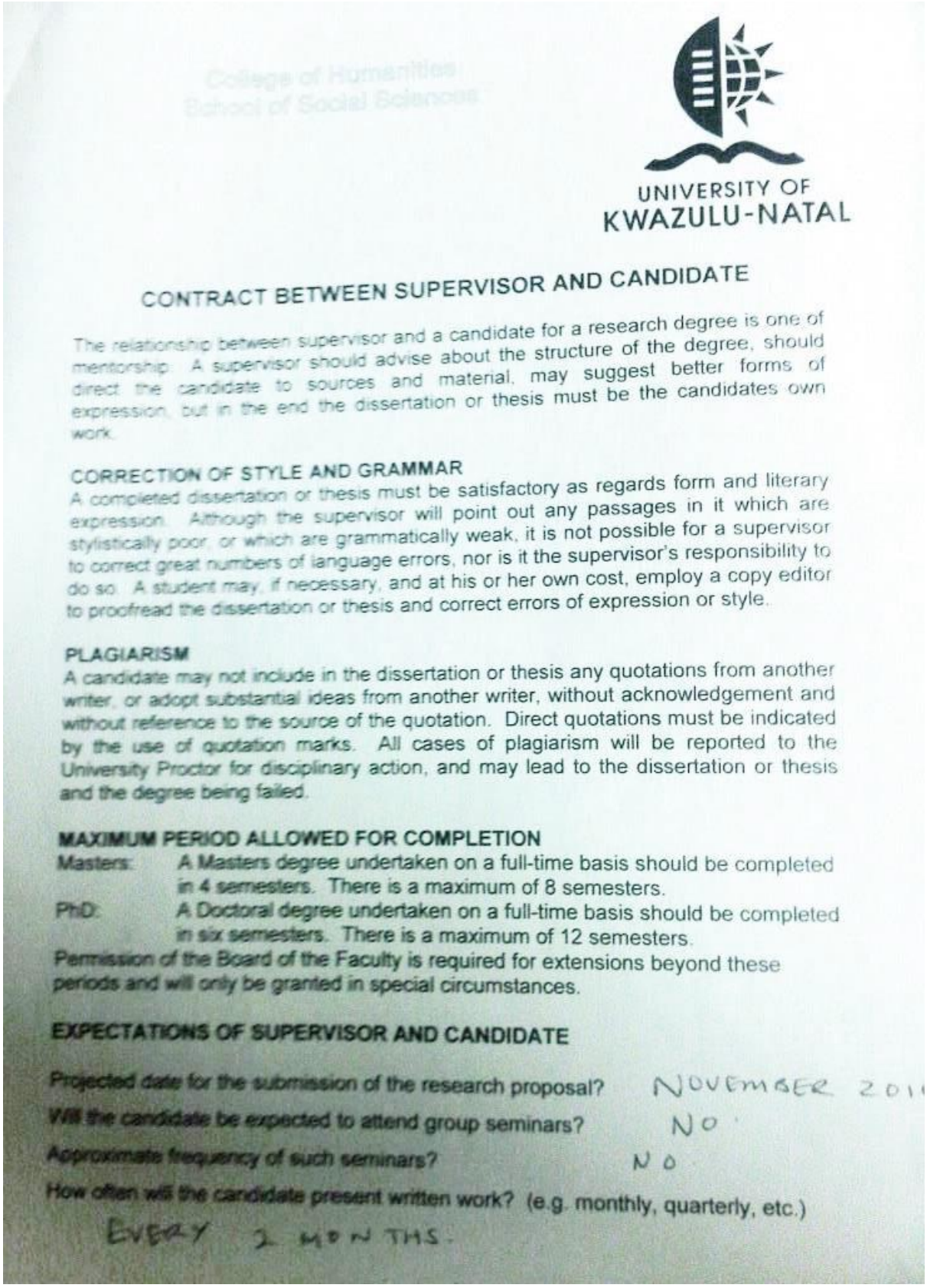
ORIGINALITY REPORT

9%	8%	4%	2%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	www.biomedcentral.com Internet Source	1%
2	www.mohamedrabeea.com Internet Source	1%
3	www.iiste.org Internet Source	1%
4	www.uaps-uepa.org Internet Source	1%
5	epdf.tips Internet Source	1%
6	Evans, Emily C.. "A review of cultural influence on maternal mortality in the developing world", Midwifery, 2012. Publication	1%
7	Submitted to De LaSalle University - College of Saint Benilde Student Paper	1%
8	www.safemotherhood.org Internet Source	1%

APPENDIX H: Contract between Supervisors and Candidate



College of Humanities
School of Social Sciences

UNIVERSITY OF
KWAZULU-NATAL

CONTRACT BETWEEN SUPERVISOR AND CANDIDATE

The relationship between supervisor and a candidate for a research degree is one of mentorship. A supervisor should advise about the structure of the degree, should direct the candidate to sources and material, may suggest better forms of expression, but in the end the dissertation or thesis must be the candidates own work.

CORRECTION OF STYLE AND GRAMMAR

A completed dissertation or thesis must be satisfactory as regards form and literary expression. Although the supervisor will point out any passages in it which are stylistically poor, or which are grammatically weak, it is not possible for a supervisor to correct great numbers of language errors, nor is it the supervisor's responsibility to do so. A student may, if necessary, and at his or her own cost, employ a copy editor to proofread the dissertation or thesis and correct errors of expression or style.

PLAGIARISM

A candidate may not include in the dissertation or thesis any quotations from another writer, or adopt substantial ideas from another writer, without acknowledgement and without reference to the source of the quotation. Direct quotations must be indicated by the use of quotation marks. All cases of plagiarism will be reported to the University Proctor for disciplinary action, and may lead to the dissertation or thesis and the degree being failed.

MAXIMUM PERIOD ALLOWED FOR COMPLETION

Masters: A Masters degree undertaken on a full-time basis should be completed in 4 semesters. There is a maximum of 8 semesters.

PhD: A Doctoral degree undertaken on a full-time basis should be completed in six semesters. There is a maximum of 12 semesters.

Permission of the Board of the Faculty is required for extensions beyond these periods and will only be granted in special circumstances.

EXPECTATIONS OF SUPERVISOR AND CANDIDATE

Projected date for the submission of the research proposal? NOVEMBER 201

Will the candidate be expected to attend group seminars? NO

Approximate frequency of such seminars? NO

How often will the candidate present written work? (e.g. monthly, quarterly, etc.)

EVERY 2 MONTHS.

How often will the supervisor and the candidate expect to meet? (e.g. monthly, every two months, etc.) MONTHLY

Approximately how soon after submission of written work may the candidate expect comments from the supervisor? 4 - 6 weeks.

Any other special provisions agreed on?

Sultan Khan

Candidate

Signed

DADA, AYOOLA ADEKUNLE

Name: (print)

MAY 15, 2014.

Date:

Supervisor DR L NADVI

Signed

DR S DE LA PORTE

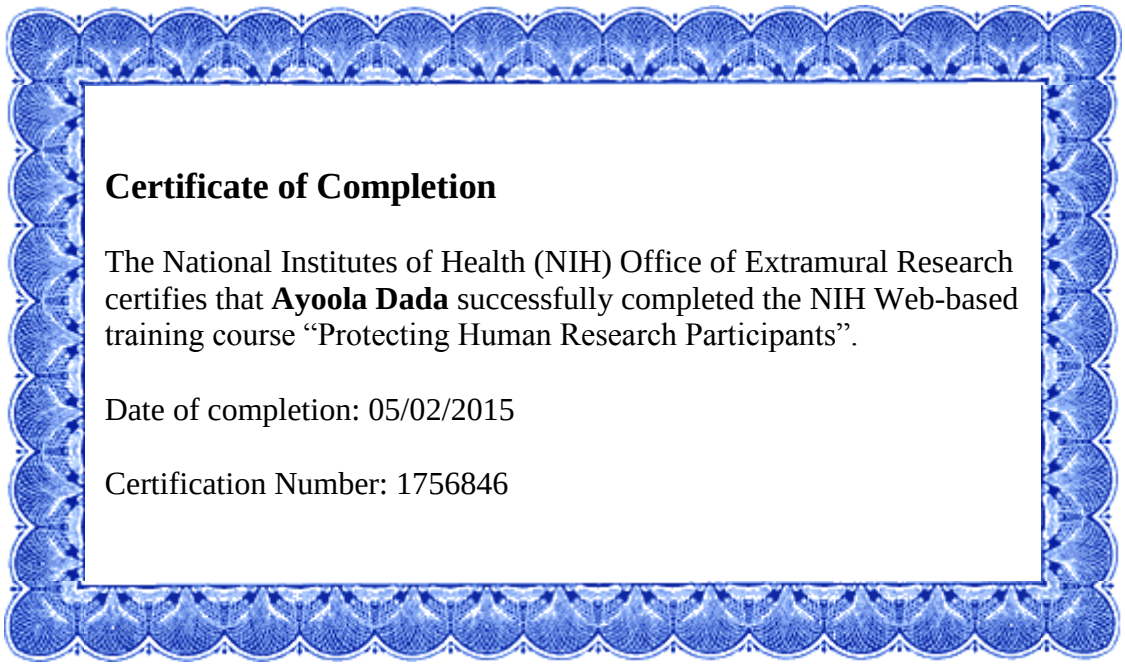
Name: (print)

15/05/2014.

Date

NOTE:
The supervisor's consent is required in order to submit the completed dissertation or thesis for examination and no thesis will be accepted by the Faculty Office for examination without the supervisor's approval. The supervisor must see the final version of the thesis before submission. A candidate may, if he/she wishes, insist on submission without the supervisor's consent, but this fact will be noted in the supervisor's report.

APPENDIX I: The National Institutes of Health (NIH) Certificate on "Protecting Human Research Participants"



Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Ayoola Dada** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 05/02/2015

Certification Number: 1756846