Exploration of women's lived experiences and perspectives of maternal stakeholders on the utilisation of maternal healthcare services in Bauchi State, Nigeria

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Abstract

Maternal health care centres are designed to provide health care services for women of reproductive age to ensure safe delivery. Over the years, the high rate of maternal mortality, despite the government provision of maternal health centres, has been an issue of concern. From the literature reviewed, these healthcare centres' utilisation levels are not encouraging in rural areas, especially in northern Nigeria. Hence, this study explored the lived experiences of women of reproductive age and the perspectives of maternal stakeholders on utilising maternal health care services in Bauchi State, Northern Nigeria. A qualitative research approach with descriptive phenomenology was adopted as a research design for the study. Purposive and snowballing sampling techniques were used to select different categories of participants in the study.

The participants were 23 reproductive women, 5 married men, 2 skilled health workers, and 2 Traditional Birth Attendants (TBAs). Focus Group Discussions (FGDs) and semi-structured interviews were conducted face-to-face to collect data from the study participants to answer the research questions raised for the study. The FGDs and interviews were recorded, transcribed manually, and translated from Hausa to English. The transcripts were analysed with Colaizzi's (1978) 7 steps and Braun and Clarke's (2006) analytic technique using NVIVO 12 Computer Assisted Qualitative Data Analysis Software (CAQDAS).

Four (4) themes emerged from the analysis of the collected data. Four themes, namely communal belief, maternal healthcare factors, healthcare worker factors, and maternal healthcare adjustments, emerged from the analysis of the perspectives of the women's lived experiences. On the other hand, five themes, namely community belief, traditional healthcare efficacy, women's issues, maternal healthcare factors, and maternal healthcare adjustments, emerged from the analysis of the perspectives shared by maternal healthcare stakeholders.

It was recommended that all TBAs in the community should be registered with the health centres for proper monitoring and follow-up, advocacy programmes targeted at educating male partners should be implemented from time to time, government, non-governmental organisations, and enlightened individuals in the community should increase the level of health advocacy in northern Nigeria.

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Chapter One

Introduction

1.1 Introduction

This study explored women's lived experiences and perspectives of other maternal healthcare stakeholders on the utilisation of maternal healthcare services in Bauchi State, Nigeria. The study was deemed necessary due to increased maternal deaths despite the provision of healthcare facilities by the government and non-governmental organisations. This chapter presents the introduction, the background of the study, an introduction to maternal healthcare, and the scope of the study, focusing on women of reproductive age in connection with utilising maternal healthcare centres in Nigeria. This chapter highlights the global and Nigerian maternal mortality rates, the aim, the research question(s), and an outline of each chapter within this thesis.

1.2 Maternal mortality in the world

In 2020, there were approximately 287,000 maternal deaths worldwide, with low-income countries accounting for 95% of these deaths (WHO, 2023). Each year, between 250,000 and 280,000 women, along with an estimated 6.55 million children under five, lose their lives during pregnancy and childbirth (Lassi *et al.*, 2014). The World Health Organization (WHO) estimates that about 536,000 women succumb annually to pregnancy-related causes, while nearly 10 million women face complications related to pregnancy (WHO, 2019a). In 2017, approximately 810 women died daily from preventable causes associated with pregnancy and childbirth, contributing to a global maternal mortality ratio (MMR) decrease of about 38% between 2000 and 2017 (WHO, 2018).

Southern Asia and Sub-Saharan Africa were predicted to account for around 87% (253,000) of all maternal deaths worldwide in 2020 (WHO, 2023). Sub-Saharan Africa alone bore the responsibility for approximately 70% of the 202,000 maternal deaths (WHO, 2023). Despite the global reduction in maternal mortality rates, Sub-Saharan Africa, to which Nigeria belongs, still grapples with maternal mortality. Maternal mortality is a pressing global issue frequently employed as an indicator to assess population health and categorise nations into "developed" and "developing" (Gulumbe *et al.*, 2018). Disparities in access to high-quality healthcare and the gap between the wealthy and the poor contribute to high maternal mortality rates in certain parts of the

world (WHO, 2021). Discrepancies in MMR reveal distinctions between developed and developing nations. In 2017, the MMR in low-income countries stood at 462 per 100,000 live births, contrasting with the rate of 11 in high-income nations (WHO, 2021). According to WHO (2021), developing countries (low and middle-income) collectively accounted for 94% of all maternal mortality, emphasising the disproportionate burden of maternal mortality in these regions.

1.3 Maternal mortality in Nigeria and Northern Nigeria

Africa has the highest maternal mortality rates, with 17 of the top 20 countries globally affected (Kassebaum *et al.*, 2014). Nigeria, along with Afghanistan, Ethiopia, Pakistan, India, and the Democratic Republic of the Congo, contributes over 50% of global maternal mortality (Hogan *et al.*, 2010Maternal outcomes in Nigeria are concerning, as only 36% of women give birth in Western maternal healthcare centres (Afolabi-Ojo, 2019). With 576 deaths per 100,000 live births, Nigeria ranks among the top 16 countries for maternal mortality (Afolabi-Ojo, 2019). There is a noticeable decline in the maternal mortality ratio, accompanied by variations in the percentage of maternal deaths per 100,000 live births (Sharma *et al.*, 2017). Concerns within the Nigerian health sector regarding maternal mortality are warranted, given the worrisome increase in recorded deaths. Notably, 62.9% of women neglect postnatal check-ups (National Bureau of Statistics (NBS) and United Nations Children's Fund (UNICEF), 2018).

According to the National Post Natal Care (PNC), only 58.9% of women in urban areas and 27.8% in rural areas utilise maternal healthcare for postnatal care (National Bureau of Statistics (NBS) and UNICEF, 2018). In rural areas, maternal healthcare centres are underutilised for antenatal and postnatal care, as evidenced by 81% of women in the northwest region preceding postnatal check-ups, compared to 24% in southwest Nigeria (NBS and UNICEF, 2018; World Health Organization (WHO), UNICEF, UNFPA, 2015). These statistics underscore the limited utilisation of Western maternal healthcare facilities for ante and postnatal care. The Southern region has the highest rate of pregnant women attending the recommended four antenatal visits by WHO (76.8% to 89.0%), followed by North-Central (66.0–76.0%), while the North records the lowest rate (35.5–51.9%). Similarly, the South has the highest number of skilled birth attendants (73.4–78.8%), the North-Central has the second-highest (46.5–67.2%), and the North (16.1–27.8%). Births without skilled or unskilled attendants are

most prevalent in the North (77.2–86.5%), least in North-Central (7.2–13.4%), and intermediate in the South (6.3–9.5%). The antenatal care (ANC) utilisation rate remains relatively low in Nigeria despite its lower-middle-income status. While the documented average for all lower-middle-income countries is 79%, approximately 61% of pregnant women in Nigeria visited a skilled provider at least once during their pregnancy.

1.4 Maternal healthcare services and utilisation in Northern Nigeria

The state of women's health before, during, and after childbirth is termed maternal health (WHO, 2022a). Maternal healthcare encompasses the health status of women within their reproductive age range. The utilisation of maternal health care services is a significant health issue for ensuring the survival of both mothers and children. Maternal healthcare services enhance the health of mothers and their children before, during, and after birth, reducing maternal morbidity and mortality (Wanjala, 2016). For example, antenatal care (ANC) can address complications that may arise and screen pregnant women and their unborn children for actual and potential issues as the pregnancy progresses (Downe *et al.*, 2019). Addressing maternal healthcare is crucial for national thriving, particularly in achieving MDG 4, which aims to reduce child mortality. Offering excellent care to pregnant women and new mothers is essential for saving women's lives and the lives of their unborn children (Nayyar, 2018).

Neglecting maternal healthcare can have severe implications. Inadequate and prompt attention to severe bleeding post-birth may result in the loss of women's lives. Infections after childbirth can be prevented through proper hygiene, recognizing early signs of disease, and prompt treatment, thereby detecting and treating potentially fatal complications before they occur (WHO, 2019). Expanding initiatives to decrease maternal mortality is crucial for enhancing overall health and well-being. Each pregnancy and birth is unique, highlighting the need to address inequalities affecting maternal sexual and reproductive health and rights to ensure all women have access to high-quality maternity care that is respectful (WHO, 2023b). Women's experiences before delivery, their overall health, and lifestyle choices can influence pregnancy fertility, maternal health, and the likelihood of infants developing chronic conditions (WHO, 2022a). Thus, pregnant women need to have their health checked for potential challenges and problems, engaging in early treatment and signposting. This type of

care ensures a smooth delivery experience through adequate preparation balanced with necessary precautions.

Throughout pregnancy, women must receive high-quality antenatal care for a healthy pregnancy for both mother and baby, ensuring an efficient transition to positive labour and childbirth (WHO, 2022a). Emphasizing the vitality of antenatal care for every pregnant mother is essential. Attending antenatal care provides advantages such as quality information on what to do, how to do it, what to avoid, what to practice, and channels of doing it, among others. Early detection and reduction of risk factors are facilitated by antenatal care (WHO, 2002), making it easier to identify and manage obstetric complications and infections (Mohamoud *et al.*, 2022). Maternal and newborn health outcomes have improved due to the effects of antenatal care, facilitating institutional delivery and postpartum care and effective management of prenatal complications (Dahiru and Oche, 2015). However, findings show that 41% of women who used skilled ANC in Nigeria did not deliver in Western maternal healthcare (Dahiru and Oche, 2015). Dissatisfaction with the antenatal care experience may account for the low level of delivery by ANC users in Western maternal healthcare centres, according to some studies.

The phases of maternal healthcare extend beyond before and during childbirth to cover after birth. Antenatal and postpartum care services are a proximate determinant of outcomes for mothers, enabling early detection of at-risk mothers and providing prevention services (Dairo and Atanlogun, 2018). Furthermore, the risk of death is higher in the first week after birth, emphasizing the importance of the health of both mothers and their babies (WHO, 2022a). The immediate postnatal period is crucial, yet postnatal care has received little attention in Nigeria despite its significance for children's survival (Somefun and Ibisomi, 2016a). Mothers who deliver at maternal healthcare centres may have reasonable expectations about their health and the well-being of their newborns, possibly not seeing the need to return for check-ups.

On the other hand, those who utilise maternal healthcare centres may desire to return for their newborns' check-ups. A study by Somefun and Ibisomi (2016) on postnatal healthcare revealed that 63% of mothers of 19,418 born children did not use postnatal care services during the study period. Approximately 42% of the study population did not receive postnatal care. The study's findings also indicated that non-utilisation of

postnatal care services significantly correlates with antenatal care utilisation, distance, education, place of delivery, region, and wealth status.

1.5 Personal Interest

My work engagement with the World Health Organisation (WHO) in Nigeria's Jigawa State gave me a deeper understanding of the health sector's research needs. These experiences exposed me to challenges within the healthcare industry, subsequently becoming the focal point of my academic pursuits. Despite not being a member of the population under study, I leveraged my knowledge as an insider – a state resident – to contribute meaningfully to the research. This insider perspective allowed me to interact freely with the participants. Additionally, my personal experience with motherhood further enriched my interactions during the study. Being married and pregnant during the data collection period, I could empathise with the participants, given that my research centred on maternal healthcare utilisation. This alignment of personal experiences with the study's focus facilitated a deeper connection and understanding between the research participants and me.

1.6 Justification for the study

This study aimed to investigate the utilisation of maternal healthcare centres in Bauchi State, given the persistently high maternal mortality rate despite the presence of such facilities staffed by skilled health workers. Notably, in Nigeria, 41% of women did not deliver in Western maternal healthcare settings (Dahiru and Oche, 2015), and the northern part of the country, including Bauchi State, exhibits elevated maternal mortality rates (Kana *et al.*, 2015). Despite governmental efforts to provide maternal healthcare and address the lack of awareness about the importance of utilising healthcare facilities, there has not been a proportional increase in the expected utilisation among reproductive women. Maternal mortality remains exceptionally high in rural areas, as emphasised by Somefun and Ibisomi (2016b). This study identifies research gaps, revealing a scarcity of studies on utilising maternal healthcare centres, specifically in Bauchi State. The existing studies in the state predominantly employed quantitative research methods, with only a limited number of qualitative studies available.

Moreover, the few qualitative studies primarily focused on home visits, general health, and child health, differing from the objectives of this study. Consequently, there is a pressing need to investigate maternal healthcare utilisation in Bauchi State. Several

underlying factors influence women's utilisation of maternal healthcare centres. This study seeks to explore their lived experiences, understanding how they manage their maternal health, the type of healthcare centres they patronise, and the reasons behind their choice of healthcare facilities. To comprehensively grasp women's experiences, this study also includes perspectives from other key groups, including male partners of reproductive women, skilled health workers, and Traditional Birth Attendants. By incorporating these diverse viewpoints, the study aims to create a comprehensive understanding of the factors influencing the utilisation of Western maternal healthcare services in Bauchi State.

1.7 Research aim and question

This study aimed to explore women's lived experiences and perspectives of maternal healthcare stakeholders on women's utilisation of maternal healthcare services in Bauchi State, Nigeria. Specifically, the two research questions were:

1. What are the women's experiences of the factors influencing their utilisation of maternal health services in Bauchi State, Nigeria?
2. What are the perspectives of maternal stakeholders on the factors influencing women's utilisation of maternal health services in Bauchi State, Nigeria?

The two research questions helped to discover the type of maternal health care used by the women before, during, and after childbirth, together with the reasons for their choice of maternal health care.

1.8 Scope of the study

The study centred on the utilisation of maternal healthcare among women in Bauchi State, Northern Nigeria, specifically targeting women aged 15 to 49 within the reproductive age range. The study purposively selected 23 women from three distinct reproductive age groups: pregnant women, primigravida, and multigravida. The study interviewed other participants, namely male partners, skilled health workers, and Traditional Birth Attendants. However, the primary focus remained on capturing the experiences of reproductive women, with the involvement of other participants serving as a means of data triangulation to enhance the credibility of women's experiences. Triangulation was employed by incorporating diverse perspectives to gather various views on utilising maternal healthcare services in Bauchi State. This method played a vital role in ensuring the study's validity, as participants from distinct groups shared

their experiences on the same set of questions. Triangulation, in this context, helped mitigate potential researcher bias that could arise from relying solely on a specific set of participants.

1.9 Significance of the study

Maternal healthcare plays a crucial role in the health and well-being of reproductive women. Hence, this study's findings will help women understand the importance of maternal health and the need to prioritise their health in their schedule. The results from this study are likely to promote an increase in the rate of safe delivery among pregnant women and to make appropriate choices expected of them because pregnancy involves the normal, life-enhancing process of procreation, which carries a high risk of death. Hence, there is a need to attend to reproductive women's healthcare. The study's findings will hopefully convince women of reproductive health to utilise Western maternal healthcare centres. Numerous strategies have been adopted by Non-Governmental Associations as well as government health agencies and global associations like the World Health Organisation (WHO) with a focus on providing programmes on maternal health that will improve awareness, sensitisation, and discovery of healthcare challenges. However, these have not resulted in marked increases in maternal healthcare centre use or maternal mortality reduction.

The belief that women of reproductive age do not receive adequate maternal healthcare services and do not have access to good maternal healthcare due to numerous factors contributing to the problem of maternal morbidity and mortality will be confirmed, refuted, or improved upon by this study. Thus, the study will reveal the obstacles/difficulties/considerations preventing women in the Bauchi State community from utilising Western maternal healthcare services. Implementing the findings will benefit researchers, medical professionals, health advocates, and other groups interested in addressing the issue of women's health, particularly in Bauchi State and Nigeria. The study's findings will provide reference materials for subsequent research. This study will be helpful to consultants and researchers involved in research-based projects, organising seminars, or investigating related issues. Additionally, it is hoped that the results of this study will contribute to a better understanding of the concept of maternal health and its associated issues.

1.10 Researcher's reflective piece on Western and traditional healthcare

This section offers a reflective and introspective analysis of the researcher's experiences, insights, and perspectives regarding the coexistence, interaction, or comparison of Western (modern, scientific) and traditional (cultural, alternative) healthcare systems. This reflective piece usually involves the researcher sharing personal observations, encounters, and reflections on the values and benefits of Western and traditional healthcare.

1.10.1: Values of Western Healthcare Approaches

The Western healthcare system is based on values and principles that guide the delivery of medical care and public health interventions. It strongly emphasises evidence-based practices, relying on scientific research and clinical trials to validate medical treatments and interventions. Patient autonomy is highly valued in Western healthcare, encouraging individuals to make informed decisions about their healthcare and participate in shared decision-making with healthcare providers. The system adheres to global standards and guidelines, contributing to a standardised approach to healthcare that can be applied internationally.

1.10.2: Values of Traditional Healthcare Approaches

Healthcare that follows traditional practices often takes a holistic approach to well-being, considering the interconnectedness of an individual's physical, mental, and spiritual aspects. It is deeply rooted in cultural practices, valuing cultural relevance and community-specific approaches to health and healing. Natural remedies derived from plants and herbs are highly valued, emphasising a more natural and sometimes less invasive approach to healing. Preventive measures, including lifestyle and dietary practices, are necessary to maintain health and prevent illness. It's important to note that an integrated approach that combines elements of both Western and traditional healthcare can be beneficial in addressing diverse healthcare needs.

1.10.3: Benefits and Potential Harms of Western Healthcare Approaches

Healthcare in the Western world is heavily reliant on scientific research. The reliance ensures that treatments and interventions are grounded in rigorous scientific methodologies. Using cutting-edge technology for diagnostics, treatment, and surgery leads to accurate diagnoses and effective medical interventions. Patients have access to specialised care through various medical facilities, allowing them to receive comprehensive and targeted treatment from experts in specific fields. Western

healthcare adheres to international medical standards and guidelines, contributing to a globally recognised and standardised approach to healthcare.

However, there is a tendency in Western medicine to rely heavily on pharmaceutical interventions, which may sometimes lead to overmedication, dependency, or adverse side effects. Western healthcare can be expensive, and accessibility may challenge specific populations, leading to disparities in healthcare services. While advanced medical procedures can be beneficial, they also pose risks of complications, and there may be a tendency to opt for invasive interventions rather than exploring less intrusive alternatives.

1.10.4: Benefits and Potential Harms of Traditional Healthcare Approaches

Traditional healthcare often takes a holistic approach, considering an individual's physical, mental, and spiritual well-being and promoting balance and harmony. It is often deeply rooted in cultural practices, making it more acceptable and relevant for specific communities. It frequently utilises natural remedies derived from plants and herbs, potentially offering alternatives with effects. It is often embedded in local communities, fostering a sense of trust and community support in healthcare practices. However, traditional healthcare practices may lack scientific validation and rigorous testing, raising concerns about their efficacy and safety. Traditional healers may not have specialised knowledge in specific medical fields, limiting their ability to address complex or specialised health issues. Relying solely on conventional medicine may lead to delayed access to critical and time-sensitive medical interventions available in Western healthcare. Traditional healthcare practices vary widely among cultures, and what works in one context may not be applicable or practical in another. An integrated approach combining both elements can offer a more comprehensive and patient-centred approach to health and well-being.

1.11 Thesis structure and chapter content

The outline of each chapter of the thesis is briefly discussed as follows:

Chapter Two delves into examining existing knowledge regarding using maternal healthcare services. This chapter employs well-defined strategies to conduct a scoping literature review and explore the available literature on maternal healthcare. Section 2.1 outlines the scoping literature review, elucidating the review's objectives, methodologies for literature search, sources, search terms, and inclusion and exclusion criteria. The search primarily targeted articles from peer-reviewed journals

focusing on maternal healthcare utilisation, particularly in Nigeria, Northern Nigeria, and Sub-Saharan Africa. Initial keywords for the literature search included 'Maternal healthcare,' 'utilisation of maternal healthcare,' 'women utilisation of maternal healthcare,' and 'reproductive women utilisation of maternal healthcare.' Additional keywords, such as "barriers against the utilisation of maternal healthcare," "utilisation of maternal healthcare in rural areas," and "factors affecting utilisation of maternal healthcare," were incorporated to broaden the search and enhance search engine results.

Section 2.2 of the literature review delves into the descriptions of various concepts, providing an overview and historical context of maternal healthcare and presenting findings from the literature. The literature encompasses experiences from diverse perspectives, including women of reproductive age, male partners, skilled health workers, community leaders, government agencies and leaders, and traditional birth attendants. Through this exploration, the literature sheds light on women's challenges and the circumstances influencing their decisions to utilise Western maternal healthcare services. Identified factors hindering women from using maternal healthcare services are categorised as personal, family-based, community-based, and religiously based.

Chapter Three, the methodology section, details the approach employed for conducting this study. Section 3.2 outlines the research philosophy utilised for knowledge establishment. Section 3.3 encompasses available research approaches, the selected approaches, and the rationale behind their selection. The chapter delves into a discussion of quantitative and qualitative research, highlighting each approach's strengths, suitable study types, the choice of qualitative research, and the rationale for this selection. Initially considering ethnography to explore the impact of culture on the utilisation of maternal healthcare services among women aged 15-49, the study adapted due to the COVID-19 pandemic, shifting the research design from ethnography to phenomenology. Section 3.3.1 provides a detailed explanation of the research design, concluding with a selection of descriptive phenomenology and its rationale for this project.

Chapter Four outlines the procedures to answer the primary research questions, discussing settings, strategies, tools, participants, and data collection and analysis procedures. The geographic locations, research design categories, language, and participant demographics are explored. The chapter details the application of

Colaizzi's seven steps and Braun and Clarke's (2006) six steps for data analysis, emphasising data credibility. Bracketing, following Husserl's proposal, was undertaken throughout the research stages. Ethical considerations of the study are also addressed.

Chapter Five (Findings) applies Colaizzi's and Braun and Clarke's methods to analyse collected data, including examples of procedural steps. The use of computer-assisted qualitative data analysis software, NVivo, is discussed, along with its advantages. Section 5.2 describes participant demographics, discussing categories based on gender, age group, education, religion, family size, pregnancy status, reproductive stage, locations, and data collection mode. Section 5.3 presents an overview of study findings, including emergent themes, clusters, and excerpts from participant experiences to support conclusions.

Chapter Six delves into the description, analysis, and interpretation of findings, linking emergent themes to cultural, religious, socio-economic, and healthcare factors in alignment with the literature review. The chapter discusses the researcher's rationale, strengths and limitations, research design, implications of findings, and a summary.

Chapter Seven concludes the study, presenting existing knowledge, contributions, and conclusions from the findings. The chapter discusses the impact of the researcher's knowledge base recommendations for healthcare managers, skilled health workers, advocacy groups, and governmental/non-governmental organisations. The chapter highlights the study's contribution to knowledge, suggests future research, and provides a summary.

1.12: Summary of the chapter

This chapter functions as a foundation for subsequent sections, briefly discussing the concept of maternal mortality in Nigeria and emphasising the significance of healthcare services. The exploration of maternal healthcare utilisation is undertaken, and the justification for the study is presented, incorporating the study's aim and two research questions. While maintaining a broader focus on women, the chapter establishes the study's scope and outlines the potential benefits encapsulated in its significance. Additionally, the chapter includes a detailed overview of the thesis structure and summarises the content of each chapter.

1.13: Definition of Terms:

TBA: They played a dual role as women and as stakeholders.

Maternal Healthcare Stakeholders: These are healthcare stakeholders, namely, husbands of the reproductive women and skilled healthcare workers.

1.13: Acronyms

TBAs: Traditional Birth Attendants

SBA: Skilled Birth Attendants

ANC: Antenatal Care

FGD: Focus Group Discussion

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter reviews relevant literature to support the research aim of exploring women's lived experiences and perspectives of maternal stakeholders on utilising maternal healthcare services in Bauchi state, Nigeria. The review is structured into themes with reviews available in the literature to develop the general perception (from a global standpoint) of maternal health. The four themes are traditional beliefs (number 1), an inclination to deliver at home (number 2), a lack of autonomy to make decisions (number 3), and the preference for TBAs (number 4). One of the themes captured the overview of maternal healthcare, which comprises *the history of maternal health from a global perspective and an overview of Initiatives and programmes to improve maternal health in Africa and Nigeria*. A *conceptual framework* (the Anderson-Newman behavioural model) was then used to interpret this review's findings, providing an *overview of the scoping literature review*. The study adopted scoping and literature reviews for the review of relevant literature.

The choice of scoping reviews aligns with the research objectives and the nature of the available literature for this study. It was used to capture a holistic understanding of the topic under study by including a wide range of perspectives and literature sources. It was used to map the existing literature, identify key concepts, and provide a broad overview of the topic under study. A scoping review was employed to get the relevant articles and to understand the extent of utilisation of maternal healthcare in Bauchi State. The scoping review utilises the Arksey and O'Malley (2005) methods, further enhanced by Levac, Colquhoun, and O'Brien (2010). The review includes the factors influencing the utilisation of maternal healthcare services from various countries throughout the globe to identify gaps in the literature. The findings are interpreted using an inductive method, and the study concludes with a summary of the reviewed literature, discussion, and research gaps.

2.1 The scoping review

Colquhoun *et al.* (2014) recommended the following definition for a scoping review:

> *"A scoping review or scoping study is a form of knowledge synthesis that addresses an exploratory research question aimed at mapping key concepts, types of evidence, and gaps in research related to a defined area or field by systematically searching, selecting, and synthesising existing knowledge"* (Pg.5)

A scoping literature review employs clearly defined strategies to search the available literature concerning the subject matter. This kind of review is reproducible, organised, with minimal errors, highly reliable, and employs a comprehensive literature search mechanism (Munn *et al.*, 2018). Researchers call for this kind of review when the scope of relevant literature is unknown to ascertain the extent of research in the area of interest and hence serve as a means to provide policymakers and stakeholders with a synopsis of research findings and, importantly, to identify gaps in these studies (Arksey and O'Malley, 2005). However, Munn *et al.* (2018) give more fine-toned reasons for scoping literature. They state that scoping is used to study the mode of research conduct, obtain evidence, study existing concepts and definitions, and identify gaps in specified fields. It can also serve as a critical step to a systemic review.

A scoping review is a type of research synthesis to map the literature on a specific topic or research area and provide an opportunity to identify key concepts, research gaps, and pieces of evidence that guide practice, procedure, and research (Daudt, Van-Mossel and Scott, 2013). This review is painstaking and employs clearly defined steps to ensure accuracy and replicable results (Munn *et al.*, 2018). This study adopted a scoping review; scoping studies have an array of applications in the administration of healthcare (Anderson *et al.*, 2008). Adopting a scoping review is a specific target search of the literature focusing on utilising maternal healthcare-related factors. Despite its strengths, a scoping review cannot be regarded as the literature analysis's endpoint. It lacks critical evaluation as it tends to focus on the scope of literature about the topic of interest rather than the quality of research (Grant and Booth, 2009). Other limitations include missing relevant literature, the feasibility of analysing large volumes of literature, excluding grey literature, and studies published in English (Pham, 2014). Nonetheless, the scoping literature review has been used in many studies, including in healthcare-related research.

2.1.1 The objectives of the scoping literature review

The objectives of the scoping literature review are as follows:

- To identify available literature on the utilisation of maternal health
- To examine how these studies have been conducted with different research approaches
- To clarify definitions and concepts in available literature about maternal health
- To discover factors that influence the utilisation of maternal healthcare services
- To identify and analyse shortfalls in the existing literature

2.1.2 Search strategy and sources

This section covers the procedure for searching the internet for research materials from various sources

2.1.2.1 Database

Google and Google scholar were used to search for literature aligned with the research objectives. Google and Google Scholar sites connect with several peer-reviewed journals, including the topic under study. An initial search could be performed with Google Scholar to test for the sensitivity of selected search terms and discover additional search terms that could be used for scoping literature (Banke-Thomas *et al.*, 2017). The following databases were also searched for peer-reviewed journals: ProQuest Central, Psyche, PubMed, CINAHL, PsycINFO, and Oxford academic journals. The reference list of relevant publications was manually searched for articles.

2.1.2.2 Search terms

The constructs for the search were maternal healthcare, qualitative, quantitative, phenomenology, descriptive phenomenology, interpretive phenomenology, maternal health utilisation, reviews, focus group discussion, and interviews. Search keys can be modified as a search progresses (Daudt, Van-Mossel, and Scott, 2013). Hence, a lot of modifications were carried out in the course of the searches.

2.1.2.3 Inclusion and exclusion criteria

Table 1: The inclusion and exclusion criteria guiding the screening of material for the review

Criteria	Inclusion
Language	English articles
Period	January 2013 to December 2022
Type of article	Peer-reviewed
Target population	Developing countries, particularly in Africa
Emphasis of study	Studies that are related to factors influencing women's utilisation of maternal healthcare services

2.1.3 Research question

Daudt, Van Mossel, and Scott (2013) suggested forming a research question that met the research's interest. Considering the primary element of the research question is essential as this directs the course of the search strategies (Arksey and O'Malley, 2005; Davies *et al.*, 2009). Davies *et al.* (2009) regard this as an initial research question because there might be a need to revise the question (Daudt, Van Mossel, and Scott, 2013). Levac, Colquhoun, and O'Brien (2010) encourage researchers to frame questions that are adequately defined in terms of content and have a clear focus. The task includes stating the target population and, categorically, the health outcomes the researcher is concerned about. Levac, Colquhoun, and O'Brien (2010) suggest connecting the purpose of the review with the research question during formulation.

Booth *et al.* (2019), in a more recent development, propose the use of the "PerSPEcTIF" framework, where "Per" represents perspective, "S" – signifies setting, P- the phenomenon of interest/ problem, "E"- environment, "C"- comparison (optional), "Ti" – timing and "F"- findings. They argue that this framework supports a complexity perspective and acknowledges contexts such as environment and setting, considers the viewpoints of all the parties involved besides that of the target group, includes timing and place, and can promote the development of themes rather than numerical outcomes. The central research question was formulated using the "perspective" framework as presented as follows:

Perspective	Setting	Phenomenon	Environment	Comparison	Timing	Finding
From the perspective of women of reproductive age	in the setting of rural communities	how does the phenomenon of the utilisation of maternal healthcare service	within an environment of illiteracy, poor living conditions, and absence of social amenities	not applicable	in the time of gestation, childbirth, and the period following childbirth	Affects maternal clinic visits

Other research questions regulating the review included:

- What does the available literature tell us about maternal healthcare utilisation?
- How were these studies conducted?
- What are the key concepts and definitions of maternal health in the literature?
- What are the areas relating to maternal health that literature has failed to address

2.2.1 Conceptual framework

The Anderson-Newman behavioural model of health service utilisation developed by Anderson in 1968 (Azfredrick, 2016) was used to discuss this review. This model is used to determine the dynamics that affect healthcare utilisation. Additionally, it measures access to healthcare systems by a target population. Andersen *et al.* (1983) defined access as all the parameters determining the chances of entering a given population into the healthcare system. This framework has undergone several review stages and is now in its fourth stage (Andersen and Newman, 2005). The framework is summarised in Figure 1 below. The framework considers individual and societal influences (Petrovic and Blank, 2015). It proposes that healthcare utilisation is determined by predisposing, enabling, and need factors. Individual predisposing factors include age, ethnicity, literacy levels, and race, while societal predisposing factors include cultural norms and beliefs, political views, and social values of the individual's community. These variables exist before medical health is sought and govern the tendency to seek health services. The enabling factors refer to those variables that afford individual access to care. From a personal stance, these include the individual's ability to afford health services, available health insurance, and accessibility to healthcare.

At the societal level, enabling factors include the extent to which insurance covers healthcare in the community, healthcare budgets, income per capita of community

members, the types, numbers, location of health facilities, and existing healthcare personnel. Needs at the individual level are divided into perceived (how individuals perceive their health) and evaluated needs (Health professionals' assessments). At the societal level, needs are indicators of the population's health status and environmental needs, which reflect the environment's health ranking (Babitsch, Gohi, and Lengerke, 2012). They are variables that will necessitate medical attention, such as the rate of illness and perceived health status (Andersen *et al.*, 1983). Researchers have widely utilised this model in studies evaluating health systems (Babitsch, Gohi, and Lengerke, 2012; Petrovic and Blank, 2015; Azfredrick, 2016). The model has a specific focus unlike other models of health behaviour; this model examines human behaviour concerning healthcare, for instance, the patient-physician relationship, and focuses on the individual rather than the family as the basis for analysis (Petrovic and Blank, 2015).

Other models include the health belief model developed by Rosenstock in the 1950s, which ascertains why individuals avoid adopting health-conscious habits. The author proposes that six components influence health behaviour: predisposition to risk, the seriousness of the condition, obstructions to taking necessary actions, perceived advantage of activities, prompts that stimulate action, and one's evaluation of self-worth (Jones *et al.*, 2015). However, this model has several limitations, which include the absence of a clear rule that governs the relationship and the combination of varying components and small extrapolative capacity (Orji, Vassileva, and Mandryk, 2012). Another model related to healthcare is Young (1980)'s choice-making model (Young, 1980). The model comprises four elements, which he proposes are vital to the decision-making process concerning healthcare. They are the gravity of the diseased state, the knowledge of home remedies, faith in treatment (this aspect deals with individual beliefs), and accessibility to treatment sources. However, one of its limitations is that it fails to consider the experiences with it (Kohlhuber *et al.*, 2008).

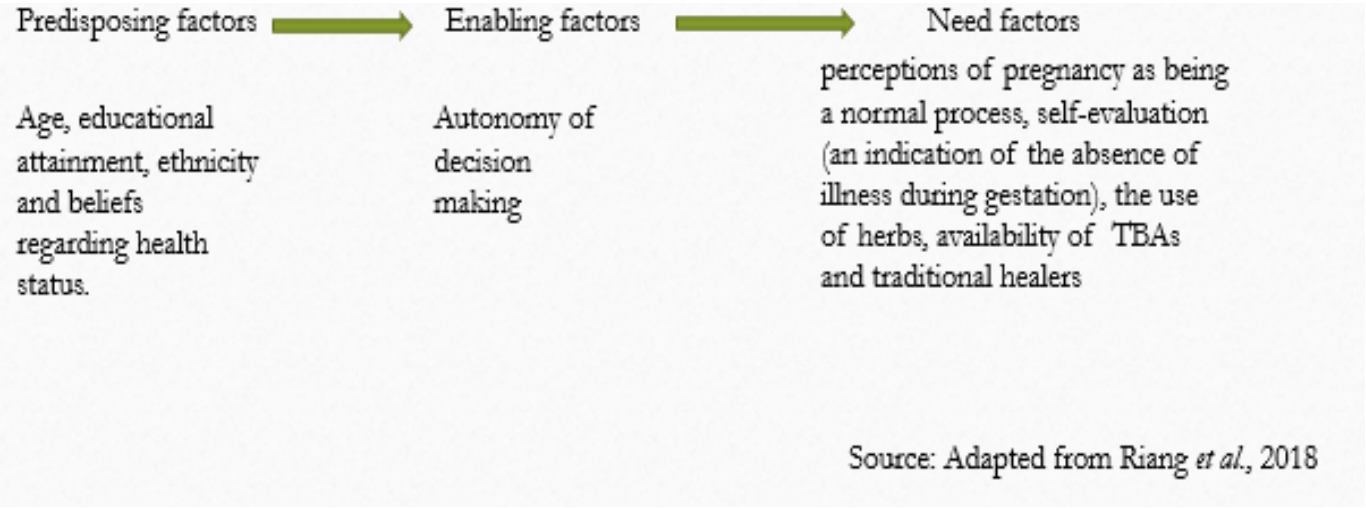
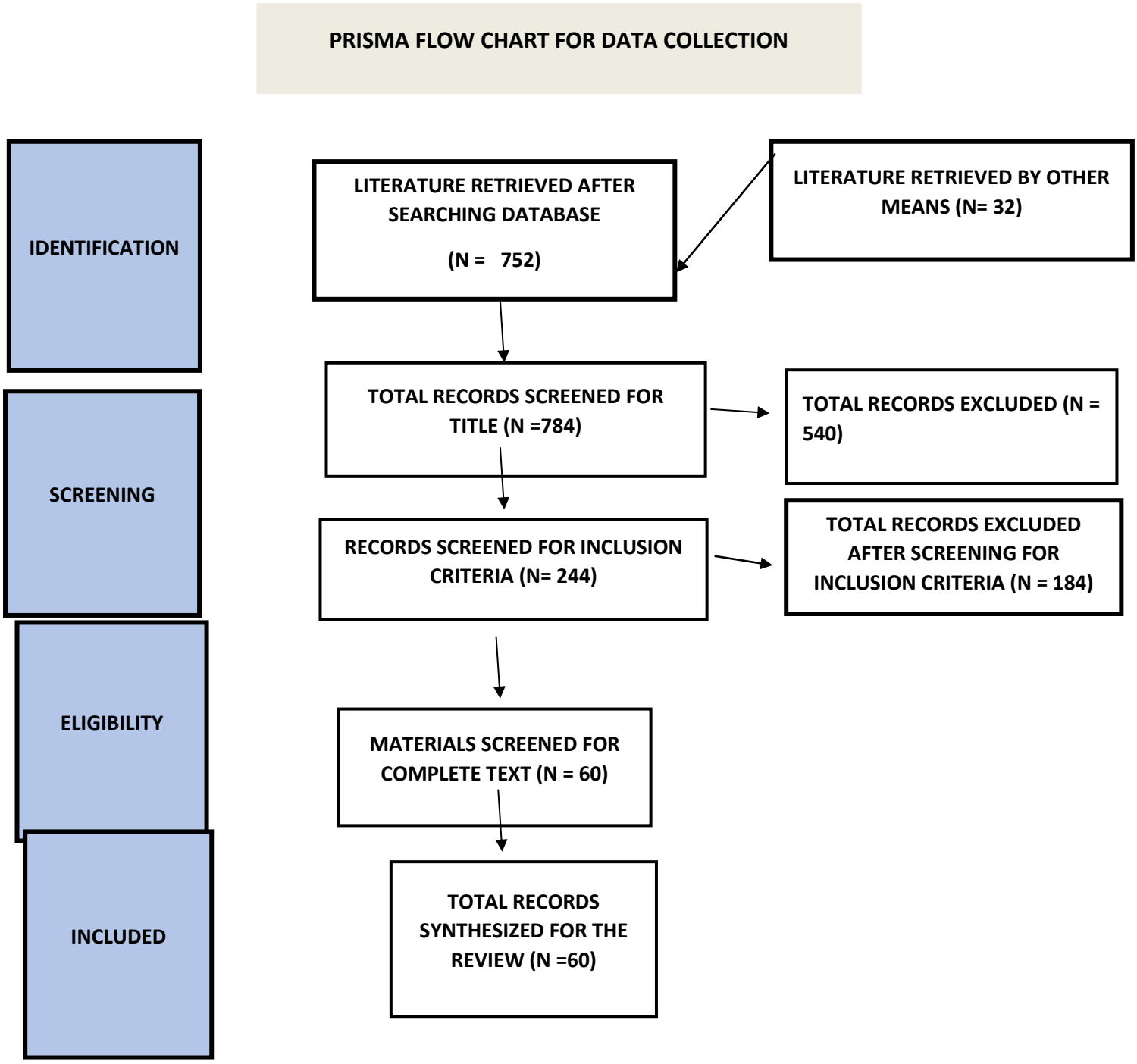


Fig 1: The Andersen –Newman framework for health service utilisation (Riang *et al.*, 2018).

The model assumes that health care services' access to and utilisation depends on three factors, namely, predisposing factors that make individuals inclined to use health services, enabling factors that assist individuals in accessing these services, and factors that allow individuals to perceive the need for health care services, known as need factors (Riang'a, Nangulu and Broerse, 2018).

2.2.2 Methodological Framework

This work adopts the Arksey and O'Malley (2005) framework that was further improved upon by (Levac, Colquhoun, and O'Brien, 2010). This stage includes identifying the research question, scouting for related studies, charting data, and organising, summarising, and reporting results. The final step, consultation, is optional (Daudt, Van Mossel, and Scott, 2013).



PRISMA FLOW CHART: adapted from Schmitz *et al.*, 2019

The total data collected after searching databases (The ProQuest central, Psyche, PubMed, CINAHL, PsycINFO, and Oxford academic journals) was 752 papers, while data retrieved from other sources were 32 in number, which yielded a total of 784 articles. After screening the titles of these papers for relevance (such as titles related to women's health), 540 materials were excluded, leaving 244. The screening of these (244 articles) for the inclusion criteria resulted in the exclusion of 184. The remaining 60 papers were then synthesised for the literature review. The exclusion process was carried out by reading each paper's abstracts, at which stage articles not related to the focus of the study were excluded. Skim reading was also employed to obtain a general

overview of the pieces, and scanning helped quickly locate some specific search strings.

2.3 Review of relevant literature

This section covers the results from the review of relevant literature on the utilisation of maternal healthcare. The six steps of thematic analysis proposed by Braun and Clarke (2006) were applied to develop the relevant themes. The six steps are as follows:

Step 1-Becoming accustomed to the data to be analysed

Step 2-Coding salient features of the data that might be pointers to emerging themes

Step 3-Identification of themes

Step 4-Re-examination of themes

Step 5-Naming themes

Step 6-Reporting the results

The content of the 60 research materials that met the inclusion criteria of being English publications, peer-reviewed, possessing publication dates between 2013-2022, and conducted in Africa that reports how non-clinical factors impact women's (15-49 years) help-seeking patterns were read. The Anderson Newman framework of healthcare utilisation (ANFH) (2005), a model for understanding behavioural patterns (Petrovic and Blank, 2015) that provides an organised design for identifying factors prompting healthcare decisions (Kaba *et al.*, 2016), was employed to categorise the developed themes into predisposing, enabling, and needs elements (Table 2 below). This framework helped reveal factors that could be used to answer the research question about the factors influencing women's decision to utilise maternal health clinics during gestation, childbirth, or the period following delivery.

Table 2: Identified factors based on the ANFH (2005)

Predisposing factors	Enabling factors	Need factors
Age, educational attainment, family size, ethnicity, previous use of maternal healthcare, and beliefs regarding health status.	The autonomy of decision-making, socioeconomic status, household head, social support, husband attitude, husband support, community support,	Perceptions of pregnancy as being a normal process, self-evaluation indicating the absence of illness during gestation, the use of herbs, availability of TBAs and traditional healers.

Identified themes were categorised into traditional beliefs, decision-making autonomy, preference for traditional birth attendants, and an inclination to home delivery. These themes do not differ from ANFH themes but rather are sub-categories under the ANFH themes.

2.3.1 An overview of maternal healthcare

Maternal health is the period in women's lives encompassing conception, delivery, and the few months following childbirth (WHO, 2019). However, Knaul *et al.* (2016) argue for a redefinition that would include all women regardless of their childbearing status. Knaul *et al.* (2016) claim that the description needs to consider various health risks women face and those associated with childbearing dangers or lifestyle choices. Rosenfield, Lambert, and Black (1985) debated the negligence to focus on women through initiatives and programmes tailored towards improving the mortality rate in mothers of reproductive age. They advocated for a functional approach in intervention programmes for women.

Nonetheless, the health of pregnant women is of immense importance. About 830 women die daily from pregnancy and childbirth-related complications, of which 99% of these cases can be traced to underdeveloped countries (WHO, 2019b). The report states that Sub-Saharan Africa and Asia are significant epicentres of maternal deaths (WHO, 2019b). The past few decades have seen an improvement in the goals and programmes to improve maternal health from a broader scope. However, there is still room for improvement in several areas (Knaul *et al.*, 2016).

2.3.2.1 The History of Maternal Health

This element covers the history of maternal health from a global perspective and an overview of Initiatives and programmes to improve maternal health. When looking at the historical trend in maternal deaths, it is striking to learn that mortality rates were

relatively high for many European countries and the United States until the end of the nineteenth century. However, by the 1930s, there was a remarkable decline in death rates attributable to the introduction of antibiotics, improved hygienic standards, blood transfusion, reduction of streptococcus infections, and a decrease in the obstruction of standard delivery (Loudon, 2018). Focus on maternal and child health is a critical component of WHO's constitution and priorities (WHO). Interestingly, these concerns can be traced back to 1930, when the League of Nations drew attention to high maternal death rates. Records show that until the 1930's developed countries had maternal deaths similar to developing nations today. A century ago, the USA had a maternal death rate of about per 100,000 births (Abouza Confidential Enquiries into Maternal Deaths (CEMD) in the UK in the UK stemmed from the need to checkmate high maternal mortality rates in the late nineteen twenties (Abouzahr, 2003).

Until 1985, maternal health had not received the much-desired global consideration it deserved. That year is notable because a publication by Rosenfield and Maine researchers at Columbia University in New York drew the attention of world bodies to the inadequacies of maternal health programmes (Tolleson and Guess, 2013; Knaul *et al.*, 2016). During the first International Decade for Women Conference held in Mexico in 1975 (Zinsser, 1990), the WHO revealed the deplorable state of maternal health, especially in developing countries, and consequently highlighted the urgent need to amend lapses in maternal health programmes and policies. The awareness raised by these events fuelled a worldwide drive to minimise maternal mortality. The climax was an International Safe Motherhood Conference held in Nairobi, Kenya, in February 1987. Three United Nations agencies funded it (World Health Organisation (WHO), World Bank, and Sustainable Development Goals and were propelled towards ameliorating the plight of women during pregnancy and delivery (Starrs, 2006). During the conference, there was a resolve to revise the trend, starting chiefly with dedication from governments and key stakeholders (Abouzahr, 2003). Consequently, the global Safe Motherhood Initiative (SMI) was launched (Knaul *et al.*, 2016).

In 2000, maternal health was incorporated as one of the eight-millennium development goals (Starrs, 2006). Millennium Goal 5 aimed to decrease the Maternal Mortality Ratio (MMR) by 75% between 1990 and 2015 (Alkema *et al.*, 2016). The Partnership for Maternal, Newborn, and Child Health, spearheaded in 2005, was formed as part of the commitment to attain Millennium Development Goals 4 and 5, reducing child and

maternal mortality, respectively (WHO, 2019). However, the Millennium Development Goals were still expected to attain the desired goals (Kalipeni, Iwelunmor and Grigsby-Toussaint, 2017). The MDGs recorded successes in several areas, such as a significant drop in MMR globally in Southern Asia and Sub-Saharan Africa and increased births attended to by professional health workers. However, MMR in developing regions is still relatively high compared to developed countries (WHO, 2019d). Despite these achievements worldwide, evaluation of countries revealed that Nigeria was categorised as having made no progress in reducing maternal mortality rates within the stipulated period (Okonofua *et al.*, 2017).

In July 2014, the UN General Assembly Open Working Group (OWG) put forward a document consisting of 17 goals. This document set the stage for the Sustainable Development Goals (SDGs) from 2016 to 2030. Goal 3 of the paper proposes to ensure healthy lives and promote well-being for all ages (WHO, 2019d) and was designed to complete the unfinished task of MDG's goal 5, which advocated for a 75% reduction in maternal deaths within a stipulated time frame (Okonofua *et al.*, 2017). The state of women's health is a historical conglomeration of decades of changes and amendments to accommodate the needs of women (Knaul *et al.*, 2016) based on mortality. Important areas that need to be reviewed include the inconsistent availability of funds and the support from the ruling powers of concerned nations. Additionally, there needs to be more attention paid to preventive measures, which deal with estimating, averting, and managing maternal-related illnesses. Research in this area is inadequate and needs to be encouraged (Tolleson and Guess, 2013).

Developed countries reduced MMR by increasing access to maternal healthcare services and increasing the number of professional staff. Illustrations abound to indicate that programmes that are aimed towards improving healthcare, as well as the provision of skilled labour, eventually address the problem of high MMR. Countries that have recorded success rates have not only improved the availability of professional workforce at all levels of maternal health and the provision of easily accessible health facilities but have additionally implemented policies and programmes that will catalyse these changes (WHO, 2019). Educational provision is related to the reduction of maternal mortality rate; education can be used as a significant tool in reducing the rate of maternal deaths in developing countries, as obtainable in developed countries. Weitzman's (2017) findings highlight education's

contributions to women's population health and health transitions and the significant role education plays in reducing maternal mortality. Women's cognitive abilities can be developed through education, particularly literacy, as they can seek information about their health and better follow written instructions (Smith-Greenaway, 2014). Additionally, education is likely to lessen the likelihood of unintended pregnancies (Trussel *et al.*, 2014), which may indirectly reduce the demand for risky abortions (Rose and Lawton, 2012).

2.3.2.2 Maternal Health Outcomes in Africa and Nigeria

Among women in sub-Saharan Africa, one in every sixteen births or pregnancies results in death, a stark discrepancy compared to developed countries with a ratio of 1 in 4000 (UNICEF, 2019). Similarly, WHO (2019) reports the proportion of dying from birth-induced complications as 1 in 39 compared to their counterparts in the developed countries, which is 1 in 4700. Statistics reveal that more than half of these women do not receive postnatal care after childbirth (WHO, 2019). However, the SDGF 2019 fact sheet reports maternal mortality in Africa declined by 41% between 1990 and 2010. Ebuehi and Campbell (2011) suggest that this positive outcome is partly due to adopting the millennium goals. Despite this development, the WHO (2019) reports that the scope of maternal health intervention programmes has varied widely in different regions of Africa. For instance, antenatal care visits in Southern Africa were reported to be high compared to Western Africa, where a third of pregnant women did not attend these clinics. Say *et al.* (2007) published a report that showed variations in maternal healthcare utilisation between and within developing countries. According to the report, factors such as economic status, place of residence, medical insurance, accessibility, literacy levels, and other variables appeared to inform the preference for expert care during pregnancy and childbirth. Some factors may have contributed to high maternal death rates in some African countries despite adopting the MDGs (Ebuehi and Campbell, 2011).

The Maternal Mortality Ratio (MMR) of 679 per 1000,000 live births in Western Africa is one of the highest in the world. Although these deaths have significantly declined due in part to the adoption of MDGs, the MMR of this section of Africa remains high (Gunawardena, Bishwajit and Yaya, 2018). Kilipeni *et al.* (2017) said a decline was below what was required to meet the 75% reduction in maternal deaths set as an objective for the 2015 Millennium development goal. As governments and

stakeholders could not meet the MDGs before the time frame elapsed, developing another set of achievable goals called Sustainable development goals (SDGs) became imperative.

MMR in Nigeria is estimated to be 800 for every 100,000 births. Globally, it was the second-highest yearly maternal death for 2010, accounting for 14% of such deaths worldwide. Yearly, there are 52,900 pregnancy-related deaths in Nigeria out of the global estimate. It is interesting to note that MMR differs according to geographical zones in the country, with the North-western and North-eastern regions being the most notable (Kana *et al.*, 2015; Olusegun, Thomas, and Micheal, 2019). In addition to the shortage of skilled health staff in poorly maintained health facilities, other contributing factors to this alarming MMR are the indifferent attitude of the women towards maternal care, family income, education, age, and, most importantly, socio-cultural elements which can predetermine the use of health facilities (Olusegun, Thomas and Micheal, 2019).

Ogu, Ntoimo, and Okonofua (2017) list some hurdles as low literacy levels, weak decision-making power, poverty, and barbaric traditional practices. Geographical accessibility is a significant barrier to utilising appropriate maternal healthcare services (Tanou, Kishida, and Kamiya, 2021). A substantial contributor to northern Nigeria's high maternal mortality rate is the low utilization of maternal health services (Idris, Sambo, and Ibrahim, 2013a). In the Northern part of the country, maternal deaths are prevalent among younger mothers (Sharma *et al.*, 2017). These young mothers are underaged females who have been given in marriage, primarily based on religious reasons. The underdeveloped reproductive organs of these mothers result in pregnancy complications. Early marriage is a practice that is quite normal and acceptable in these regions (Doctor *et al.*, 2012). Other complications that could ensue from early marriages include vaginal fistula and stillbirths, all of which can be linked to immature pelvic development (Olusegun, Thomas, and Micheal, 2019).

Insurgency in the Northern part of the country has also not helped matters as it has hindered the implementation of some of these health programmes, and this is amidst fears that if the situation is allowed to deteriorate, it will nullify the efforts of the past years to curb the high MMR (Kana *et al.*, 2015). The purdah system, which refers to the covering of the entire body by females and the seclusion of women (Adisa *et al.*,

2014), is still practised in some parts of the North and hinders the movement of women during those crucial times when medical attention is urgently sought (Olonade *et al.*, 2019). According to Ogu, Ntoimo, and Okonofua (2017), literacy levels among women can directly affect the prevalence of MMR. Statistics show that educated women are more likely to attend clinics and detect early warning signs of pregnancy complications. Therefore, low literacy levels in the Northern parts of the country, compared to the Southern regions, is a consideration attributed to the high prevailing MMR in the Northern part. Similarly, Olusegun, Thomas, and Micheal (2019) concluded that a secondary-level education increases women's chances of attending prenatal and postnatal clinics and seeking professional medical advice.

Several key components must be addressed for the SDGs to be realised by 2030. Among these are the shortage of skilled health staff in the health sector, an inadequate and obsolete healthcare infrastructure, the government's inadequate efforts towards improving maternal health, and insufficient funding of maternal health programmes. There is also a need for improved policies and initiatives to educate these women and help increase access to healthcare facilities (Izugbara and Wekesah, 2017). A close look at many of these programmes indicates that they were initiated as feasibility studies to evaluate their effectiveness. However, the plan to increase their coverage was eventually never realised (Kana *et al.*, 2015). The non-realisation of the objectives of the various programmes set up to promote the utilisation of maternal healthcare services has been based on several factors. Their short duration is usually attributable to the lack of commitment from the government and the political willingness to implement them (Aregbeshola, 2017). Additionally, the socio-cultural factors that interfere with the utilisation of healthcare services need to be evaluated. How effectively these problems are solved will eventually determine how effectively the SDGs goals of 2030 regarding reducing MMRs are met (Ogu, Ntoimo, and Okonofua, 2017).

2.4.1 Traditional Beliefs

Furnham, Akande, and Baguma (1999) note that the origins of illnesses are often attributed to the supernatural in developing countries compared to the Western world, where diseases are more likely to be associated with lifestyle choices or environmental stressors. The subthemes under this category are discussed as follows:

2.4.1.1 The burying of the placenta

Several examined papers indicated that burying the placenta after childbirth was a critical ritual families undertake. For example, Adatara, Strumpher, and Ricks (2019) reported some women in a district in Ghana linked the destiny of their babies to their placentas and felt that their babies' future had been jeopardised when the skilled health workers denied them access to the placenta. Likewise, in Southern Ethiopia, a similar culture of burying the placenta deters women from birthing at health facilities (Kea *et al.*, 2018). While in Bussie, a traditional region in Ghana, Sumankuuro, Crockett, and Wang (2017) reported the belief in burying the placenta within the vicinity of the family quarters. In research conducted by Adatara, Strumpher, and Ricks (2019), a respondent is noted to have said the following words:

> *When I delivered at the hospital, my mother requested for the placenta to be taken home for burial, according to my tradition, but the nurse refused to give it to her. My mother even pleaded with the nurse for about 30 minutes but refused to provide it to us. One thing that annoyed my family and I was the refusal by the nurses to allow us to take the placenta home for burial.* (Adatara, Strumpher and Ricks, 2019, p.9).

These practices are consistent with similar rituals in Ethiopia that require the collection of delivery blood to be disposed of according to special rites to evade witchcraft attacks (Caulfield *et al.*, 2016). Similarly, (Isidienu, 2017) points out similar beliefs in Eastern Nigeria. These beliefs include burying the placenta at the roots of economically valuable trees to portray the value attached to the child's growth.

2.4.1.2: Consumption of traditional meals and pregnancy rituals

In a study by Adatara, Strumpher, and Ricks (2019) relating to birthing practice in Ghana, the skilled workers displayed no regard for the traditional belief that encourages the consumption of special meals after birth. These special meals are every day in other parts of Africa, such as Ethiopia, where porridge consumption is part of the afterbirth pregnancy rituals (Kaba *et al.*, 2016). Similar findings were also highlighted by Laing *et al.* (2017). There were no reasons stated for the refusal. However, it can be suggested that these health workers, who were more often than not unknowledgeable about indigenous cultural practices, were trying to avoid any harmful effects these meals might have on these babies. Interestingly, Dennis *et al.* (2007) notes that Western cultural practices during the postpartum period are unusual.

Nevertheless, the influx of migrants into these developed countries indicates that medical professionals must deal with various cultures and their inherent practices.

2.4.1.3: The use of traditional herbs

In their report, Aborigo *et al.* (2014) highlighted that some families disallowed visits to health facilities and evaded orthodox medicine in some parts of Ghana. Some women even administered drugs to themselves or consulted traditional healers. These women chose not to visit health facilities because they could use traditional herbs. Alabi *et al.* (2015) report that some women in Cape Town, South Africa, also use herbs. The women of Masaka district in Uganda use herbs to prevent high body temperatures from averting miscarriages, among other things. There are similarities between these practices and those of Western culture (Kennedy *et al.*, 2015). However, the researcher feels the major issue revolves around herbs' potency, dosage, and contradictions.

Interestingly, the cordial reception between the women and the vendors of these herbs, in addition to the payment mode, which could be credit-based or in-kind, discourages patronage of maternal health facilities (Atekyereza and Mubiru, 2014). Likewise, women in Southeast Madagasgar are reported to consume traditional medicine to treat pain, inflamed abdomen, and fever during the postpartum period instead of visiting a maternal healthcare institution (Morris *et al.*, 2014). Alabi *et al.* (2015) posit that some women in East Cape, South Africa, take native medicine to hasten the delivery process. Similarly**,** Serizawa *et al.* (2014) add that the afterbirth ritual performed on women in Eastern Sudan deters them from taking tetanus injections during pregnancy. Antenatal care (ANC) is accessible in some parts of Nigeria (Fagbamigbe and Idemudia, 2017), and this has produced favourable outcomes (Galadanci *et al.*, 2010). However, the tenacious belief in the efficacy of herbs makes them the most preferred means of treatment (Ojua *et al.*, 2014). The researcher would like to propose that for most of these women, herbs are linked to a strong connection with their cultural roots. Even though this is most improbable in countries like the UK, where maternity care is relatively accessible (Hollowell *et al.*, 2016), the inability to afford health care cannot fully account for using herbs.

2.4.1.4: Secrecy during pregnancy and childbirth

It is not uncommon for pregnancy to be concealed to avoid attracting people's attention (Chi *et al.*, 2015). Equally, pregnant women in Ntcheu District, Malawi, felt it imperative

to hide pregnancy in the first few months to prevent the baby from being bewitched (Chimatiro *et al.*, 2018). One of the study participants in Chimatiro *et al.* (2018) was documented to have said, *"'I think most women here do not start ANC early because they normally try to hide the pregnancy in its early stages to avoid being witched"* (Chimatiro *et al.*, 2018, p.4). The situation is not so different in Southern Ethiopia, where some women delay antenatal care registration to hide pregnancy (Kea *et al.*, 2018).

The same pertains to Madagascar, where witchcraft is believed to be transmitted by actions as simple as harbouring evil thoughts about the victim. As a result, there is a fear of disclosing pregnancy or delivery dates (Morris *et al.*, 2014). Similarly, some women feel susceptible to witchcraft during the postpartum period in Eastern Sudan. Therefore, the mother and child are made to stay out of public glare for 40 days (Serizawa *et al.*, 2014). Some women in the upper West region of Ghana undergo cleansing rites alleged to prevent complications and miscarriages and protect the unborn child from witchcraft (Sumankuuro, Crockett and Wang, 2017). In the Gambia, there were similar reports of the concealment of pregnancies in the first trimester to ward off evil intentions (Laing *et al.*, 2017). Similar beliefs prevail in Nigeria, where witchcraft is believed to cause ill health in some instances (Archibong, Enang, and Bassey, 2017), including secrecy during pregnancy (Ezeama and Ezeama, 2014).

2.4.2 Inclination to Home Delivery

This theme covers experiences and factors that promote alternative healthcare to western maternal healthcare. Subthemes under this category were discussed in the subsequent sub-sections.

2.4.2.1: Warm and cordial environment

In Ethiopia, there is a general perception that health facilities are hostile and unsupportive of birthing babies. At the same time, home deliveries are warm and caring when the presence of elderly female members is considered. A perceived conducive atmosphere allegedly hastens childbirth (Caulfield *et al.*, 2016). Kaba *et al.* (2016), in another study conducted in Ethiopia, remarked that the women in selected districts, including Oromia and Amhara, shared related views when they stated that delivering in familiar surroundings coupled with the prayers, cheers, and encouragement derived from home births were soothing and more comfortable. Likewise, in Eastern Cape, South Africa (Alabi *et al.*, 2015) and some districts in

Ethiopia (Kaba *et al.*, 2016), the women preferred home delivery because they received help from relatives and neighbours. Home deliveries occurred with or without TBAs in Nigeria. This practice was quite common, especially for inexperienced mothers unable to identify early labour signs (Egharevba, Pharr, and Wyk, 2017).

2.4.2.2: Pregnancy is normal and does not require medical attention

In South Africa, home births were linked to strength and courage, while birthing in a health facility was associated with weakness (Alabi *et al.*, 2015). Similarly, health facility deliveries were viewed as a procedure for "weak females" in northern Uganda. Again, Caulfield *et al.* (2016) note that birthing without assistance is considered an act of bravery in some Ethiopian communities and an indicator that the woman is a "real woman" compared to seeking medical treatment care during delivery. There is a related perception in the Eastern Cape, South Africa (Alabi *et al.*, 2015) and Burkina Faso (Some, Sombie and Meda, 2014). A study participant in research carried out by Chi *et al.* (2015) made the following remarks:

> *'People think that when you are pregnant, it is a normal condition and you do not have to go to the health facility. They feel that when you go there, you are a coward.' NGO-health provider, IDI – Gulu, Northern Uganda.*

The belief that a woman is supposed to be resilient is further strengthened by the idea that pregnancy is an entirely normal condition that requires no special attention (Chi *et al.*, 2015). Pastoralist women in Kenya (Caulfield *et al.*, 2016) and some Ethiopian women in research conducted by (Kaba *et al.*, 2016) shared the same opinion. These women have a shared view of pregnancy and its accompanying symptoms as a normal process that does not require medical attention. Reiterations further compound these conditions by the women about how female relatives have been through pregnancy deprived of medical care and did not develop complications. Kea *et al.* (2018) also cited related attitudes in the Sidama zone in Southern Ethiopia. Visits to a health facility are attributed to an illness or pregnancy complication, and pregnancy check-up routines are deemed unnecessary. The case is not dissimilar in Eastern Sudan and Kalenjin communities in Kenya, where the chances of seeking medical help are reduced with the number of pregnancies the women have experienced (Serizawa *et al.*, 2014; Riang'a, Nangulu and Broerse, 2018). Atekyereza and Mubiru (2014) noted that the women of the Masaka district of Uganda also shared comparable views.

2.4.2.3: Discretion of home delivery

The discretion of home delivery is another significant factor in favouring its acceptance. It is what informs unassisted delivery in some parts of Sub-Saharan Africa. Home delivery is a robust cultural belief alleged to be linked to quick delivery and protection for both mother and child from witchcraft (Caulfield *et al.*, 2016). In the Maasai communities of Ethiopia, where female circumcision is the norm, women who have not been circumcised were reluctant to give birth in health facilities because of the fear of being exposed and stigmatised as being uncircumcised (Caulfield *et al.*, 2016). Furthermore, Abubakar *et al.* (2017) note that even though some women in Kano state in Northern Nigeria endorsed delivery by skilled workers, they would prefer this procedure within the confines of their homes for privacy. Interestingly, this can be compared to birthing conditions in the UK, where home births are one of the four options available to women carrying natural pregnancies (Hollowell *et al.*, 2016).

2.4.2.4: Religious Beliefs

Nigeria, with a population of 211 million in 2021 and an estimated 216 million in 2022, is the most populous country in Africa (Findeasy, 2021). Nigeria is home to a variety of religions. Nigeria has one of West Africa's most prominent Muslim populations. Muslims make up roughly 50-52% of the population in Nigeria; 99% of the people in Northwestern Nigeria (Hausa, Fulani, and other groups) and Northern Eastern Nigeria (Kanuri, Fulani, and other groups) adhere to Islam (Findeasy, 2021). Nigeria is religiously divided into the South, with 84% Christians dominating, while 81% Muslims dominate the northern part. In comparison, the middle belt has a fair distribution of religious faith, with 42% Muslims, 56% Christians, and 2% other religions (United States Embassy in Nigeria, 2012); Federal Ministry of Health, National HIV&AIDS, and Reproductive Health Survey, 2013). Several factors, religion included, influence human behaviour. Prominent cultural elements, such as religion and spirituality, give meaning to human behaviour, values, and experiences (Ramezani, Ahmadi, and Mohammadi, 2016).

Religion, not scientific precision, is the foundation of spirituality. Rhys (2014) believes that science offers patients a 25% opportunity for healing, while religion provides trust, backing, and solace. Patients want clinicians to know their spiritual and religious background (Akeredolu, Harbinson, and Bell, 2018) so that they will be informed about what to say, do, and prescribe. Religion affiliation is a significant factor in a country

like Nigeria that could influence the healthcare-seeking behaviour of women of reproductive health. The fact that all women practice one religion or another further suggests that they may have been exposed to religious beliefs or practices that could influence their decisions about reproductive health (Solanke *et al.*, 2015).

Age, religion, maternal education, husband education, marital status, and employment status are among the socio-demographic factors linked to utilising maternal health services. In addition, adherents of various religions use health care differently because they spiritualise health situations when deciding when to seek medical help or western medicine (Adeyemi, 2020). In this respect, Al-Mujtaba *et al.* (2016) observe how Muslims have dominated Northern Nigeria and the spread of Christianity in Southern Nigeria. Similarly, a study conducted among Hausa in Northern Nigeria revealed that an Islamic religion that places a low value on women is the most significant factor in maternal mortality (Azuh, Fayomi, and Ajayi, 2015). This finding, among others, shows the dictate of religion on the community members of this part of the country.

Furthermore, studies on the effect of religious utilisation of medical care among women from the Islamic religion showed that faith-related factors hindered Muslim women's access to maternal health services. For example, they have to get permission from their husband to receive healthcare (Doctor *et al.*, 2012; Omer *et al.*, 2014; Fagbamigbe and Idemudia, 2015). Another factor is women's unwillingness to have a male healthcare provider attend to them (Doctor *et al.*, 2012; Omer *et al.*, 2014; Fagbamigbe and Idemudia, 2015). Some studies have established the influence of religion on the utilisation of maternal healthcare services (Nmadu *et al.*, 2010; Okafor and Arinze, 2012; Akinbi and Akinbi, 2015; Sadiq Umar, 2017b). In light of the influence of religion on the utilisation of maternal healthcare services in Nigeria, some studies have established the dichotomy between Christians and Muslims in the utilisation of maternal healthcare services. Secondary data analysis of the Nigerian Demographic and Health Survey (DHS) was used by Umar (2018) to investigate whether women's religious and ethnic backgrounds impact their utilisation of antenatal care and delivery services. In the study, 33,385 women ages 15 and 49 were selected randomly from 286 and 602 urban and rural clusters in the 36 states and the Federal Capital Territory (FCT) in proportion to their respective populations. The study's findings showed that Christians have a higher proportion of women who have had four or more ANC visits (28.2%) than women of the Islamic faith.

Furthermore, the number of pregnant women's ANC visits was statistically related to religious beliefs. Christian women were five times more likely than Muslim women to deliver in a health facility. In addition, Christian women were more likely than Muslim women to have four or more antenatal care visits.

Religion has also been found to affect women's choice of location for child delivery. Most Muslim women in northern Nigeria do not utilise western maternal healthcare services. In addition, the most conservative form of Islam and traditions is found in the North West, where 70% of pregnant women give birth at home (Adewuyi, David, and Bamidele, 2021). These traditions view risk-taking as an act of bravery and tolerance for pain as a sign of strength. According to a study conducted among Hausa Fulani women in Northwestern Nigeria, women prefer to deliver in their homes because they find the lithotomy position and being supervised by someone other than a close relative to be embarrassing (Ityavyar as cited in Sadiq Umar, 2018).

Furthermore, women in the Islamic religion had a higher preponderance of underutilisation of western maternal healthcare services, delivering their babies at home (80.2%) than their Christian counterparts (43.5%) (Adewuyi, David, and Bamidele, 2021). These findings have also been corroborated by other researchers from other parts of the world (Saxena *et al.*, 2013), West Africa (Ganle *et al.*, 2014), South Africa and Southeast Asia (Anwar *et al.,* 2015). A few possible explanations have been offered as likely reasons for the dichotomy between the Christian-dominated area and having a high likelihood of using western maternal healthcare services. For example, Christian women in Nigeria may be more likely to use healthcare services because they typically have higher levels of education than predominantly Muslim women in northern Nigeria (Solanke *et al.*, 2015). Solanke *et al.* (2015) add that women typically receive social support from religious groups, which may explain the religious factor in health care utilisation. Such support includes free medical counselling and treatment for members of religious groups, particularly Pentecostal Christian groups, which has been shown to increase health care utilisation. However, the researchers did not undermine the absence of social help for Muslim women.

Other studies, such as Al-Mujtaba *et al.* (2016), established a significant relationship between religion and the utilisation of maternal healthcare services. According to Al-

Mujtaba *et al.* (2016), religion appears to have little effect on barriers to using maternal health services. The indicators of the use of antenatal services have been better in the Christian-majority South than in the Muslim-majority North. Al-Mujtaba *et al.* (2016) studied how religious factors affected women in rural and urban North-Central Nigeria concerning maternal health. The targeted participants in the Federal Capital Territory and Nasarawa were HIV-positive, pregnant, or of reproductive age. In the study, 68 women, 72% Christian and 28% Muslim, were sampled for the study. Obstacles to participating in maternal service were not found to have significant religious influences. All participants favoured facility-based services. Muslim and Christian women did not have gender preferences for providers. One of the possible explanations was that competence and a cheerful outlook of the healthcare service providers were more important than religious influences.

2.4.2.5: The preference for female health workers

The women in the predominantly Muslim population of Northern Nigeria were influenced by religion, and the use of health institutions was considered. The presence of male health workers during women's birthing process in rural areas in Northern Nigeria has been a major issue for a long time. This is evident in several studies (Abubakar *et al.*, 2017b; Ariyo, Ozodiegwu, and Doctor, 2017). In addition, several studies have established the presence of male health workers during delivery as a barrier against utilising maternal health services in northern Nigeria (Doctor *et al.*, 2012; Omer *et al.*, 2014; Fagbamigbe and Idemudia, 2015; Sharma *et al.*, 2019).

Abor *et al.* (2011) also note religious background's role in healthcare use. The Islamic faith of reproductive women is considered the primary reason for the preference for the service of female health workers (Oyeniran, Adeyeye, and Sowunmi, 2020). Sowunmi *et al.* (2016) explained women's difficulties when receiving healthcare from male health workers and explained why Muslim women do not utilise maternal healthcare services (Fapohunda and Orobaton, 2013a). Some women's belief system influences their decision during delivery because the need to undress before other men (healthcare workers, though) who are not their husbands stops them from using maternal health facilities. The vulnerability due to exposure of women's intimate bodies to male healthcare workers is a secondary factor, which should be a primary factor. The issue is further exacerbated by the presence of male birth attendants (Caulfield *et al.*, 2016). Mweemba *et al.* (2021) found that male health workers dominated

maternal healthcare centres. Women can get detailed information like the available number of healthcare workers and male health workers at the healthcare centres when they attend antenatal clinics. Antenatal visits where male healthcare workers mostly attend to them could inform their conclusion on the number of healthcare workers based on gender category in the healthcare centres.

The preference for female health workers has also been traced to cultural beliefs. For example, there were reported cases in South Korea and Nigeria about women who chose not to utilise a western maternal health care service because they were not ready to undress before any male health workers; after all, the women would only undress for their husbands (Okeshola and Sadiq, 2013; Kim, Kim, and Sohn, 2017). Similarly, in his view, Onasoga *et al.* (2014) traced this phenomenon to the mode of operation in some maternal health care centres. Such a mode of operation demands that women expose part of their body to male health workers during an examination, an act they found at variance with their religious values. Hence, they tend to refuse to utilise maternal health care while seeking an alternative where they are sure of women attending to them.

The religious belief system in Northern Nigeria aligns with that of Pakistani women, who prefer female health workers to attend to them during their birthing process (Bharj, 2007). However, Pakistan women allow male health workers to attend to them, provided no female health workers are available. The health care service excludes an intimate examination from the male health workers. There seems to be no explanation that can appease the women of reproductive age from the northern part of Nigeria to subject themselves to male examination. Empathy and understanding of women's gender were why some women prefer female health workers to attend to them than male health workers (Orpin *et al.*, 2018). Some believe women are naturally compassionate and can easily relate to women in labour due to their experience of child delivery or as potential mothers (Orpin *et al.*, 2018). Several studies have shown women's preference for female health workers over their male counterparts in attending to pregnant women during delivery. However, studies by some researchers showed gender preference was not a significant factor affecting women's utilisation of maternal health care services in Northern Nigeria. These findings from the previous studies imply that the presence of male workers during child delivery does not affect the woman's decision to utilise the maternal health care service. The finding directly

contrasts with the previous study by Al-Mujtaba *et al.* (2016), who found no significant influence of religion on reproductive women's utilisation of maternal health care in North-Central Nigeria. The researchers carried out the study in rural and preurban North-Central Nigeria. The study focused on the effect of religion on the women's decision to utilise general and HIV-related maternal healthcare services in the study population. The researchers engaged 68 Christian and Muslim women, while the majority (72%) were Christians.

The findings showed that none of the participants, Christians, and Muslims, preferred either male or female health workers to attend to them during child delivery. The researchers explained the reason for this finding, which deviates from the expected results on the subject matter. Their explanation for the result was connected to the male health workers' professionalism, respect, and caring attitude. The caring attitude of the male health workers won the hearts of the reproductive women, while such good gestures overrule their religious beliefs. Similarly, Muslim women from Ghana and the Democratic Republic of the Congo appreciate healthcare workers who practice religious tolerance while performing their duties. As a result, it can be deduced that regardless of the gender of the male healthcare workers, education, educational exposure, religion, and settlement are likely factors that can cause women to accept the healthcare services of male healthcare workers.

Conversely, some female participants in the study by Al-Mujtaba *et al.* (2016) indicated their preference for male health workers because men are generally patient and show better understanding than female health workers. The participant's level of education and religion were probable factors that may have influenced the study's findings. Most of the participants in the survey were Christians, while an average number had primary and secondary education. The implication is that religion is also a likely factor in determining women's attending maternal health care services. This finding differs from most findings regarding reproductive women's gender preference for health workers attending to them during child delivery.

2.4.3: Decision-Making Autonomy

Husbands are regarded as the head of the family, the first agent of socialisation. Husbands play a vital role in every family system. There is a religious aspect to husbands' positions, jobs, and obligations to their spouses; they are regarded as the household's head and overseer, alluding to the holy book (Azuh, Fayomi, and Ajayi,

2015). The husbands make the majority of family decisions while they provide direction for their families. Nigeria, especially the Northern parts, is patriarchal (Baba-Ari, Eboreime, and Hossain, 2018). In the northern region, the husbands' role is often stretched to the extreme, where they dominate the family decision-making process. This act of extreme husband controlling the family is known as male dominance(ref). Male dominance allows husbands to make the most important decisions about their spousal healthcare and health-seeking behaviour; this evidence shows the husband's role significantly impacts the utilisation of maternal health services (Baba-Ari, Eboreime, and Hossain, 2018).

Another significant overarching theme is that women lack the freedom to make decisions in households where male dominance is typical. In Northern Ghana, the power to make decisions about their health lay in the hands of their husbands or older male relatives, even when their condition was life-threatening (Aborigo *et al.*, 2014). Women in Ntecheu District in Malawi delayed antenatal registration in the first trimester of pregnancy to consult marriage counsellors concerning their clinic visits (Chimatiro *et al.*, 2018). Fagbamigbe and Idemudia (2015) note a similar trend in a study conducted in Nigeria. Decision-makers included mother-in-law, husband, mother, traditional birth attendants, and community members, according to a survey by Ganle *et al.* (2015). A respondent in research by (Ganle *et al.*, 2015a) is documented to have said:

> *'Are you asking me if I went to the hospital for antenatal care? No, I did not. I wanted to, but my husband and mother-in-law said I could not leave the farm work and go for antenatal; after all, I was not sick.' (Lactating Mother, FGD, Sankpala) (*Ganle *et al.*, 2015a, p.9)

Women's literacy level, religion, and place of residence determine women's autonomy. In regions where Islam dominates, the women depend on their spouses to make decisions of any kind as the religion teaches submission to husbands, who are regarded as the heads of the family. In Nigeria, many Muslim women are not allowed to work, socialise, or leave their homes to shop without obtaining their husbands' permission. Their request is often not granted (Sinai *et al.*, 2017b), including requests for antenatal care. However, Solanke *et al.* (2015) argued that the reason behind the low patronage of maternity care in the Northern parts of Nigeria is related to a shortage of health personnel rather than support from their spouses. Al-Mujtaba *et al.* (2016)

expounded the situation further when they stated that Islam prohibits travelling or visiting married women without a suitable escort or companion. Therefore, when spouses refuse to make the necessary provision for their wives' maternal clinical visits, it results in poor patronage of ANC clinics. However, urban women have greater autonomy in decision-making and live more liberal lives. Polygamy also plays a significant role in supporting women to utilise maternal healthcare. For instance, the chances that a younger wife in a polygamous setting will use maternal healthcare facilities during her pregnancy becomes slim if the older wives give birth at home (Ganle *et al.*, 2015a).

Women's independence is not every day among Hausa-Fulani and Kanuri/Bari-Bari ethnic groups of Northern Nigeria due to adherence to long-standing traditional practices that promote male dominance. These practices have underutilised maternal healthcare services in developing countries (Hatcher *et al.*, 2014). Chol *et al.* (2019) emphasised the importance of achieving the purpose of maternal healthcare services. They believed it is important to remember that failing to attend the recommended number of antenatal care visits and giving birth in a medical facility will invariably defeat the fundamental goal of maternal healthcare services. Male dominance limits activities and opportunities for women, including essential requirements such as antenatal care. These limitations on women's freedom and independence affect their utilisation of maternal healthcare centres.

Conversely, when women are permitted, it helps them achieve many goals, including enhancement of personal goals and quality of family life. In a qualitative study in Zambia by Sialubanje *et al.* (2015), women's independence was found to be part of the factors that caused low patronage of the services of skilled healthcare workers in the maternal centres. However, it resulted in high usage of alternative healthcare-traditional healthcare services provided by Traditional Birth Attendants (TBAs). The husband's dominance is part of the cultural factor that affects women's healthcare-seeking behaviour in healthcare services. Husband dominance significantly limits women's freedom to seek healthcare services (Shamaki, Yew, and Dahiru, 2017). However, when women are not supported by their husbands, they can patronise the TBAs, whose services are cheap and accessible, depending on the situation.

Nigeria has multiple ethnic groups with numerous cultural practices (Adedini *et al.*, 2015), all with their customs and peculiarities. These ethnic groups also face different ethnic challenges. In northern Nigeria, women's decision to leave their home environment needs their husband's approval. Any decision to do otherwise may result in problems in the family, like the probability of divorce by their husbands. Shamaki, Yew, and Dahiru (2017) showed a significant relationship between husbands' approval and women's freedom. In Nigeria, specifically the northern part of the country, Adedini *et al.* (2014) believed that women's access to timely medical care, especially in emergent health needs, was hindered by various ethnic factors, such as women's difficulty obtaining permission from husbands. Adedini *et al.* (2014) added that many Hausa women are subject to male dominance and social control because of this culture of spatial constraint, which limits their autonomy and mobility.

Women need their husbands' permission in almost every matter, including when they need to leave the vicinity of their homes. The findings from a study in Sokoto State by Ajayi and Akpan (2020) showed that the underutilisation of western healthcare services was due to the husband's dominance as the family's decision-maker. The study by Ajayi and Akpan (2020) demonstrates that the decisions of women of reproductive age, especially pregnant women, to seek maternal healthcare services can be promoted or discouraged by the attitude/beliefs of their husbands. Women's request to utilise healthcare facilities is subject to their husband's approval. The study by Ononokpono and Odimegwu (2014) showed that Hausa/Fulani/Kanuri women have fewer antenatal care visits than women of other ethnic groups. The predominance of cultural and traditional practices from women from various ethnic groups in Nigeria is one of the major obstacles to improving maternal health, particularly in the northern states (Shamaki, 2019). Okeshola and Sadiq (2013) shared their views on this subject matter. They believed that in many low- and middle-income countries, including Nigeria, women's access to services had been hindered by sociocultural beliefs and the need for immediate and specialised services.

Women's decision to give birth at home has also been connected with male dominance and a patriarchal society. The perceptions are the same in the Massai community of Kenya, where the choice of visiting a maternal healthcare facility lies solely with the women's spouses (Karaja *et al.*, 2018). Comparable situations prevailed in Ethiopia (Woldemicael and Tenkorang, 2010; Kea *et al.*, 2018), Madagascar (Morris *et al.*,

2014), Zambia (Sialubanje *et al.*, 2015b), Burkina Faso (Some, Sombie and Meda, 2014) and Togo (Arnold *et al.*, 2016; Japutra and Situmorang, 2021) Mali (White *et al.*,2013) and in Nigeria (Adeniyi and Olusola, 2012). However, there are instances where women's spouses support their antenatal clinic visits, as noted in Eastern Sudan (Serizawa *et al.*, 2014) and Tanzania (Kohi *et al.*, 2018). Some, Sombie and Meda (2014) note only men possess economic power, so women cannot travel and visit antenatal facilities because they cannot afford the fees.

It can be inferred that male dominance is multifaceted and multi-dimensional. For example, there is a financial aspect and a relationship aspect. The relationship aspect of male dominance occurs when male partners do all they can to ensure their wives are mostly available at home. The relationship form of male dominance could result in a choice of the purdah system. A tradition that separates married women from other men is known as the purdah system and is prominent among women from the Islamic religion (Shamaki and Buang, 2014). Shamaki and Buang (2014) believe homebirth happens when a pregnant woman gives birth in her home. She may ask a family member or a Traditional Birth Attendant for help cleaning the baby or removing the placenta from the baby. Shamaki and Buang (2014) agree that some women do not attend antenatal care because their husbands might forbid them from going, possibly because of the purdah system. So, the more the women opted for a home birth due to male dominance, the less the tendency of deciding to utilise western maternal healthcare facilities.

In contrast, a study by Shamaki and Buang (2014) demonstrates that women of reproductive age underutilise maternal healthcare even when they do not experience husband dominance. The implication is that some women were underusing maternal healthcare services despite enjoying family independence. Regarding some, Shamaki and Buang (2014) took note of three countries where women who wanted higher freedom were less likely to use maternal healthcare services. Both antenatal care and women's autonomy were found to have weak but statistically significant associations in a pool of data from all 31 nations and in Chad, Mali, and Senegal, Shamaki and Buang (2014) conducted country-level analyses revealing that women who scored higher on some autonomy measures were less likely to use maternal healthcare services.

2.4.4 Preference for Traditional Birth Attendance:

Adedokun and Uthman (2019) cited one of the problems of poor utilisation of maternal services in rural areas in Nigeria as being due to an increase in traditional birth attendants (TBAs). Easy accessibility and cost were mentioned as reasons for patronage (Ebuehi and Campbell, 2011; Arnold *et al.*, 2016; Adedokun and Uthman, 2019; Ebuehi and Akintujoye, 2022). Pastoralist women in Kenya regarded TBAs as an indispensable part of the birthing process. The TBAs were said to perform several functions, including treating ailments with herbs, proffering advice on what to eat, and encouraging the reduction of physical labour. The rural women prefer skilled birth attendants to these women who have undergone no formal training. Some qualities that endeared these TBAs to the women were: TBAs are females, they understand and promote culture and are affectionate to their patients, they can be easily reached, and they are inexpensive (Caulfield *et al.*, 2016). TBAs are reported to accompany women of the Massai community in Kenya to healthcare centres where they assist during childbirth and play the roles of interpreters to skilled healthcare workers (Karanja *et al.*, 2018). In Southern Ethiopia, TBAs are in high demand despite initiatives by the government to discourage their use. There were suggestions that women prefer them to skilled birth attendants because they know their customs and traditions (Kea *et al.*, 2018; Ebuehi and Akintujoye, 2022). In Madagascar, many women visited TBAs and traditional healers during pregnancy.

Sometimes, there seemed to be a collaboration between TBAs and skilled health workers (Morris *et al.*, 2014). For example, some women in Lagos state, Southwestern Nigeria, use TBAs and maternal health care facilities. At the same time, some of them shun health facilities completely to avoid being administered injections or drugs. Some reports also suggest that these women believe TBAs are better skilled and conversant with pregnancy complications than professional health staff (Okafor *et al.*, 2016). TBAs have assumed a position of trust in the Kalenjani community in Kenya. A study by Serizawa *et al.* (2014) cited two main factors that made TBAs the preferred birth attendants: experience and accessibility. These factors were experience and accessibility. Additionally, TBAs receive considerable patronage in Northern Uganda, where they are readily available and esteemed (Chi *et al.*, 2015).

The Nigerian healthcare system is financially multifaceted and incorporates private and public contributors. The private sector includes profit and non-profit providers,

traditional healers, and spiritualists. In the public sector, the three tiers of government, namely the federal, state, and local governments, are responsible for secondary health care (teaching hospitals and medical centres), secondary health care (state hospitals), and primary health care services (primary health care centres) respectively, in a decentralised manner (Emmanuel, 2014). However, despite some significant reforms in the healthcare system, institutional corruption has continued to impede progress (Aregbeshola, 2017). Dilapidated and over-strained facilities are the hallmarks of many primary healthcare centres in rural areas where more than half the nation's population resides. Therefore, it is not surprising for rural dwellers to resort to traditional healers due to problems of cost and accessibility (Emmanuel, 2014).

2.4.4.2: Socioeconomic status

Different authors describe socioeconomic status (SES) in different ways. SES is the capacity of individuals concerning their educational qualification, occupational status, and income earnings. Education, social group, and income earned are often presented as the significant components of people's socioeconomic status without providing a basis for choosing such indicators (Ploubidis, Benova, Laydon, and DeStavola, 2014). SES is part of the factors that influence people's health-seeking decisions. The higher the SES of individuals, the higher the tendency to seek healthcare services (Darin-Mattsson, Fors, and Kåreholt, 2017). Several studies have established the influence of socioeconomic status on the utilisation of maternal healthcare services (Dehingia *et al.*, 2019; Agho *et al.*, 2018). Past studies have shown that women in low- and middle-income countries are vulnerable to utilising maternal health care services below expectation (WHO, 2003).

Similarly, Simkhada *et al.* (2007) acknowledged the role of the socioeconomic status of families and individuals in utilising maternal healthcare services. The economic impact of working women is another factor in this regard. Working mothers can probably provide basic needs to support their male partners and their families. Hence, they can pay for transport fares or healthcare service charges without depending on their husbands to meet such needs.

The maternal mortality rate is high in northern Nigeria, among other states. The National Bureau of Statistics record for the socioeconomic status of states in Nigeria showed Zamfara State as the poorest state in Nigeria in 2017 and Sokoto State in 2019, while Zamfara State fell among the 10 poorest states in Nigeria, with over 70.8%

poverty rate. Bauchi State was also ranked 8th among poor states in Nigeria in 2020. The reports of the National Population Commission (2014) and findings of Sinai *et al.* (2017a) established the North-Eastern and Northwestern parts of Nigeria as part of the minimum developed regions regarding socioeconomic and educational activities. According to the 2013 reports of the National Population Commission, low socioeconomic status is not limited to northern states. It is found in other parts of the country, like the South-South, which has also witnessed a high level of low socioeconomic development. In contrast, the factors highlighted probably have the possibility of causing a lower utilisation of healthcare services in the geopolitical zones.

The concept of finance as a subset of SES depicts the income level of individuals to meet their basic needs, including their health needs. The test of financial capability shows an individual's financial income, with either sufficient or insufficient funds, at the end of the month (Ploubidis *et al.*, 2014). Finance enhances education, and the essence of work is to source income to meet human needs. Some authors have established the importance of economic factors in utilising healthcare services (Arnold *et al.*, 2016; Wilunda *et al.*, 2016). Finance is a specific pointer of material resources, powerfully and positively related to longevity (Chetty *et al.*, 2016). The choice of the terminology, finance, is to capture the financial capability of a different group of people, either salary and wages or any form of income.

Disparities in accessing healthcare services are related to patients' socioeconomic status. The financial strength of households regarding their healthcare decisions has been established from previous findings (Novignon *et al.*, 2015). Several researchers have found the influence of finance-related issues on the utilisation of healthcare services. Agho *et al.* (2018) showed that mothers' employment status significantly predicted maternal healthcare services utilisation. It was clarified that unemployed mothers in poorer families underutilised maternal health care services compared to employed mothers.

2.4.4.2.2: Cost of medical care and utilisation of maternal healthcare services

Every service has a cost, and patients are expected to pay for the health services they enjoy in the healthcare centre. The financial capability of the patients is a foremost cost determinant. Patients with high SES may not find the cost of drugs or healthcare services high because they can afford to pay. Patient willingness to pay is another

factor tied to their financial capability. However, readiness to pay may push patients to seek help to utilise health services, especially when a case is urgent and there is no alternative. The high cost of health care services implies patients' failure to make payments for health care services even when prices are not disproportionate (Yaya *et al.*, 2019a). There is no free service, but there could be sponsors or provision of a highly subsidised cost to promote the usage of healthcare services for a while. Idris *et al.* (2013) found 100% antenatal care attendance among pregnant women when the government provided free healthcare services in the northern region.

The high cost of health care services was established as one of the reasons for women's non-utilisation of maternal health care provided by the government (Banik, 2016; (Okonofua *et al.*, 2018). The cost is relative, as what is considered high in a region may have alternative implications in another part. The people's socioeconomic status in rural areas is related to their perceptions of cost issues. Some researchers have identified this same reason within and outside Nigeria (Dubourg *et al.*, 2008; Egbewale and Odu, 2013). It implies that the women's financial capability could not cater to maternal healthcare providers' health service costs. The high price of services covers different components of the healthcare needs of reproductive women.

Okedo-Alex *et al.* (2021) compared users' satisfaction with the quality of service in private and public maternal healthcare centres. In their study, most of the respondents attending public maternal health care centres were dissatisfied with the high cost of services in the centre, compared to the respondents attending private hospitals. As a result, one would have expected respondents who used private healthcare facilities to be more dissatisfied. Nevertheless, patients of lower socioeconomic status were more likely to use public healthcare and underuse healthcare facilities. However, other findings from the study showed poverty as a factor that accounted for the non-utilisation of maternal health care centres in rural areas.

The high service cost pushed many reproductive women to seek alternative traditional health care (Oladipo 2014). Their decision invariably stemmed from their low socioeconomic status, which caused a reduction in the number of people utilising the maternal health centre. Similarly, as Yaya *et al.* (2018) specified, the perceived reduced health service cost odds were 2.2. Lack of financial wherewithal led some women to avoid the western maternal healthcare centre for another alternative (Geleto

et al., 2018; Dahab and Sakellariou, 2020). Similarly, in a qualitative study by Yaya *et al.* (2019) and (Yaya *et al.*, 2019b) in a rural area in Edo State on the perception of men on barriers to utilisation of maternal health care, the cost of health facilities was one of the sub-themes. The findings showed a high cost of health care for the centre facilities as a participant felt delivery cost should be based on women's experience of complications during childbirth. The finding implies that women should not be charged for delivery when they have a safe delivery. Likewise, in a study by Yaya *et al.* (2019), both male and female participants expressed concern about the effects of the high cost of healthcare services. However, they were cheaper than healthcare costs in a private hospital. The participants adjudged the cost of health services as one of the primary reasons they should have patronised the health centre. However, a keen look at the expense of the health centre showed their socioeconomic status and power were responsible for such responses. Hence, Fapohunda and Orobaton (2013) affirmed the high rate of health services in Nigeria, while they found that the economic insecurity of some mothers would hinder them from taking advantage of available health services.

In contrast, Atinge, Ogunnowo, and Balogun (2020) did not find the high cost of medical care to be a significant factor in determining maternal health service utilisation. Similarly, in a study by Adegbe (2021), the female participants did not see the high cost of healthcare services as a challenge that affected their utilisation of maternal healthcare services. Buttressing the issue of the cost of health services, the findings from the study carried out by Yaya *et al.* (2019) showed that the cost of health services was not a problem. The participants in the study were men who emphasised all-around preparation, especially financial preparation on the part of the male partners of the pregnant women since that is the next stage after pregnancy. The explanation was associated with comparing human life with health care bills, as the life of a pregnant woman is more precious and should be valued more than the health care bill, no matter the amount. The survival of the woman and the child should be of utmost priority for the men. This view has attracted different perspectives, both supporting and opposing ones. Some other participants from other FGDs, who were older, between 40 and 54 years, held contrary views on the cost of health services and demanded that health care services be free.

People in a particular region's location and socioeconomic status are probable reasons for divergent views on the cost of healthcare services. The findings of Adegbe (2021) showed a high willingness of the study participants to pay for their health care as most of them considered the cost of health care affordable. Yaya *et al.* (2019) were of the view that quality of care, in addition to the cost of service, is an essential factor that may change the minds of reproductive women and their male partners in the utilisation of maternal health care service regardless of the cost of service, either high or low. The researchers opined that providing quality service by skilled health workers would influence women's readiness to pay for health care services as long there are necessary facilities and availability of trained health workers. The view of Yaya *et al.* (2019) seems possible in an urban centre with a concentration of individuals with high levels of educational qualification and income status.

In rural areas, decisions about the cost before quality may occur due to individuals' capability. Health care is expensive in rural areas, and incomes are lower, resulting in women and their male partners having limited means to pay. Reductions in healthcare at source have resulted in criticism in the rural areas in northern Nigeria unless there are no costs attached. In Bangladesh, Banik (2016) found that pregnant women's families go the extra mile to borrow money to pay for health care services, especially when it involves caesarean delivery. However, there were records of unfair increases in the cost of such caesarean delivery, up to five times. Patients with few other options are forced to borrow money to pay for their health care because of their financial situation. Some of their mode of sources of borrowing include personal savings, friends, and sharecropping. This action showed a level of understanding and commitment to the health aspect of the patients and their families.

2.4.4.2.3 Access to drugs and utilisation of maternal healthcare services

Drugs are essential to healthcare services to address human health challenges. Doctors prescribe medications for patients to take care of one ailment or another. Medications can be prescribed for women before and after childbirth for various reasons. For example, they can be prescribed for pregnant women for preventive purposes or to handle complications before and after delivery. The literature has shown that the availability and cost of drugs affect women's utilisation of maternal healthcare centres. Purchasing medications inside the health care centre was more expensive than purchasing them outside. Patients, most of the time, resort to local

drug vendors to buy but at higher prices (Edu *et al.*, 2017). This issue is often caused by a lack of transparency among some health workers, driven mainly by corrupt practices in Nigeria. The report of a survey on the rate of reduction of child and mother mortality in Nigeria showed how pregnant women have a habit of avoiding the health care centre because they cannot afford it. The reports cited northern Kano and Zamfara, where women opted for traditional healthcare when considering the cost of medications to be non-affordable.

This phenomenon discourages mothers from further utilising the health care centre. Buying medications outside the health care centre in rural areas is not without some side effects, apart from the cost issue. Patients sometimes face the challenges of buying expired, sub-standard drugs from unlicensed chemists (Kunnuji *et al.*, 2022). However, some women were content with buying drugs outside, even if it was free in the health centre. The reason was the low quality of the medicines in the healthcare system compared to the ones in the pharmacy outside the healthcare system (Edu *et al.*, 2017). Shortage and non-availability of medications lead to increased demand. The situation puts women in a precarious position where they need their medications but cannot afford them. Where there are free drugs, there are reports of corruption among health workers. The financial ability of reproductive women is a factor that is pivotal to the use of maternal health care services. The purchase of medications prescribed by skilled health workers is determined by the financial power of the women and the support of their husbands.

Edu *et al.* (2017) observe the non-availability of prescribed medications for women in the pharmaceutical unit of the health care centre. Hence, the women seem to have no option but to resort to the conventional stores to buy the medications, which are most times considered expensive, more than when they are available in the pharmaceutical unit in the health centre. However, some women expressed a change in this phenomenon, unlike unpalatable previous experience. A study(ref) participant shared mothers'' previous experience of non-affordability of cost of service and drugs and recent positive change where healthcare workers were ready to do anything to save their lives. Patients buy medications outside the healthcare centre when medicines are in short supply or not available in the healthcare centre. The issue of shortage and non-availability of drugs, which lead some mothers to either buy medications from

outside vendors provided they have financial capability or resort to other healthcare alternatives, have been reported in the literature by several authors.

Non-availability and shortage of drugs are very prominent in these accounts of maternal healthcare services. The findings from the literature showed inadequacy and unavailability of medications in the health centres (Ajayi, Ahinkorah, and Seidu, 2022). There have been several complaints about this shortage and the non-availability of drugs. The few available medications are sold at exorbitant rates, higher than the usual price, and some mothers are forced to buy these by health workers before delivery because they are not available in the health centre (Yaya *et al.*, 2019a). Two male and female participants from the study shared how difficult it was for them to buy medications outside since health care frequently had none available. The difficulty was associated with the high cost of drugs and the cost of transportation to buy the costly pills. The shared experience of mothers is the ease of access when the medications are available at a lower price or free of charge. However, the ease of access is made difficult by some corruption in the healthcare system among healthcare workers.

2.4.4.2.3 Transportation and utilisation of maternal healthcare services

Transportation is part of daily human activities. It involves the movement of goods or humans from one place to another. By application, situations warrant patients to visit the health care centre. It is unrealistic to expect healthcare centres to be situated near all patients within an area. As a result, transportation to healthcare centres will always be necessary. Patients may get to the health care centres by car or public transport, which requires money. Findings from previous studies (Silal *et al.*, 2012; Ganle *et al.*, 2014) (have shown long distances limit access to healthcare centres for mothers and their relatives. Owumi and Raji (2013) trace women's experience of difficulty utilising healthcare centres to the distance from their residences. Many women with low socioeconomic status in rural areas live far away from the healthcare centres, which demands they travel far to utilise the healthcare facilities in their regions (Ajayi, Ahinkorahb, and Seidu, 2022). The researchers pointed out that women with low socioeconomic status pay a lot for transportation compared to what they or their families earn. Sometimes, the government enacts a policy on reducing health costs to encourage women to attend maternal healthcare centres. The achievement of health care policy is hinged on access to health care for women who need it to meet their needs (Ganle *et al.*, 2015b).

Extensive travelling to health care centres is not the only issue; there is also the problem of the means of getting there, which is connected with finance. Finance is a barrier that affects the frequency of contact with medical practitioners, whereby pregnant women may find it challenging to utilise the health centres (Tsawe and Susuman, 2014). Therefore, women seeking medical attention place a premium on accessibility and affordability. Women may be more likely to apply for alternative healthcare centres, which may be closer and more affordable. The issue of travelling long distances is not limited to Nigeria. In South Africa, travelling long distances to seek health care was also identified as a barrier to medical attention in rural areas. Rural settings challenge the government as most houses are located at some distance from each other (Tsawe and Susuman, 2014). Moreover, transportation costs pose a challenge to women in rural areas for economic reasons.

Shamaki, Yew, and Dahiru (2017) established a significant relationship between distance and utilisation of ante-natal care services in Sokoto State, northern Nigeria. The findings of their study showed an in-depth analysis of the women's distance and the utilisation of the health care centre, both for ante and post-natal care. Participants covered a range of 0 to 30km (0-19 miles) to the nearest health centre. The researchers found that most participants covered more than 10 kilometres (6 miles) to attend the nearest health centre. A keen observation from the findings showed that women living a short distance from their health care centre found it challenging to pay transport fares that would take them to the centre. Given this is the experience of those close by, socioeconomic status and costs are the main factors relating to access to health care services for rural areas in northern Nigeria.

The roads in rural areas are poorly maintained, a challenge that invariably affects the utilisation of health care centres. Women in rural areas face bad roads and long distances to the healthcare centre (Yaya *et al.*, 2019a). A study in Jahun, in northern Nigeria, by (Uzondu *et al.*, 2015) found that the cost of transportation was associated with the state of the bad roads. The high cost of transportation, along with the socioeconomic status of the women, tends to deter them from utilising health care centres. With the state of the roads, there is no certainty of the availability of a car to convey mothers to the health care centre. Mothers can do nothing if they miss the available care at the health centre (Uzondu *et al.*, 2015).

Similarly, Ayamolowo, Odetola, and Ayamolowo (2020) conducted a study to determine women's choice of delivery in rural communities in southwestern Nigeria. The researchers adopted a mixed method and sampled mothers who gave birth five years before the study. The findings showed that most mothers not utilising the western maternal health care centre indicated the long distance of the facility to their residence and lack of transportation as the main reason for the non-utilisation. Some of the participants interviewed in the study shared the need for most of them to utilise the health care centre to travel a long distance, which is another challenge due to the lack of transport fares. One of the participants shared how she gave birth in her room when she could not go to the maternal health centre because there was no means of transportation. There was alignment between the findings from the quantitative aspect and qualitative aspects. The qualitative elements provided further explanation for the quantitative aspects. Hence, the study concluded that the proximity of the healthcare centres to the mothers' residences enhances their willingness to engage with them.

Some women in rural areas sometimes walk to utilise maternal health care within their communities. Some participants in a study by Yaya *et al.*(2019a) shared their painful experiences of walking long distances before they could eventually get the bike (motorcycle) to the healthcare centre. Some of them preferred to give birth at home because of this experience. A man shared his painful experience when his wife got pregnant, which resulted in the baby's death because of the distance from the health centre to their residence. Studies have also shown the influence of distance as a barrier to utilising the maternal health care centre (Ganle *et al.*, 2014; Kyei-Nimakoh, Carolan-Olah, and McCann, 2017; Dahab and Sakellariou, 2020). The studies showed that women in rural areas whose houses were far from the maternal health care centres underutilised the health centres more than women whose homes were closer. The unavailability of the transportation system to distant healthcare centres was another challenge reported in the literature (Egharevba, Pharr, and Wyk, 2017). Ajayi, Ahinkorah, and Seidu (2022) share their views on the effect of the availability of the transportation system to the health care centre. They were concerned with the unpredictable nature of pregnant women, who may enter into labour unexpectedly. They concluded the challenging transportation system might force such women to give birth at their preferred settings apart from the Western health care centres in addressing the long-distance challenge. However, only a few indicated long distances

as a barrier to utilising maternal health care in a study by Abubakar *et al.* (2017a) among women using antenatal health care centres in Kano. The reason for the finding may be traced to the location of the health centre, Bagwai town, a catchment area of over 162,847 population. The catchment area is an advantage where most patients can access the health facility.

2.4.4.2.4: The attitude of Health workers and utilisation of maternal health care services

Attitude is essential in every system. The decision of reproductive women to seek maternal health care from the health care centres is connected to the behaviour of skilled health workers. It implies the attitude of trained health workers is a chief determinant in the healthcare-seeking behaviour of women, especially in rural areas. Their attitude can encourage the women to utilise the maternal health care centre and equally can serve to discourage. Several studies have been conducted on the influence of skilled workers' attitudes on women's utilisation of maternal health care services.

There is a high expectation of professionalism from skilled health workers. Unfortunately, some studies on women's utilisation of maternal health care showed that the attitude of the health workers affected their decision to utilise such maternal health care centres. For example, the study by Bohren, Hunter, Munthe-Kaas, Souza, Vogel, and Gulmezoglu (2014) reported women's dissatisfaction with the manner of approach from the health workers. The women's dissatisfaction was based on verbal assault, poor attitude in handling health matters, and an absence of empathy displayed by the health workers. Similarly, Eke, Ossail, Eze, and Ogbonnaya (2020) conducted a study in Ebonyi State to compare the population's perception of the barriers to utilising ante-natal care services. The researchers sampled 12 health service providers from both urban and rural areas. The study's findings showed that most rural participants attributed barriers against utilising maternal health care to the poor attitude of skilled health workers. A participant shared that the attitude of the health workers, who rarely came to work, discouraged the women from utilising the maternal health care centres. The participant added that such poor attitudes of the health workers pushed women to seek alternative health care, which was considered somewhat friendlier than Western healthcare.

A study in Ghana, West Africa, Nachinab, Yakong, Asumah, Ziba, Antwi-Adjei, Benewaa, and Aidoo (2022) found the interaction between midwives and the women utilising maternal health care as very appalling with no iota of compassion for the women. Some participants complained about appointment refusals due to lateness, an action contrary to professional conduct, unlike their experiences in alternative healthcare centres. This experience was corroborated by another participant, who shared the effect of her unpalatable experience on their child's health condition since she was always turned back home due to acclaimed lateness by the health care workers. Negative findings about health workers' attitudes have also been reported in Nigeria. Some studies showed the poor attitude of healthcare workers as part of the reason for women's non-utilisation of maternal healthcare services (Fagbamigbe and Idemudia, 2015). Time is a measurement of human life. People value their time; a waste of their time is considered a waste of their life. The waiting time in the health care centre goes a long way to promoting the utilisation of maternal health care centres among reproductive women. In Nigeria, maternal healthcare waiting time is often long and unsatisfactory (Adeyanju, Tubeuf, and Ensor, 2017).

Perceived long waiting times can affect patients' assessment of their satisfaction with the health care service providers (Dairo and Owoyokun, 2010; Oyerinde, Harding, and Amara, 2013; Bleustein *et al.,* 2014; Lea, Jitka, Sulova, Simona, 2015). Studies have shown further explanations of the state and the effect of waiting time on women deciding to utilise Western health centres (Banik, 2016; Ntoimo *et al.*, 2019). Long waiting times, for example, deter women from using maternal health care (Ntoimo *et al.*, 2019). Some (do you have a number) of the participants in the study carried out by Ntoimo *et al.* (2019) showed that subjecting mothers to a long waiting time was a result of the poor and uncaring attitude of the health workers, which is characterised by unnecessary lengthy protocols for registration even in an emergency. A female participant from the study expressed dissatisfaction with the health workers' non-attentiveness, which eventually resulted in a long waiting time.

Long waiting times discourage the male partners from accompanying their wives to maternal health care centres (Byamugisha, Tumwine, Semiyaga, and Tylleskar, 2010; Ditekemena, Matendo, Koole, Colebunders, Kashamuka, Tshefu, Kilese, Nanlele, and Ryder, 2011; Banik, 2016). The male partners need encouragement rather than discouragement because they do not attach importance to attending the maternal

health centres (Lowe, 2017). Similarly, Chris (2015) expressed his dismay at the discouraging healthcare environment, which included long waiting times even when male partners were compelled to attend healthcare. Their wives' efforts to ensure they follow healthcare with them may be hampered by this alone. Some researchers suggested making the waiting room more comfortable by providing televisions in the rooms and shortening the time patients and their families had to wait (Redshaw and Henderson, 2013; Chris, 2015; Gibore *et al.*, 2019). In a study by Ngwibete *et al.*, 2021, the health workers acknowledged long waiting times as a challenge facing patients during maternal care. Nearly half of the health workers were willing to ensure a drastic decrease in needless waiting time in their wards. A reduced waiting time is likely to increase the interest of the mother and their male partners in utilising maternal health care services. The long waiting times may reflect an inadequate number of health workers. With high waiting times, unnecessarily long administration processes, and insufficient numbers of health care practitioners, women (and their support networks) become frustrated, seeking alternative care measures. Hence, Igboanusi *et al.*, 2019 recommended employing more skilled health workers to ensure patients spend less time waiting to utilise the health care services.

The long waiting time does not necessarily imply the provision of low-quality service by the health workers. This assertion aligns with the view of participants in a study by Ntoimo *et al.* (2019). A female participant appreciated the effort of the skilled health workers and the service they provided but was unhappy about the long waiting time despite the quality of the health service. Similarly, Okedo-Alex *et al.*, 2021 conducted a study to determine the difference in mothers' willingness to recommend private or public health centres based on some outlined characteristics. The researchers sampled 620 women from public and private health care centres and interviewed some mothers from the health centres. A notable difference was found between willingness to recommend private health care centres due to a short waiting time compared to the public health centres. This finding showed the importance of waiting time and how mothers appreciate their time being valued. The state of facilities in the health care centres was found to be one of the reasons for the long waiting time. Nnebue (2011) found that the non-functionality of healthcare facilities causes delays during consultation. The mother feels the effect in the form of long waiting times because the

non-functionality of the facilities demands extra time in attending to the patients, which affects the time spent waiting.

Free healthcare service contributes to long waiting times in maternal healthcare centres (Olaitan *et al.*, 2017). Offering free or subsidised health care attracts more patients than when free service or subsidy was not attached. Offering free or subsidised health care services without a corresponding increase in the number of health workers may result in long waiting times among workers. Research by Asekun-Olarinmoye *et al.* (2009) and Sumithra *et al.*, 2006) show that free or subsidised health services would stretch the facilities in the public health centres and adversely affect the utilisation of the health centres. The reason is due to the high tendency of health workers to keep the patients longer than necessary. Shortages of healthcare workers and longer waiting times directly resulted in a reduction in the satisfaction rating of the patients in healthcare services (Gerein *et al.,* 2006). Hence, increasing the number of health workers was suggested as a critical way to improve patient satisfaction (Banik, 2016).

Nnebue (2011) found adequate waiting time in her study. However, few respondents indicated long waiting time as a principal factor for cessation of maternal health care service utilisation. Among the respondents who reported a prolonged waiting period, the primary reasons cited were delays in consultation and laboratory services. Patients experience extended waiting times as they await the attention of skilled health workers. The waiting time holds for individuals seeking healthcare services, including those donating samples for tests. The effects of long waiting times are numerous. Long waiting times adversely affect patients attending to other activities outlined for the day (Nnebue, 2011). Missing appointments disrupted the entire day's activities, resulting in delays. A study by Onwudiegwu (1999) found 1 and 6 hours for minimum and maximum time patients spend waiting, respectively. The finding showed that most patients expressed displeasure with the health workers for making them wait too long.

2.5 Discussion/Appraisal of Literature Reviewed

Health decisions are influenced by cultural beliefs and the norms regarded as acceptable modes of conduct in communities. How individuals conduct themselves is determined by how community members perceive their actions (Kifel *et al.,*2018). The utilisation of maternal health care services, including delivery in a health facility under the management of health care professionals, is linked to a reduction in MMR (Doctor

et al., 2018). However, in Nigeria, where only one out of every three births are registered (UNICEF,2019) and death registration is rare (Tobin *et al.*, 2013), the correlation between antenatal clinical visits and successful birth rates is difficult to determine. While the impact of culture varies from society to society, its variables are not easily quantifiable (Atekyereza and Muribu,2014), especially in Nigeria. Nonetheless, the utilisation of maternal healthcare facilities is influenced by several factors, which range from cultural beliefs and norms to problems of accessibility and cost.

This review consisted of 60 peer-reviewed journals meeting the inclusion criteria and yielding results that further elucidated inhibiting cultural factors that deterred women of African descent from using maternal healthcare facilities. These women's culturally linked factors, which resulted in the underutilisation of maternal health centres, were identified under four themes: traditional beliefs (number 1), an inclination to deliver at home (number 2), lack of autonomy to make decisions (number 3), and the preference for TBAs (number 4). The themes were identified as societal predisposing, enabling, and need factors using the Anderson-Newman model of healthcare utilisation (Anderson-Newman, 2005).

2.5.1 Theme 1: Traditional Beliefs

Traditional beliefs were identified as a resounding theme with secrecy during pregnancy, burying the placenta, using traditional herbs, and consuming traditional meals and pregnancy rituals as subthemes. Scrutiny of these beliefs will reveal a spiritual undertone common in the African tradition and similar to those of the Western civilisations, where sociology and culture have had an early impact on the evolution of medicine (Lupton, 2019). In the African culture, diseases are invariably connected to discord between individuals' social, physical, or spiritual environments (Chukwuneke *et al.*,2014). In addition, there are beliefs that ailments occur because of witchcraft or the maltreatment of ancestors drives, which drives people to consult traditional healers rather than utilise Western medicine. These practices are further consolidated by being passed down from generation to generation, either in written forms or orally (White, 2015). This strong connection between the living and the spirit world informs some traditional beliefs, including those identified during the review, cited from Ghana, Ethiopia, Malawi, Madagascar, Uganda, and South Africa. For instance, some traditional beliefs in Nigeria include the following:

'*The umbilical cord and placenta are buried where the child is expected to inherit (land). It is marked to ensure that no one marches on the buried items and to prevent fetish practices to protect the mother and baby from harm. The carer or the child's grandmother cleanses the umbilical cord till it falls off within four to seven days, and the cord is buried under a palm tree of the land to be inherited by the child*.'

(Elochukwu,2019, p.49)

In a study about religion and spirituality conducted by Ohaja, Murphy-Lless, and Dunlea (2019), one of the midwives was documented to have stated the following remarks.

'Some go to prayer houses. They want to go to a prayer house; one woman abandoned her drugs and went for prayers. Some will tell you that this disease/complication was sent, i.e., sent by witches or evil forces; that is the language. It was a spiritual attack, you know.' (M2)

(Ohaja, Murphy-lawless and Dunlea, 2019, p.6)

The belief in taboos and the implications of disobeying them sometimes result in harmful practices that can severely affect maternal health. For example, birthing plans refer to birth preparedness, which increases the chances of seeking and utilising professional health personnel (Ndeto *et al.*, 2017). For instance, one such taboo is the prohibition of making birth plans, which was identified in the Massai community in Kenya (Karaja *et al.*, 2019). Food taboos are prevalent in the sub-Saharan region of Africa during pregnancy and lactation. It is undoubtedly true that certain foods should be prohibited during pregnancy, such as raw or uncooked eggs, foods rich in vitamin A, and some kinds of cheese (NHS, 2019). However, when food avoidance is based on assumptions, without scientific evidence, such that it results in inadequate nutrients, it potentially leads to severe effects on the mother and the developing baby in her womb (Onuorah and Ayo, 2003). Some of these food taboos result in prohibiting specific foods rich in nutrients to avoid alleged harmful effects on the unborn child. In South-eastern Nigeria, for example, pregnant women are discouraged from eating snails for fear that it will make the baby sluggish after birth (Echochi *et al.*, 2016). Avoiding these foods that are densely packed with nutrients can have profound implications for pregnant women (Cusick and Georgieff, 2016).

Traditional beliefs influence Africans' health practices and health-seeking behaviour before, during, and after childbirth. Some beliefs include consuming traditional meals and pregnancy rituals, using traditional herbs, and secrecy during pregnancy and childbirth. Community members and skilled health workers disagreed that special meals should be consumed after birth. Community members believed in the power of special meals, while skilled health workers did not see anything special about such meals (Zepre and Kaba, 2017; Adatara, Strumpher and Ricks, 2019). Both parties have justifiable reasons for focusing on child protection from different perspectives. It could be deduced from the studies reviewed that some mothers did not utilise modern maternal healthcare because of dependence on traditional medicine, which they have tested and trusted over the years. Hence, they saw no need to visit modern healthcare for health needs. Some use traditional medicine for different reasons to treat pain, inflamed abdomen, and fever postpartum, while some mothers take native medicine to hasten the delivery process during childbirth.

The review of the studies (Kea *et al.*, 2018) concerning traditional beliefs before childbirth shows that mothers conceal their pregnancy to avoid drawing attention to it and to prevent their babies from being attacked through witchcraft. Hence, these traditional beliefs affect the utilisation of modern healthcare centres. Some mothers would not start registration for their antenatal care on time to hide their pregnancy. This decision would make them miss some orientation and talks the skilled healthcare workers give to pregnant women during the antenatal care session. Some mothers may decide not to attend antenatal care to hide their pregnancy. This decision affects their knowledge of some basic things they need to learn from antenatal care.

A prominent traditional belief attached to childbirth is the issue of the placenta. Traditional beliefs connect the placenta to different people, like the mother and the child. Although superstition may appear to underline traditional African practices, the placenta's reverence in African and other cultures cannot be denied (Philips-Kemenanabo, 2011). A placenta is considered beyond being an object that should be thrown away. They also ensure that the placenta is appropriately buried far from the child's home because it is regarded as the baby's "travelling companion," accompanying the child from its previous realm to the one where it is born. It is believed to be connected to the future conception of the mother and should be hidden from those wishing to prevent her from having any additional children (Philips-

Kemenanabo, 2011). The traditional belief systems in African communities' value having access to their babies' placenta, whereas denying them access is thought to impact their children's future (Adatara, Strumpher, and Ricks, 2019). Some other traditional beliefs recommend the right place to bury a placenta. These beliefs advocate burying the placenta at the roots of economically productive trees to demonstrate the significance of the child's development. This traditional belief system is at variance with the practices in modern maternal healthcare centres. Community members who hold traditional high esteem may not utilise modern maternal healthcare centres because of previous experiences of refusal by skilled health workers to release the babies' placenta to their mothers for them to be buried.

2.5.2 Theme 2: Inclination to Home Delivery

A second resounding theme was the preference to deliver at home. The following subthemes were highlighted: the need to evade male presence, the notion that pregnancy is an ordinary condition that requires no special attention, the discretion of home delivery, and the supportive presence of relatives. Most pregnant women give birth at home due to religious factors (Adewuyi, David, and Bamidele, 2021). Hence, the underutilisation of modern maternal healthcare services is more rampant among Muslim women than their Christian counterparts (Adewuyi, David, and Bamidele, 2021). These women prefer to deliver their babies at home because their assessment and perceptions of the skilled health workers' operations were contrary to their religious beliefs. Male population dominance in the workforce of the modern maternal healthcare centres did not concur with the religious stance of the community members in the rural areas in northern Nigeria. The women and their husbands prefer female health workers to attend to their wives during check-ups and delivery. The findings of Caulfield *et al.* (2016) and Mweemba *et al.* (2021) showed that the husbands of pregnant women were not comfortable with their wives undressing before another man in the name of healthcare. Their stands were based on the religious injunction that considered such a phenomenon an act of defilement.

The World Health Organisation (2014) stipulates that delivery should be undertaken by an accredited birth attendant who can provide the necessary services and make referrals if needed. Home deliveries have been associated with high MMR. Home deliveries occur in unhygienic surroundings; they are unpredictable, unexpected, and primarily attended to by family members and neighbours without professional training.

Home delivery potentially harms women and their babies, especially when complications arise (Moindi *et al.*, 2016). The influences of cultural perceptions cannot be overlooked. Home deliveries are related to literacy levels, location of residence, age, number of births, and social status (Tsegay *et al.*, 2017). It is a practice quite common in the Northern region of Nigeria and fostered by the prevailing Islamic religion. Muslim women are known to prefer deliveries attended to by only females (Umar, 2017b). This finding correlates with Gulumbe *et al.* (2018), who report that 91% of females in the Kebbi state of Nigeria deliver at home.

2.5.3 Theme 3: Lack of autonomy

The lack of autonomy when making decisions was presented as the third central theme of the reviewed papers. The position of Adedini *et al.* (2014) and Shamaki, Yew, and Dahiru (2017) affirmed the lack of freedom for wives in northern Nigeria. The men enjoyed their rights to the full while women's rights were constantly put under check and monitored in a state where women were not free. An example was women requesting permission from their spouses to access maternal healthcare facilities. Some reasons stated for the total dependence of the women on crucial decisions include the belief in dowry payment by the men, which secures the right to control every aspect of the women's lives according to tradition. Gender inequality affects African women and girls' access to health care and other facilities, job opportunities, decisions, and freedom of movement (UNICEF, 2018). In patriarchal societies in Africa, the men control every aspect of family life, such as financial flow, wives' movement, and the utilisation of facilities (Aborigo *et al.*, 2018)

Permission might also be sought from mothers-in-law, elders in the family, or TBAs (Ganle *et al.*, 2015b). The autonomy of decisions is crucial to utilising healthcare facilities, as studies show that women's freedom is related to increased use of maternal health services (Wado, 2017). It is also consistent with the findings of Ameyaw *et al.* (2015), whose work revealed the ability to make decisions about health resulted in increased utilisation of healthcare facilities. However, it was noted that maternal age and educational achievement affected decision-making power. Educated women had more knowledge about the importance of maternal services and would be more persuasive in their demands (Ganle *et al.*, 2015b).

Older women prefer to deliver at home, perhaps because of unfavourable past experiences with skilled health staff or the notion that they have accumulated enough

experience from past births (Ameyaw *et al.*, 2015). These findings suggest that the success of maternal health care lies partly in the need for women to independently choose what they deem to be the best option for their health. Additionally, programmes should be designed to educate men about the ills of gender inequality. Finally, the government should collaborate with community leaders and stakeholders to develop initiatives on how women can be granted more decision-making autonomy.

2.5.4 Theme 4: Preference to use the services of TBAs

The last theme was the preference to use the services of TBAs rather than skilled health staff. The review's findings aligned with a study by (Adatara, Strumpher, and Ricks, 2019). In the study, the roles of TBAs were enumerated to include attending to deliveries, providing transportation to health facilities for the women, escorting women to health facilities, and educating women on proper nutrition during pregnancy. Interestingly, TBA's payment mode can be in kind. Noteworthy is the fact that TBAs are part of the community. Therefore, they have prior knowledge of beliefs and norms regarding maternal care (Kayombo *et al.*, 2013). These roles, coupled with the notion that the TBAs are not paid, make them an attractive option for rural women. TBAs play crucial roles in the community, providing health facilities that skilled health staff are unable to deliver. Nonetheless, Kayombo *et al.* (2013) argue that some TBAs perform some procedures on pregnant women that could be hazardous. Adatara, Strumpher, and Ricks (2019) and Kayombo *et al.* (2013) propose training and incorporating TBAs into developing strategic programmes to help reduce MMR.

The findings from the reviewed literature showed that several factors accounted for the reasons mothers prefer and utilise the services of TBAs. The financial state of the women, most times, influenced their decision to use the TBAs more than the skilled health workers. The services of the TBAs are considered affordable (Adegbe, 2021). Hence, the socioeconomic status of the women in rural areas would prefer TBAs to modern maternal healthcare centres. Utilising maternal healthcare centres has cost implications of different forms, such as transportation, healthcare services, drugs, and other necessary healthcare materials. The cost implications surrounding the utilisation of modern maternal healthcare services are opposite to the services of the TBAs. A review of some studies, such as Egbewale and Odu (2013), (Yaya *et al.*, 2018a), Geleto, Chojenta, and Musa (2017), and Dahab and Sakellariou 2020) showed that the cost of TBAs services is considered cheap compared to the cost of utilising modern

maternal healthcare services. This situation does not mean that all the mothers who prefer TBAs do not know the importance of using modern maternal healthcare services. Still, their socioeconomic state eventually led them to choose TBAs by circumstance, not out of choice. It was also found that most TBAs live close to the women who patronise their services. The proximity of the TBAs to the mothers, with the fact that transport fares of healthcare services considered high are not involved, are factors that influence the mothers to have a high preference for the TBAs. Drugs in modern healthcare centres are expensive, and their availability is not guaranteed. On the other hand, traditional medicines such as herbs, concoctions, or special meals given by the TBAs are almost free and available with or without the mother's request.

A relationship is an asset that people value. The form of relationship women enjoy with the TBAs won their hearts to utilise their services. The TBAs are considered more compassionate than skilled health workers (Nachinab, Yakong, Asumah, Ziba, Antwi-Adjei, Benewaa, and Aidoo, 2022). The form of care women enjoys from the TBAs aligns with Downe, Finlayson, Oladapo, Bonet, and Gülmezoglu (2018), who advocate for a holistic approach to maternity care that prioritises childbearing women's well-being, preferences, and cultural considerations. They highlighted women's desire for a positive birthing experience and the significance of tailoring care to align with their personal preferences and cultural contexts.

The Traditional Birth Attendants (TBAs) are women with firsthand experience in childbirth, allowing them to empathize with pregnant women. In contrast, not all skilled health workers may have the same knowledge about the delivery process. The expertise and gender status of the TBAS may account for the compassion displayed by the TBAs more than the trained health workers. Long waiting time is a discouraging factor for the women utilising modern healthcare centres as many pregnant women always come for healthcare (Banik, 2016), waiting to be attended to by few skilled health workers while the women could get full attention from the TBAs. The mothers know these TBAs. Hence, they are not treated as strangers who come for healthcare.

2.6: Research Gaps

The literature review revealed that among Nigeria's six geopolitical zones, northern Nigeria had the highest rate of maternal mortality, making it a significant obstacle for women of reproductive age (Guerrier *et al.*, 2013; Sharma *et al.*, 2017; Gulumbe *et al.*, 2018; Meh *et al.*, 2019). The low utilisation of Western maternal healthcare facilities

in rural areas is primarily linked with maternal mortality (Fagbamigbe and Idemudia, 2015; Fantaye *et al.*, 2019). Studies carried out similar to the objectives of this study were mainly conducted in other states, while few studies on maternal healthcare had been carried out in Bauchi State. A keen look at the various parts of the studies reviewed (Andersson *et al.*, 2011; Omer *et al.*, 2014; Ansari *et al.*, 2016; Cockcroft *et al.*, 2018; Cockcroft *et al.*, 2019; Abdullahi *et al.*, 2020; Omer *et al.*, 2021) revealed the studies that had been carried out in Bauchi State, Nigeria focused mainly on general and child health, which differs from the present study.

The study by Cockcroft *et al.* (2019b) was an experimental trial carried out in two communities in Bauchi State. The study's objective was to determine the effect of home visits on maternal and newborn outcomes using video clips in the wards to talk about household factors linked to higher maternal risks. Pregnant women were majorly engaged as samples for the study. The researchers analysed the study's data using a quantitative analytical method. It was found that the impact of home visits and knowledge of possible mechanisms may have significant implications for lowering maternal morbidity and mortality in settings with limited access to high-quality antenatal care services. The present study focuses on factors influencing women's utilisation of Western maternal healthcare services rather than home visits. The present study adopted a qualitative research approach (descriptive phenomenology) as a methodological approach where different sets of participants, namely reproductive women, husbands, and skilled and traditional birth attendants, served as the participants for the study.

Abdullahi *et al.* (2020) conducted a study on quantitative analysis of the geographical distribution of maternal mortality cases in Bauchi Town. The researchers used secondary data and records from existing hospitals, while the present study used primary data collected through interviews and FGD. The researchers focused on the causes of maternal mortality in the state but not on the effect of the factors influencing the utilisation of maternal healthcare services in the state, which is part of the objective of this study. The researchers were interested in the monthly distribution of maternal mortality rates covering 2018 and 2019. Findings from the study revealed that women between the ages of 20 and 24 were particularly at risk of maternal mortality. These women are primarily Hausa by tribe, majority Muslim, and have little or no formal education. The study's findings showed the age and tribe analysis of women at risk of

maternal mortality. The study was one of the few studies related to this study, as the researchers carried out a quantitative analysis of age and tribes. However, the researchers used records of only pregnant women; they did not capture the experiences of pregnant women or other groups of people to discover the factors that influence their utilisation of maternal healthcare services, a specific area the present study covers.

Abegunde *et al.* (2015) conducted a study using quality assurance for maternal and child health intervention targets in Nigeria's Bauchi State. The researchers used secondary data mixed with self-reports by mothers and children. The findings showed that most LGAs surveyed were classified as a high priority, necessitating increased intervention programmes and interventions that must be rapidly scaled up to address the situation. The researchers' suggestions for various programmes to handle healthcare situations need some assessment. The study revealed Bauchi State as one of the targets of MDG with some maternal and child mortality indicators. The present study serves as a follow-up study to discover the state of utilisation of maternal healthcare services, possibly reducing the maternal mortality rate if there is a high-level utilisation of the healthcare centres.

Orude (2021) carried out a study of how poverty influenced the death of mothers in Bauchi State. The study was conducted in Bauchi Local Government Area, Bauchi State, North East Nigeria. The researcher adopted a qualitative approach with four Focus Group Discussions for data collection. Participants in the study revealed that poverty has several adverse effects on their lives, including a high rate of community mortality; women's health is affected, and human development is impeded by poverty. The study was another one of the few studies carried out in Bauchi State but had related objectives to the present study. The present study conducted a detailed assessment to confirm the current healthcare issues in the state. Hence, the few available studies affirmed the cases, causes, and distribution of maternal mortality in Bauchi State. However, they did not include women's experiences and the factors influencing their utilisation of maternal healthcare services. Most studies adopted a quantitative approach, while a few adopted a mixed-method approach. Also, most studies focused on home visits as they affect various maternal outcomes, while the few that cover some aspects of maternal use were conducted a few years ago. Therefore, this study was designed to address the identified gaps in the literature.

2.7. Limitations of the reviewed literature

While every effort has been made to include all research that meets the search criteria, omissions may have occurred in the reviewed studies. Additionally, the results might have barely reflected people's views when considering possible omissions during data transcription. Most studies reviewed had small sample sizes, were mainly qualitative, and used interviews, questionnaires, and FGDs to collect data.

CHAPTER THREE

METHODOLOGY

3.1. Introduction

Research methodology involves the scientific approach adopted to conduct a study (Ryan, 2018). It is a systematic process of solving an investigation problem, and the scientific process involves carrying out a study (Kothari, 2004). Research methodology is the theoretical framework that explains a study's chosen methods and philosophy, which drive the conduct of a survey (Schmidt, 2020). The central theme of these descriptions is that methodology serves as the blueprint for a study embedded with the systematic and scientific process. A research methodology drives methods. A philosophical underpinning of a methodology describes the methods used in a study (Wallace, 2018).

This chapter contains a detailed account of the research methodology employed in this study. The rationale for choosing the methods in examining the utilisation of maternal health services in Bauchi State, North-Eastern Nigeria, is presented in this chapter. The study was carried out to answer the following research questions:

1. What are the women's experiences of the factors influencing the utilisation of maternal health services in Bauchi State, Nigeria?
2. What are the perspectives of the maternal healthcare stakeholders on women's experiences of the factors influencing the utilisation of maternal health services in Bauchi State, Nigeria?

The section covers the types of research approaches and the chosen approach for the categories of research philosophies and the chosen philosophy underpinning the study, research designs, the chosen research design, and the justification for the selected phenomenology research design.

3.2. Research Philosophy

According to Saunders, Lewis, and Thornhill (2019), research philosophy describes how knowledge is established and the quality of expertise. It permits a view of the researcher's perspective and how its assumptions support the methods utilised in the research process. The terminology describing how people view the world is a paradigm (McBride and Bergen, 2015). Researchers are influenced by the paradigm they perceive to resonate with them, which is reflected in the mode of the investigative process. Researchers usually utilise two methods to observe the world. These two

methods are typically quantitative or qualitative (McBride and Bergen, 2015). Quantitative research is generally represented in numbers, founded on a philosophical paradigm known as positivism, and characterised by the collection of measurable variables which are subsequently subjected to statistical analysis (Walker, 2005). The implication is that concepts become absorbed into the body of knowledge only if they conform to a set of laws (Gray, 2018). Positivism was the leading social science epistemological paradigm between the 1930s and 1960s. Central to the arguments of positivism is the assumption that the properties of the social world can be quantified through observations. Positivists maintain that reality is what the senses can perceive. Investigations should, as a result, be founded upon quantifiable variables. These variables are then expressed as numerical data and analysed statistically to obtain generalised scientific laws.

On the other hand, qualitative research utilises words rather than quantifiable variables as data. It seeks to discover knowledge by identifying themes while taking note of target individuals' language, lived experiences, and narratives (Creswell, 2013). This research concerning maternal healthcare utilisation was borne from observable themes in the reviewed literature, suggesting a link between perceptions of healthcare facilities construed from cultural viewpoints with a profound impact on health decisions (Vaughn, Jacquez, and Baker, 2009; Jia *et al.*, 2017). It was posited that utilising maternal healthcare facilities was a function of cultural beliefs, norms, and values. In that regard, qualitative research provides a comprehensive, in-depth exploration to enable understanding from the participants' unique perspectives. It allows participants to share their experiences and views about a phenomenon of interest.

3.2.1 Ontological perspective:

Ontology is concerned with the question, "What is real?" In the quantitative paradigm, the answer to this question is one in which only one specific objective truth is influenced by the same set of laws (Scotland, 2012). On the other hand, the qualitative paradigm is based on the doctrine of relativity. It postulates that there is no objective or universal truth, but that truth is relative and subject to individuals. Interpretivists or constructivists, as practitioners are also known, belong to this school of thought (McBride and Bergen, 2015). Relativism is the ontological stance of interpretivism, which seeks to understand human phenomena. It proposes that reality is subjective and varies from one person to another. For example, the researcher is an indigenous

of Bauchi State, one of the northern states in Nigeria. She is familiar with the culture of the region. Hence, she studied and acknowledged the similarity of their cultural concepts. The researcher experienced acceptance from the communities during data collection. She was welcomed and well-accommodated. The endorsement could be partly attributed to her cultural background. It is assumed that culture's influence on utilising maternal health care services was based on the human definition of health care in these communities. This assumption is consistent with relativism, which proposes the effect of the human senses in defining reality (Scotland, 2012).

In this study, the qualitative researcher did not hypothesise or intend to test a hypothesis but, instead, explored the social interactions that pertained to the use of maternal health. As a result, the perceptions of utilising maternal healthcare facilities were unique for every individual and further shaped by previous knowledge or experiences with the healthcare system, as discussed in chapter two. Again, this is consistent with interpretivism, suggesting that reality is borne when human consciousness interacts with objects laden with meaning. In other words, realism depends on the subject's perception of their environment (Thanh, Thi, and Thanh, 2015). Humans perceive their surroundings and elicit reactions based on these perceptions. Hence, perceptions vary (as no two humans can think alike, paving the way for several interpretations regarding a particular phenomenon (Pham, 2018).

This perception is opposed to positivism, where "truth" concerning a particular phenomenon is obtained by quantifiable measurements (Pham, 2018). This ontological perspective led the researcher to focus on the participants (subjects) rather than the object (maternal health care facilities) to elicit the reasons that would influence the patronage of the health facilities. Since reality is subject-specific and individually created (Scotland, 2012), it became necessary to employ an interpretivist approach that sought the subjects' constructs regarding maternal health care.

3.2.2: Epistemological perspective

Epistemology offers a philosophical context determining which knowledge is acceptable and sufficient (Gray, 2018). The researcher's ontological stance on the perception of maternal healthcare facilities being relative and moulded by past knowledge and experiences support constructivism's epistemological stance. Constructivism is consistent with the Thomas Theorem conveyed by an American sociologist, William Isaac Thomas (1863–1967), who described human reality as the

construct of the person who experiences it (Chandler and Munday, 2011). An essential feature of this theorem is that the participant is the focus and creates knowledge independent of input from other individuals. The participant is also answerable for the acquired knowledge and experiences they gain during interactions with their environment using their senses and cognitive domains. Thus, knowledge is formed from the meaning one confers to the environment and natural surroundings due to personal observations (Ültanır, 2012).

Constructivism proposes that knowledge is acquired through perceptual creation (Olusegun, 2015). It offers explanations as to why individual perceptions regarding a similar phenomenon differ. Constructivism is a theorem that helps to describe how individuals might learn and the type of knowledge acquired. It posits that proper understanding is construed from past experiences and previous knowledge. New knowledge develops from interactions between background knowledge and the daily beliefs, occurrences, and concepts people encounter (Ültanır, 2012). In other words, it can be said that individual understanding of maternal health care is shaped by previous experiences or interactions with these facilities that, in turn, create individual perceptions. Beliefs can also alter these perceptions, events, and ideas in daily interactions, as explained by Honebein, Duffy, and Fishman (1993), who adds that knowledge is not dependent on individual perception. However, individuals construct it by viewing the same object in varying contexts against previous experiences. Therefore, perceptions of maternal health care can be fictitious for the participants and are confined exclusively to the human mind, continuously being modified with the latest experiences (Olusegun, 2015). Meaning is conferred to the phenomenon from experiences acquired, in this case, the experiences of maternal health care. As a result, the knowledge gained over time by individuals becomes a function of maternal healthcare experiences accumulated during that period (Suhendi and Purwarno, 2018)

3.2.3 Theoretical perspective

How individuals experience healthcare is critical to improving healthcare delivery (Coyle and Tickoo, 2007). Therefore, a theoretical perspective that would reflect the human experience and sufficiently answer the research questions while at the same time agreeing with the ontological and epistemological stance of the researcher was sought. Interpretivism, a qualitative paradigm that enables researchers to understand

the phenomenon within its unique context, met the criteria. Qualitative research offers ways to comprehend and interpret the complexities of the human experience with particular references to observations, narratives, and languages. It allows the researcher to use the participants' perceptions of the phenomenon through their descriptions to understand further (Thanh, Thi, and Thanh, 2015). The adoption of the philosophical stand for the study was based on the fact that the study population involved human beings who are not objects, unlike in the natural sciences, which deal with objects. Hence, they cannot be quantified or condensed into measurements. The important thing is their experiences, which provide a basis for addressing a significant societal problem. Through interacting with the people who have experienced the phenomenon, the study explored women's experiences and perspectives of maternal healthcare stakeholders on utilising maternal healthcare services and the factors that influenced their decisions for the utilisation.

Chowdhury (2014) argues that data obtained cannot be devoid of inputs from the researcher. The interactions between participants and the researcher sometimes change the researcher's and participants' stances. This change is known as the Hawthorne effect (McCambridge, Witton, and Elbourne, 2014). Interpretivism acknowledges that the interpretation of collected data cannot be dissociated from the context within which such data was gathered. Hence, the researcher gains access to the meaningful outcome and insight into the events that led to the results. Advocates of interpretivism maintain that research into human behaviour must be subjective, as objectivity is impossible. Additionally, there is no 'one-way' guideline for conducting research; instead, the guidelines for research are the resultants of the group or culture in question. Contrary to the positivists, who usually seek a single valid answer to understand a phenomenon, interpretivists are flexible in their approach and make room to accommodate differing views from participants (Thanh, Thi, and Thanh, 2015).

3.3 Qualitative Research

Qualitative research is a type of research that is used to explore participants' unique experiences (Merriam, 2009.) Qualitative research is utilised when there is a need to study a group of people having issues or problems that need to be explored (Creswell and Poth, 2018). It explores detailed information from a specific group of people not so large as obtainable in quantitative research. Qualitative research is more helpful in digging deep than scratching the mere surface of a matter on a subject of interest. It

provides a broader view of a problem under study. Hence, it involves collecting data in words, pictures, body language, or artefacts by the researcher in the natural settings of the participants. The collected data is then subjected to detailed scrutiny to infer the meaning of the observed phenomenon, which is recorded in clear language (Worlds *et al.*, 2005).

Qualitative research is valuable when trying to get responses from participants' viewpoints. Underestimation of the value of perceptions is one of the criticisms against positivists (Green and Thorogood, 2009). Qualitative research admits the weight of evidence, has a deeper level of empirical evidence, and addresses the limits of the meaning of statistical implications (Borbasi and Jackson, 2012). According to Vilakati (2009), the advantages of qualitative research include understanding human emotions, such as non-acceptance, distress, compassion, powerlessness, rage, and effort, which can be accomplished through qualitative analysis. Qualitative research appears more effective than quantitative research at exploring emotive reactions because human emotions are challenging to quantify. In addition, qualitative research adheres to the health science philosophy by concentrating on comprehending the whole. Conceptual reasoning cycles are utilised to foster discoveries from which hypothetical ramifications arise.

Qualitative research can be approached using a variety of research methodologies. The qualitative research methodology for this study aligns with the position of Howitt (2010), who posits that qualitative research helps provide detailed information that captures individual participants' perspectives. According to Patton (2015), qualitative methods encourage great depth and detail in data collection and provide significant information about a small group of people. The choice of qualitative research methodology also agrees with the view of Smith (2003), who describes its power for exploring participants' individual and social experiences and their construction of reality. Hence, the methodology adopted in this study was to examine the experiences of women of reproductive age 15-49 years and the perspectives of maternal healthcare stakeholders on factors that influenced the utilisation of maternal health services and to understand the factors that influenced their decision to use maternal health services in Bauchi State, Nigeria. The chosen methodology enabled the researcher to go in-depth, get the answers from the concerned people, and know what might have affected them in utilising maternal services in the study area. The

qualitative research approach enabled the researcher to get the feelings, views, and experiences of the women of reproductive age and other participants who could provide detailed information to corroborate experiences shared by the reproductive women. Also, the approach aided the researcher in capturing words and non-verbal expressions by the participants.

Qualitative research methodologies include ethnography, grounded theory, case study, and phenomenology. However, reviewing the available literature and scrutinising various methods led the researcher to choose the most appropriate type to answer the research questions. Different forms of qualitative research design are discussed in the subsequent sub-sections, including the rationale for selecting the qualitative approach and phenomenology over others.

3.3.1 Ethnography

Ethnography is a qualitative methodology best designed to comprehend similar conformations in a cultural group (Creswell and Poth, 2018). It is qualitative when a person acts as a member of a particular community or organisation to gain a first-hand understanding of their culture (Caulfield, 2020). It is a descriptive study of a specific human society or the method used to conduct one. The majority of contemporary ethnography is grounded in fieldwork. It requires the researcher to completely immerse themselves in the culture and daily life of the people they study (Britannica, 2020). Gerhard Friedrich Müller- a professor of history and geography, took part in the Second Kamchatka Expedition (1733–43) and developed the idea of ethnography as a separate field (Vermeulen, 2008). He distinguished a distinct research area while participating in the expedition. After Schöpperlin introduced the Greek neologism ethnography and Thilo introduced the German variant in 1767, this became known as "ethnography (Vermeulen, 2008).

Ethnography has deep roots in empiricism and naturalism and does not involve testing or generating hypotheses but is explorative (Reeves *et al.*, 2014). Naturalism believes that the senses perceive reality; in other words, objects cannot be abstract (Oppy, 2001). Empiricism claims that human knowledge is a function of sensory mechanisms (Hossain, 2014). Ethnography reveals the factors related to a problem to detect, comprehend, and design intervention strategies to address these problems (Goodson and Vassar, 2011). Its methods necessitate the researcher's absorption into the study setting and are suitable for healthcare-related research (Goodson and Vassar, 2011).

Ethnography is inductive as it does not seek to generate a hypothesis or test one but involves the entrance of the researcher into the field to explore a cultural group. Interactions are studied in natural settings rather than under predetermined conditions the researcher sets (Reeves *et al.*, 2014). This method involves a detailed description of the target people and environment, preventing it from documenting superficial interactions. However, the researcher's interpretation of gathered details depends on the researcher's skills and background and is usually not devoid of the researcher's opinions and thoughts (Leslie, Lamy, and Hans, 2013).

However, according to Reeves *et al.* (2014), ethnography is not a qualitative methodology that depends exclusively on interviews to produce data but embodies three data-collecting techniques: interviews, observations, and documented data. Data gathered from these sources are then compared and contrasted, a method also known as triangulation, to grasp the complexities of these social interactions. The philosophical standpoint of the researcher is that maternal health care utilisation is a function of individual perceptions that have been construed against the background of cultural beliefs, norms, and values. The method enabled participants to relive their experiences comfortably and freely, allowing the researcher to examine how maternal health care was perceived.

The qualities of ethnography include occurring in a natural setting, close interaction with participants, using an iterative and inductive approach during data collection, accurately representing participants' views, and using cultural concepts to interpret data (Goodson and Vassar, 2011). It also resonated with the researcher's perspective of constructivism and interpretivism. Being in a natural setting and closely interacting with the participants supported the researcher's epistemological application of constructivism. Knowledge is not universal but is created by individuals interacting with the phenomenon in question. As a result, knowledge can only be understood if the researcher is nearby to perceive the context within which the phenomenon occurs and is produced. More important is the possibility of observing unknown and undocumented cultural aspects (Reeves *et al.*, 2014). It is a method that includes learning about a social setting by absorption into the real world of the participants to acquire detailed information about the phenomenon under investigation while considering the historical, religious, and social background of social interactions. The researcher makes observations during close interactions with these groups. The

inferences made from these observations could help comprehend behavioural patterns in health care (Jones and Smith, 2017).

Ethnography has some limitations, including the investment of time required by the researcher and the generation of thick descriptions of the phenomenon. Interviewing participants involves plenty of time (Goodson and Vassar, 2011). Data collection, for instance, can be interrupted because participants might decide to withdraw from the study because of changes in their social lives, capital, and human resources (Reeves *et al.*, 2014). Sometimes, the researcher cannot complete the research or might become prejudiced when making judgments. In this case, the researcher has to be reflexive in the methods used (Reeves *et al.*, 2014). The reflection is referred to as bracketing and is typical of phenomenological approaches (Chan, 2013). The dual roles of the researcher as both an insider (participant in the daily affairs of the community) and outsider (an observer of circumstances playing out) can assist the researcher in collecting rich data from the two perspectives, as suggested by (Bruskin, 2019).

This study initially adopted ethnography to carry out observations and conduct Focus Group Discussions in two communities. The researcher observed the participants and conducted the Focus Group Discussion in the first community. However, the researcher could not proceed to the second community due to the Covid-19 pandemic. There was a total lockdown during the COVID-19 pandemic when people were forced to stay indoors to curtail the pandemic's effect. Hence, it was impossible to continue the Focus Group Discussion and observation. The pandemic prevented the researcher from continuing with observation and focus groups in the second community. Hinkes (2021) shares the effect of the COVID-19 pandemic on data collection for ethnographic studies, which demands interaction between the researcher and participants. Specifically, she asserts how the pandemic affects Focus Group Discussion (FGD) and observation due to the need for social distancing, which alters the default characteristic of ethnography, that is, social interaction.

It must be emphasised that ethnography was a valuable tool that helped the researcher engage with the community. The researcher used participant observation, as one of the ethnography tools. The participant observation was carried out in the first community before the pandemic but could not be used in the second community.

Participant observation helped the researcher relate to the participants in their natural environment and acquire detailed information that may not be readily available using other methodologies. However, as previously explained, its use was unsustainable because of Covid-19. Hinkes (2021) suggests an alternative to face-to-face data collection involving online data collection. This approach was also impossible as the study area was a rural community where phone interviews or video conferencing was not feasible due to the participants' lack of internet connectivity, electricity, phone networks, and technical know-how. In addition, ethnography was not adopted for the study because the researcher did not intend to study the effect of the group's culture to interpret her data but to understand the participants' lived experiences. Nevertheless, the data gathered from this stage helped provide first-hand knowledge of the participants' mode of living in the community and assisted in discussing the findings.

3.3.2 Grounded Theory

Grounded theory entails producing a theory from the data gathered from the participants. It is primarily utilised in the investigation of social processes. The methodology was established by Glaser and Straus (1967), and its primary description tends towards an analytical approach rather than a qualitative research approach (Field and Morse, 1985). Grounded theory was propounded by Glaser and Strauss, American Sociologists (Kenny and Fourie, 2014). They were unhappy with some existing sociological research theories, so they came up with a solution that led to the development of the theory. Their argument for developing the grounded theory was centred on the need for a method to allow researchers to create a theory from data collected in the field (Mfinanga, Mrosso, and Bishibura, 2019).

According to (Goulding, 2002), the goal of the methodology is to develop a theory based on data that has been systematically collected and analysed. In this scenario, the theory emerges during the research process and results from the relationship between data collection and analysis (Cepellos and Tonelli, 2020). Two ideas were the foundation of Glaser and Strauss's strategy: theoretical sampling and constant comparison, which imply that data are gathered and analysed simultaneously (Cepellos and Tonelli, 2020).

Glaser and Strauss conducted a study in hospitals focusing on death awareness. Their primary focus was producing new theories rather than verifying existing ones (Chong

and Yeo, 2015). Hence, they used the study to establish a grounded theory. Morse (2016) claims that grounded theory makes it possible to identify and describe phenomena and their primary characteristics. The grounded theory conception can be viewed in a variety of ways from different epistemological perspectives: ones that are interpretative, critical, and post-modern (Charmaz, Belgrave, and others, 2012). Researchers interact with the reality of the subjects because the language used in the codification gives the observed realities shape and meaning. Then again, the old-style papers on the grounded hypothesis composed by Glaser and Strauss manage the revelation of a hypothesis as something that surfaces from the information, confined by the spectator (Strauss and Corbin, 2008). As a result of their positivist upbringing, the objectivist grounded theorists believe in the accuracy of the data. Data already exist in the world under this method: The theory based on them is discovered by researchers.

From the data collection and analysis angle, grounded theory has been defined as a channel to produce categories, known as theory, to provide a phenomenal explanation of a subject matter of focus to the researcher (Opie, 2004). Similarly, this qualitative approach was described by Creswell (2013) as a potent tool that is useful for researchers who need a wide-ranging theory of a natural event. Creswell further explained the importance of the word "grounded" to mean the emergence of theory from the data, which helps to provide a more detailed explanation. Data collection revolves around semi-structured interviews, in-depth interviews, and focus groups. The essence of its data collection is an analysis centred on identifying and exploring the antecedents and factors related to the phenomenon under study based on the perspectives shared by the participants (Kassebaum *et al.*, 2014). One of the strengths of grounded theory is the consideration of researchers' perceptions in the research process (Brant, 2011). Researchers' values and understanding are highly considered for generating a new theory, even from an intricate phenomenon (Chong and Yeo, 2015).

It is a methodology that utilises strict procedures during data analysis to obtain hidden social constructs in the researcher's area of interest (Noble and Mitchell, 2016). Grounded theory is quite similar to ethnography in its use of methods such as observations and Focus Group Discussions (FGDs) (Noble and Mitchell, 2016), coding in its analysis of data (Creswell and Poth, 2018), and its suitability for use when the

phenomenon to be studied is poorly understood (Tie, Birks and Francis, 2019). Data collection may be a qualitative, quantitative, or mixed method. For example, interviews use open-ended questions, adjusted as a theory emerges (Noble and Mitchell, 2016).

Participants are purposefully sampled to ensure their selection can answer the research questions raised in a study. The simultaneous collection of data and its analysis is an essential feature of grounded theory. The comparative and repetitive analysis produces concepts and theories by induction (Tie, Birks, and Francis, 2019). Its limitations include being time-consuming and generating overwhelming amounts of data (El Hussain *et al.*, 2014). Nevertheless, (Creswell, 2007) describes grounded theory as the creation of theories from the views collected from participants. It is a research methodology whereby the investigator provides a generalised description of the phenomenon. This description is formed based on the opinions of the participants. However, it is used to study group behaviour and human relationships, while ethnography produces detailed accounts of the phenomenon of interest (Leslie, Lamy, and Hans, 2013). However, grounded theory was not used because this study did not focus on developing or testing a theory based on the participants' responses. In addition, the researcher did not intend to formulate a theory based on the collected data. Understanding and identifying the lived experiences of reproductive women using maternal healthcare services was the primary objective of this study. In addition, the research aimed to determine the factors that influence utilising maternal healthcare services in Bauchi State. The specialist was likewise keen on deciding the variables that impacted the ladies' usage of maternal medical care administrations. In a similar vein, the purpose of this study was not to develop a theory about how women in their communities use maternal healthcare services.

3.3.3 Case Study

A case study is one of the earlier used research tools in qualitative methodology (Mills, Durepos, and Wiebe, 2010). Case study research brings about the development of the present empirical world (Flyvbjerg, 2014). The origin of the case study is the subject of some debate. Nevertheless, it is generally acknowledged that a French sociologist, engineer, and economist named Pierre Guillaume Frédéric Le Play developed the approach to writing such studies. In 1829, he developed a better method for analysing statistical data and its connection to family budgeting (Anthony, n.d). Le Play's

approach led to the creation of the case studies we know today. Before publishing their findings, social scientists, psychologists, anthropologists, and others began utilising Le Play's methods to test their hypotheses and theories. One example of such work is the well-known Grounded Theory paper by sociologists Glaser and Strauss (Anthony, n.d).

A case study is a detailed account of an individual case in addition to its analysis, that is, the detailed description of the characteristics of the matter in addition to its events (Mesec, 1998). It is the universal word for exploring an individual or a collection of people or phenomena (Sturman, 1997). A case study is a methodology that covers a bounded unified structure for the in-depth description of a single phenomenon (Stake, 1990; Merriam, n.d.)—the standard terms of these definitions centre on the analysis and reports of cases. According to Mesec (1998), the purpose of the description is to detect variables, constructions, procedures, and sequences of contact between participants in a situation. For individuals, analysis and report can be done for each of them separately, covering what they like doing, their specific needs, life circumstances, and life history, among others (Sagadin, 1991). Also, for groups, analysis, and description can be carried out based on different departments in the organisation, participants with special needs, number of participants, among others (Sagadin, 1991). The characteristics of cases, which may differ from one case to another, are the centre of phases that cover various features. The following factors are expected to be considered when designing a case study: (i) the objective of the study should be to provide an answer to 'how' and 'why' questions; (ii) participants' behaviour cannot be manipulated; (iii) the relevance of the contextual conditions to the phenomenon under study, and, (iv) unclear boundaries between the phenomenon under study and its context (Yin, 2003). There is a link between research questions raised to guide a study and the type of case involved (Baxter and Jack, 2008); a case stands as the unit of analysis (Miles and Huberman, 1994).

Case studies include exploratory, explanatory, collective, intrinsic, instrumental, and multiple-case studies. The exploratory case study explores circumstances when there is no clear and sole set of outcomes in the evaluated intervention (Yin, 2003). It is used when a study seeks to answer a question seeking an explanation for supposed connecting links in real-life interventions that are too complex for the survey or experimental strategies (Baxter and Jack, 2008). Such an explanation would provide

a link between a programme and the effects of the programme (Yin, 2003). Collective case studies are similar and describe multiple case studies (Yin, 2003). The instrumental case study is used for the refinement of a theory and to provide an understanding of a specific issue; it serves a supportive or helping role in understanding a case (Baxter and Jack, 2008). A multiple case study is helpful to compare and contrast within and between cases to reproduce findings across cases (Baxter and Jack, 2008).

Case study research differs from ethnography, phenomenology, and grounded theory. Case study employs a holistic approach to studying a person, group of persons as a unit, or community within a defined system to deduce generalisations from these studies. It seeks to conduct a thorough analysis of an issue within the same context as perceived by participants to understand this issue from the participants' standpoint—the researcher's immersion into the field assists in generating data. Consequently, constructivism and interpretivism run through the research design (Harrison *et al.*, 2017). It is also highly organised and exhaustive in its scrutiny of circumstances. The study of several related cases from varying sites by comparing and contrasting them gives more valid answers to the research question than scrutinising a single case (Heale and Twycross, 2018). One of its advantages is analysing data by giving a detailed account of the case and the emerging themes using sources such as interviews, documented work, observations, and relics (Creswell and Poth, 2018). As a result, information is not taken out of context; validity is high.

Finally, it helps generate hypotheses (Krusenvik, 2016.). However, limitations of the methodology include the challenges involved in identifying a case or cases investigated per research and the lack of defined borders regarding variables such as time and events (De, 2015). Additionally, the knowledge generated is context-dependent. As a result, it cannot be extrapolated (the result cannot be applicable or extended to other groups). Finally, the likelihood of conveying the researcher's feelings cannot be completely ruled out. However, a case study was not adopted in this research because the analysis and description of the cases of the study are out of the scope of this research. The focus of this study was to describe the women's lived experiences concerning utilising maternal healthcare services in the study area. The researcher collected study participants' data to discover factors limiting their utilisation of maternal healthcare services. The detailed description of the participants'

characteristics was not the study's primary focus, which was the description of the participants' lived experiences.

3.3.4 Phenomenology

As part of qualitative methodology, phenomenology explores the commonality of a particular phenomenon (Creswell *et al.*, 2007). Phenomenology involves capturing and interpreting people's experiences and attributing meaning to their existence and 'lived experience' (Frechette *et al.*, 2020). In addition, researchers have widely used phenomenology to study numerous phenomena in health care (Bradbury-Jones, Sambrook, and Irvine, 2009). It was first developed by Edmund Husserl (1931) to understand people's lived experiences and the meaning of their experiences. Since Husserl's work, several scholars from different disciplines have expanded the approach in alignment with qualitative research (Van, 1990; Moustakas, 1994). Phenomenology describes an experience from two angles: what was experienced and how it was experienced.

Phenomenology is a method of research that aims to describe the essential core of a phenomenon by examining participants with such experiences under study (Teherani *et al.*, 2015). It focuses on explaining the experience's meaning in terms of what it was and how it was experienced (Teherani *et al.*, 2015). Phenomenology can be broken down into subfields, each informed by conceptions of human experience's "what" and "how." To put it another way, a distinct school of philosophy serves as the foundation for each phenomenology approach. When choosing a phenomenological research method, the researchers should consider their philosophy; it should not come as a surprise that there is a wide range of phenomenological traditions from which a researcher can draw, given that scientists can adhere to a wide range of different philosophical perspectives (Neubauer, Witkop and Varpio, 2019b). A study using a phenomenological research design aims to comprehend people's perceptions, views, and comprehension of a particular phenomenon (Pathak, 2017).

According to (Creswell, 1998), the best criterion for determining the application of phenomenology is when the research problem necessitates a comprehensive comprehension of a group of people's shared human experience. Phenomenological research emphasises personal experience and interpretation and is founded on a paradigm of unique insight and subjectivity (Pathak, 2017). According to (Wertz, 2005), phenomenology is a meditative, low-lying philosophy that emphasises the

concreteness of individual relationships and places lived experience, with all of its uncertainty and ambiguity, above the known.

There are various phenomenological approaches, each based on a different philosophical background. Consequently, there are different approaches to phenomenology. Some approaches include descriptive (transcendental) phenomenology, naturalistic constitutive phenomenology, existential phenomenology, generative historicist phenomenology, genetic phenomenology, hermeneutic (interpretive) phenomenology, and realistic phenomenology. However, descriptive and hermeneutic (interpretive) phenomenology are the two classical approaches mostly adopted in psychological research (Chan, 2013). The type of phenomenology adopted will depend on the researcher's philosophy of choice (Neubauer *et al.*, 2019). Husserl introduced the descriptive phenomenology method to identify the essence of a phenomenon (Mapp, 2008). Phenomenology starts in philosophical practices that developed over hundreds of years; However, most historians attribute the early 20th-century definition of phenomenology to Edmund Husserl (Kafle, 2013). A better understanding of Husserl's descriptive approach to phenomenology can be gained by studying a portion of his academic career. The subject of Husserl's initial research was mathematics (Jones, 1975), but he later expanded his scope to include other phenomena. Husserl argued that the object of scientific investigation ought to be the event professed by the people's consciousness, rejecting positivism's insistence on the absolute importance of objective observations of external reality (Neubauer, Witkop, and Varpio, 2019b). As a result, Husserl argued that no assumptions should guide the inquiry of phenomenology. Any philosophical or scientific theories should not drive the investigation, methods of deductive logic, empirical science, or psychological speculations (Neubauer, Witkop, and Varpio, 2019b). Instead, the focus should be on what comes directly from individual intuition (Moran, 2000). According to Husserl, in the end, inner evidence is the foundation of all genuine knowledge, including scientific knowledge (Husserl, 1970).

Descriptive phenomenology involves describing a phenomenon's vital aspects in a way devoid of interpretation (Bradbury-Jones, 2009). Descriptive phenomenology involves investigating a phenomenon void of judgment or making an assertion (Koch *et al.*, 2009). The adoption of descriptive phenomenology implies the investigation of phenomena free of assumptions or judgment about the world (Koch *et al.*, 2009). The

procedure involving returning to the default state of consciousness regarding the phenomenon is known as phenomenological reduction. In contrast, the state of achieving the process is referred to as bracketing.

The concept of bracketing was derived from mathematics, where brackets contain some formulas. The exact use applies to phenomenology, where imaginary frames acknowledge and set aside daily assumptions (Wall, 2004). These prejudices, beliefs, and mental habits are called the 'natural attitude' in phenomenology (Paley, 1997). Husserl opines that humans live naturally in their natural attitude (Husserl, 1983). "Natural" indicates originality before human theoretical reflection (Van, 1990). Thus, descriptive phenomenology assumes that the researcher is blank; they have no prior descriptions, expectations, or suppositions but depend on participants' experiences to understand the crux of a phenomenon (Neubauer, Witkop, and Varpio, 2019b).

Based on Husserl's approach to phenomenology, a researcher's goal is to constantly assess the neutrality of the influence of the researcher's biases, preconceptions, and experiences. The researcher is expected to stand separate to avoid the impact of their subjectivity on the descriptions offered by the participants (Neubauer, Witkop, and Varpio, 2019a). Human beings, by default, have their experiences and prejudices. Husserl (1971) focuses on keeping the experiences and biases abeyance to give way to originality. The outlined examples of what researchers should set aside include 'scientific theories, knowledge, or explanation; truth or falsity of claims made by participants; and personal views and experiences of the researcher.

It is important to note that contemporary philosophers are still debating Husserl's concepts of bracketing. If bracketing succeeds, the researcher removes themself from the world and all its contents, including their own body (Staiti, 2012). Despite the dedication to this bracketing, there are records of some practices from other qualitative research methods to achieve this objective (Varpio, Martimianakis, and Mylopoulos, 2015). For instance, multiple researchers could be asked to triangulate their reductions in a study to ensure that appropriate bracketing was maintained. Alternatively, a study might involve member checking (Birt *et al.*, 2016) to validate the data to ensure that the participants' experiences matched the identified essences. Several researchers have taken Husserl's descriptive phenomenology and applied it. In 2012, for instance, Tavakol, with some other researchers, engaged in descriptive phenomenological

research to examine how medical students understood empathy (Tavakol, Dennick, and Tavakol, 2012).

Interpretive phenomenology is based on Martin Heidegger's writings. Heidegger moved into academia as a philosophy student after beginning his career in theology. Although Heidegger's philosophical research initially aligned with Husserl's, he later questioned several essential aspects of Husserl's transcendental phenomenology. A primary break from his predecessor was the focal point of phenomenological request. Heidegger, on the other hand, was more concerned with being and temporality (an ontological focus) than Husserl was with knowledge (an epistemological focus) (Reiners, 2012). Interpretive phenomenology departs from Husserl's emphasis on "acts of attending, perceiving, recalling, and thinking about the world (Laverty, 2003) and human beings as knowers of the phenomenon with this focus on human experience and how it is lived.

Heidegger was interested in people as actors in the world and the relationship between them and their lifeworld, which Heidegger used to describe the concept that truths are constantly affected by the world in which people live (Lopez and Willis, 2004). People are seen as already understanding themselves within the world because of this orientation, even if they are not always explicitly or consciously aware of it (Staiti, 2012). According to Heidegger (1967), a person's conscious experience of a phenomenon is not distinct from the individual's personal history or the world. Instead, consciousness results from a person's historically lived experiences, such as their unique history and the culture in which they were raised (Lopez and Willis, 2004).

People cannot escape their world without alluding to their experiences and understandings. Therefore, Interpretive phenomenology aims to understand how the individual's lifeworld, or the world as they pre-reflectively experience it, influences the deeper layers of human experience hidden beneath surface awareness (Bynum and Varpio, 2018). The difference in the phenomenology of Husserl and Heidegger was that the former was interested in knowledge (epistemology), while the latter focused on being and temporality (ontology) (Reiners, 2012). Their theological background influenced his phenomenological approach (Neubauer, Witkop, and Varpio, 2019b). Heidegger (1967) conceived the concept of Dasein, where entities are denoted and interpreted as a personality and a lens through which a phenomenon can be

ontologically unveiled. Thus, he emphasises the meaning of being to revive the forgotten Greek argument on the ‘'Being-in-the-world'' (Dasein), which is described as the way of human existence and acting (Van, 1990). The focus of Heidegger, shaped by ontology, is understood in terms of 'Being in the world' rather than 'being of the world.' (Ray and Peter, 2004).

Interpretive phenomenology is the study of how texts and theories emerged due to the necessity to translate literature into various languages and in situations where it was difficult to access the original text (such as the Bible) (Verzosa Hurley *et al.*, 2017). Interpretive phenomenology must go beyond the description of the phenomenon to the interpretation of the phenomenon if the individual's lifeworld informs all human experience and if all incidents must be interpreted against that background (Neubauer, Witkop, and Varpio, 2019b). According to situated freedom, individuals can make choices freely, but this freedom is not absolute. It is constrained by the particular circumstances of their day-to-day lives (Lopez and Willis, 2004)'. The study of an individual's meanings in the world and how these meanings and interpretations influence their choices is known as Interpretive phenomenology (Laverty, 2003). To illuminate the fundamental structures of participants' understanding of being and how that shaped the individual's decisions (Neubauer, Witkop, and Varpio, 2019b), this necessitates the Interpretive phenomenologist's interpretation of the narratives provided by search participants regarding their contexts (Heidegger, 1967).

Heidegger's type of phenomenology goes beyond merely describing human experiences and interpreting human experiences through the human context. His primary focus of interpretive phenomenology is discovering a phenomenon by removing layers of forgetfulness in a human's daily experience (Frechette *et al.*, 2020). Heidegger's interpretive phenomenology concerns human lived experience but disagrees with Husserl's emphasis on description rather than understanding (Bradbury-Jones, Sambrook, and Irvine, 2009). The link between human knowledge and understanding their background is essential in hermeneutic/interpretive phenomenology. Heidegger (1927a), in contrast to Husserl, acknowledges the impossibility of bracketing human presuppositions. Instead, he opines that presuppositions help uncover phenomena (Heidegger, 1927a; Buckley, 2018). Hence, in the act of inquiry, researchers and the participants who share their experiences are recognised as entities. Therefore, researchers are advised to openly acknowledge

their presuppositions with reflections on their subjectivity as part of the analytical process (Moran, 2000).

Some limitations associated with phenomenology include identifying individuals with a lived experience regarding a phenomenon to be explored (purposive sampling). Hence, the researcher engaged vital informants who had experienced using maternal healthcare in the study area and helped the researcher with the participants. Another limitation is the abstract nature of philosophical assumptions in the collected data to be identified by the researcher, which might not be found in documented materials, and the flaws caused by the researcher's preconceptions (De, 2015).

3.3.5 Justification for the Use of Descriptive Phenomenology

Selecting an appropriate research methodology among myriads of research methodologies is somewhat daunting but significant in the research process. The choice of phenomenology for this research was premised on the belief in the source of knowledge from those primarily connected to a study rather than other people, like experts in the field of learning from the literature. Hence, this choice was based on the need to hear the voices of the participants and to listen to the lived experiences of those with direct and detailed information from personal experience. In this instance, the study sought to listen to the adventures of a group of people regarding the underutilisation of maternal health services in Bauchi State, North-Eastern Nigeria. Phenomenological research methods place the service user's voice at the centre of care delivery (Parkes and Freshwater, 2015).

Furthermore, the choice of descriptive phenomenology was based on the researcher's interests, in that the participants would describe their experiences and what influenced their utilisation of maternal health services. Descriptive phenomenology was chosen to gain comprehensive and in-depth descriptions of the participants' lived experiences concerning their utilisation of maternal healthcare services. The researcher intended to understand the accurate picture of the phenomenon, that is, the need to have a broad view of why women were utilising or underutilising maternal health services. The researcher used descriptive phenomenology to set aside her biases and prejudices so that the participants' responses could reveal their shared experiences concerning utilising maternal healthcare services. The reason was to ensure the researcher understood how reproductive women used maternal health services in the study area.

3.4 Conclusion

The chapter opened by describing the research methodology, and the research questions were aligned with the research methodology. Different research philosophies underpinning the study were discussed, justifications were provided for the choice of qualitative research, and likely different research designs, such as ethnography, grounded theory, and case study, were explained with the reasons why they were not considered. Finally, phenomenology was described with a justification for adopting descriptive phenomenology.

CHAPTER FOUR

METHODS

4.1 Introduction

Research methods are strategies researchers use to answer research questions. They are practical procedures used in conducting research. They are the "tools of the trade" that enable data collection and analysis (Walliman, 2021). The strategies also include utilising algorithms, procedures, and other components of research methods. All methods used by a researcher in a study are considered research methods; they are essentially scientific, value-neutral, and planned (Sam, 2012). They include theoretical methods, experiments, numerical schemes, statistical methods, and other procedures; problem-solving and data collection are realisable with the help of research methods (Sam, 2012). Scientific research methods require explanations based not solely on reasoning but on the facts, measurements, and observations collected. Scientific methods generate answers with the support of experiments in finding solutions to research problems (Sam, 2012).

Understanding research methods within the context of a study is very important (Walliman, 2021). The best approach for a research project is deeply influenced by the data types needed and the participants from which data could be collected (Muncie, Sobal, and DeForge, 2022). All fields employ research methods. The selection of research methods affects an entire study. Hence, there is a need for its inclusion as part of the plan from the beginning of the study (Schmidt, 2020). This section shows the research procedures concerning the study's population, tools for data collection, selection of research participants, recruitment and data collection procedure, method of data analysis, and ethical considerations.

4.2 Research question

A researcher's decision to study a population is hinged on the research questions raised to guide the study (Silverman *et al.*, 1999). There is a relationship between research aims and research questions. Research aims produce research questions. This study explored women's experiences and perspectives of maternal healthcare stakeholders on utilising maternal healthcare services in Bauchi State. A descriptive phenomenology was adopted as the research design in this study. At the same time, various methods were used to identify women's lived experiences on utilising maternal

healthcare services and the factors that influenced their decisions to utilise the maternal health services available in their communities.

4.3 Study Sites

Every research using a primary mode of data collection has a study setting. Study sites are places where research is conducted to discover the meanings of the phenomenon under investigation (Major and Savin-Baden, 2012). A study site includes a social, physical, or experimental setting in which research is carried out. This study was carried out in Bauchi State, Nigeria. Bauchi State is a state in Nigeria's North-East geopolitical zone. It is bounded to the north by Kano and Jigawa, to the south by Taraba and Plateau, to the east by Gombe and Yobe, and to the west by Kaduna. It is named after the historic city of Bauchi, its capital. The dissolution of the former northeastern state in 1976 led to the formation of the state. It initially incorporated the region currently Gombe State, which turned into a specific form in 1996. With an estimated population of over 6,530,000, as of 2016, Bauchi is the seventh most populous and fifth largest of the 36 states in the region (Figure 1 below). Geographically, the state is divided between the dry, semi-desert Sahelian savanna in the north and the West Sudanian savanna (Britannica, n.d).

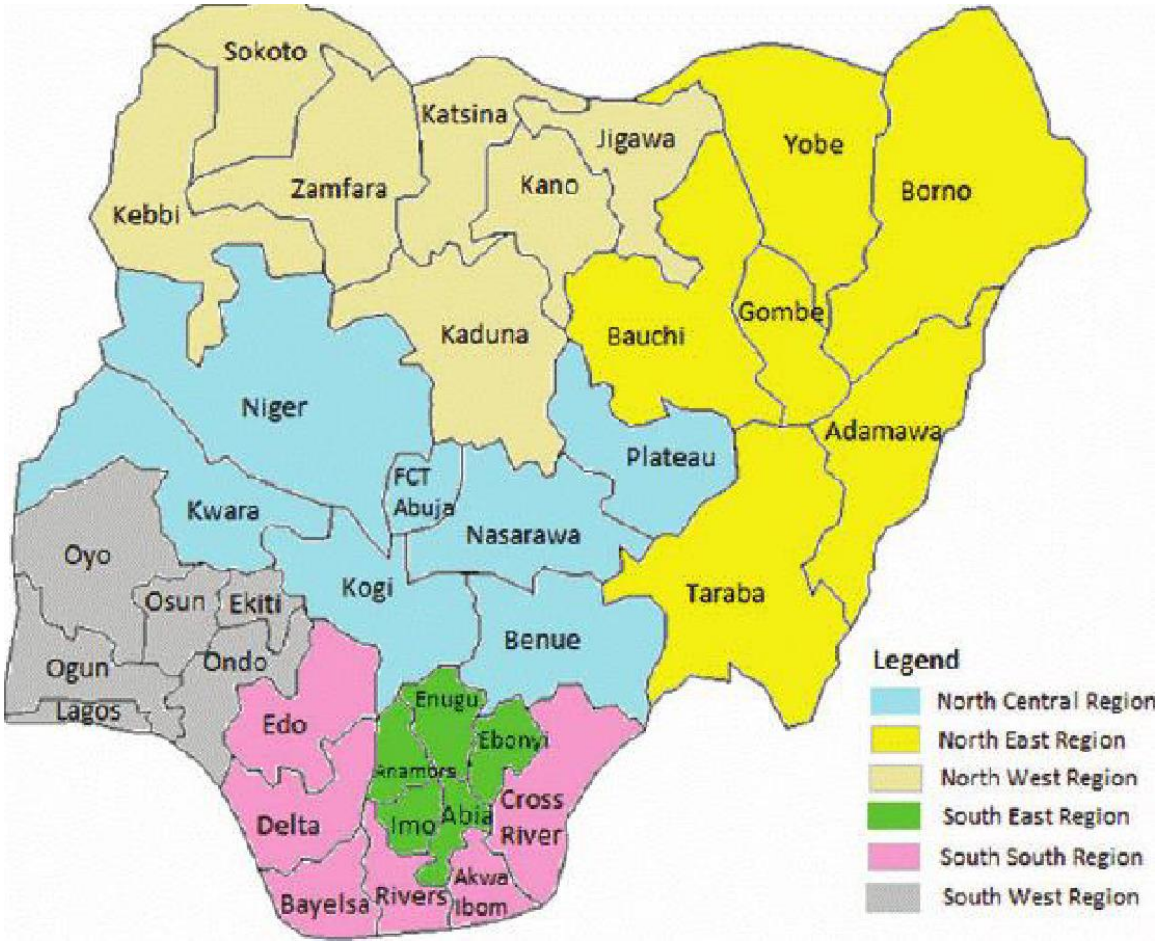


Fig. 2: Map of Nigeria (Research Gate, 2020).

The study's site was the Bauchi Local Government Area in Bauchi State. Two communities were selected for data collection. There were obvious indicators in the communities that marked them as rural areas. One of the communities had no social amenities when the researcher travelled to the site for data collection. None of the women interviewed had access to a phone. Most of the community members had radios that used batteries. Almost all northerners have radio sets to listen to the news, even though most are uneducated. The community had a primary school with a dilapidated building and a faraway healthcare centre. The distance was the main reason for the lack of health personnel in the community. There were no drugs when there were complications, and patients were sometimes referred to the urban areas, which were affected by the bad roads and had no means of transportation. The researcher would have taken advantage of technology for data collection using phone interviews. Still, the participants' state regarding access to phones and electricity posed a challenge. The other community visited by the researcher for data collection

had some social amenities, such as electricity, but not all houses had this. The people who enjoyed electricity could afford to pay for it. The researcher observed some of the men, the husbands of these women, had mobile phones, while none of the women had phones.

4.3.2: Justification for selecting Bauchi State

The choice of Bauchi State out of the other northern states was based on the maternal mortality rate. The northeastern region of Nigeria has the highest MMR in Nigeria, with 1,549 maternal deaths per 100,000 live births (Abimbola *et al.*, 2012). The nature of maternal and infant care services in Bauchi state, upper east Nigeria, the Maternal Death Rate (MMR) and Neonatal Death Rate (NMR) in Bauchi are among the highest in the country (Abegunde *et al.*, 2015). Statistics indicate that only 2.7% of women of reproductive age attended higher education, 11.1% of women between the ages of 15 and 49 can read a whole sentence, 12.6% can read part of a sentence, and 73.6% cannot read at all in Bauchi State (National Population Commission (NPC) [Nigeria] and ICF, 2019). Women's social status is associated with numerous factors that significantly impact health-seeking and reproductive behaviours; this puts women of reproductive age at risk of high maternal mortality (Abdullahi *et al.*, 2020). The researcher hailed from the state; there is a shortage of research on women's utilisation of maternal healthcare services.

4.4 Participants

The participants were the Birshi and Dan Iya community residents in the Bauchi Local Government Area of Bauchi State, Northeastern Nigeria. The participants include women of reproductive age, male partners, skilled health workers, and Traditional Birth Attendants (TBAs). The participants were people who met the inclusion criteria for the study. The age of the reproductive women ranged from 15 to 49 years, while the age range of the men ranged between 20 to 65 years. A relatively homogenous group of participants is required in phenomenological studies (Creswell, 2007). Thus, each data collection group was similar because the participants shared similar language and cultural values traits. The women, men, and TBAs were community natives, while the skilled health workers worked in the community healthcare centre. All the participants resided within the target communities. The people of the communities spoke the same dialects and had the same cultural connections.

4.4.1: Selection of Study Participants

Standardisation of research procedures and random sampling of participants is necessary for quantitative research to ensure the generalisability of results and eliminate the influence of exterior variables (Sargeant, 2012). In contrast, qualitative research employs deliberate subject selection; one of the most crucial tasks in the study design phase is selecting participants who can answer the research questions appropriately and improve comprehension of the phenomenon under investigation (Kuper, Lingard, and Levinson, 2008). The research questions, theoretical perspectives, and evidence underlying the study inform the decisions for selecting the participants. Hence, purposive and snowball sampling were used to determine the study participants.

The purposive sampling technique is commonly used in phenomenological studies for selecting participants with rich and detailed knowledge of the phenomenon of interest (Polit and Beck, 2012). Purposive sampling involves selecting participants for a study based on unique characteristics. Purposive sampling involves carefully selecting settings, persons, and events to obtain information that cannot be obtained elsewhere (Taherdoost, 2016), necessitating access to key informants who can assist the researcher in identifying cases relevant to the study (Suri, 2011). Small purposive samples are typical in phenomenological studies because of the richness and diversity of participants' experiences. The actual sample size is not a significant issue, but the richness of the data collected supersedes the sample size (Mapp, 2008). The sample size is not challenging since the primary focus is not generalising but describing participants' lived experiences. Lincoln and Guba (1985) observe that readers can judge the possible transfer of findings from well-described experiences. This study used purposive and snowball sampling techniques to select participants. Purposive sampling was used to determine community members with expertise utilising maternal healthcare services. Using snowball sampling ensured that some community members with experience in maternal healthcare helped connect the researchers with other members in the same category.

4.4.2: Selection of Key Informants

The initial recruitment of participants in this study was through crucial informants. Qualitative in-depth interviews with community insiders are known as key informant interviews. Key informant interviews aim to get information from a wide range of people

with first-hand information on the phenomenon under study. Various groups of community experts, such as community leaders, professionals, or residents, can offer suggestions for solutions and insight into the nature of issues under study based on their expertise and knowledge (Akhter, 2022). These groups of individuals are usually influential and occupy positions of responsibility. Most definitions of key informants emphasise knowledge and openness to sharing information (Cossham and Johanson, 2019). According to Marshall (1996), key informants are knowledgeable, communicative, impartial, and have a role in the community or understanding of the phenomenon that provides them with the information that the researcher is looking for expert information source who, "as a result of their skills or position within a society, can supply more details and more profound insight into happenings in the society" Moreover, they possess abilities that enable them to provide profound information concerning the phenomenon in question (Marshall, 1996). According to Tremblay (1957), the criteria for selecting key informants are that:

- The informant's role should provide an avenue for the information being sought.
- The key informant should possess the desired knowledge and be able to pass this knowledge insightfully.
- The key should be the cooperation and willingness to share the desired knowledge, and the manner of communication should be intelligent.

The last criteria are related to reducing the key informant's personal biases to the barest minimum. The researcher was aware of these biases and the need to evaluate them during data analysis. The only criteria determined with certainty was that of the informant's role. After identifying informants who played key roles in the community, the remaining criteria were considered to certify that only the informants who could contribute meaningfully to the study were recruited. The degree to which the informant fulfilled these criteria determined the value of the information provided by the informants (Marshall, 1996). The informants can provide information regarding the family system, economic structure, politics, the community's socio-cultural patterns, and cultural norms and beliefs. This method is suitable for collecting qualitative data that would have otherwise been time-consuming and difficult to access (Tremblay, 1957). Key informants can also provide descriptive information, reveal the motivation behind a target population's attitudes and perspectives, and proffer solutions and

recommendations to problems. The informants directed the researcher to situations, events, or people likely to be helpful to the progress of the research (Kumar, 1989).

Locating the communities to collect data was the first thing the researcher did. The researcher identified one of the communities through networking with one of the sons of the community heads working in the city. Upon arriving at the first community, locating key informants who could open access and ease the data collection process was necessary. One of the sons of the community head connected through the researcher's contact achieved this. The purpose of the research was communicated with the community head after the connection through his son. The community headset is a date for the researcher to visit the community. The essence was to enable the researcher to explain her research in detail. The road network affected the researcher's car to the point that the vehicle was parked, and motorcycles were used because the roads were terrible and were not motorable.

It was the rainy season, which worsened the state of the roads. Eventually, the researcher got to the community and communicated the purpose of her research with the community head, who spoke with the gatekeepers, the husbands, and the women (their wives). The group, the researcher, was later used for data collection. The researcher was able to get access to the women who met the inclusion criteria for the study to carry out sensitisation of the participants and give them an information sheet to sign. In this research, key informants also included community or religious leaders who were influential and knowledgeable about the community. This sampling technique was applied to all the methods used to collect data: observations, interviews, and focus group discussions.

4.5: Data Collection Procedures

Data collection techniques are a medium for collecting data for a study. Methods for qualitative data collection are unstructured and adaptable, capturing verbatim reports or observable characteristics and generating data that typically does not take the form of numbers (Vilakati, 2009). The researcher collected data from observations, semi-structured interviews, and Focus Group Discussions (FGDs). Interviews are the primary data collection method for phenomenological studies (Kvale, 1996). However, Paley (2014) notes the insufficiency of using only interviews to discover phenomena in phenomenological studies. Hence, combinations of other data collection methods were suggested by other researchers (Frechette *et al.*, 2020). Combining Focus Group

Discussions (FGD), interviews, and participant observations was necessary. Each data collection technique is elaborated upon in the subsequent sections.

4.5.1: Participant Observation

The research method known as participant observation (PO) involves a researcher becoming engrossed in the participants' day-to-day activities (Zieman, 2012). The goal is to record behaviour in as many different situations as possible. Historically, participant observation has been associated with research where the researcher spends extended periods in a small community; it is used in many contexts and over many periods, from single links to considerable years (Zieman, 2012). Observation involves actively registering or recording the interactions and events of the target group in their natural environment (Sangasubana, 2011). In a paper by Kawulich (2016), observation is described as a process that enables the researcher to blend into the community of interest to make the participants act naturally without the researcher losing focus of the research. Participant observation has the qualities of being overt, non-judgemental, showing genuine interest in learning about people, being conscious of cultural shock, and having the tendency to make mistakes (Kawulich, 2016).

The researcher must be skilled enough to recognise the truth rather than deception, which can be achieved by complete immersion into their daily lives. Using pilot observations and interviews also assisted the researcher in gaining the necessary experience. Conducting a pilot study is an efficient method of engaging the community and gaining access to the community. Researcher bias can be overcome by reflexivity, requiring the researcher to completely enumerate and explain the steps involved in the research design, especially during data analysis. Furthermore, detailed knowledge of the researcher's background helps readers understand how it has affected the research (Starman, 2013). The effectiveness of this method depends on the researcher's ability to observe, document, and interpret what has been observed (Kawulich, 2016). The researcher can assume a spectrum of roles (Fig 3 below).

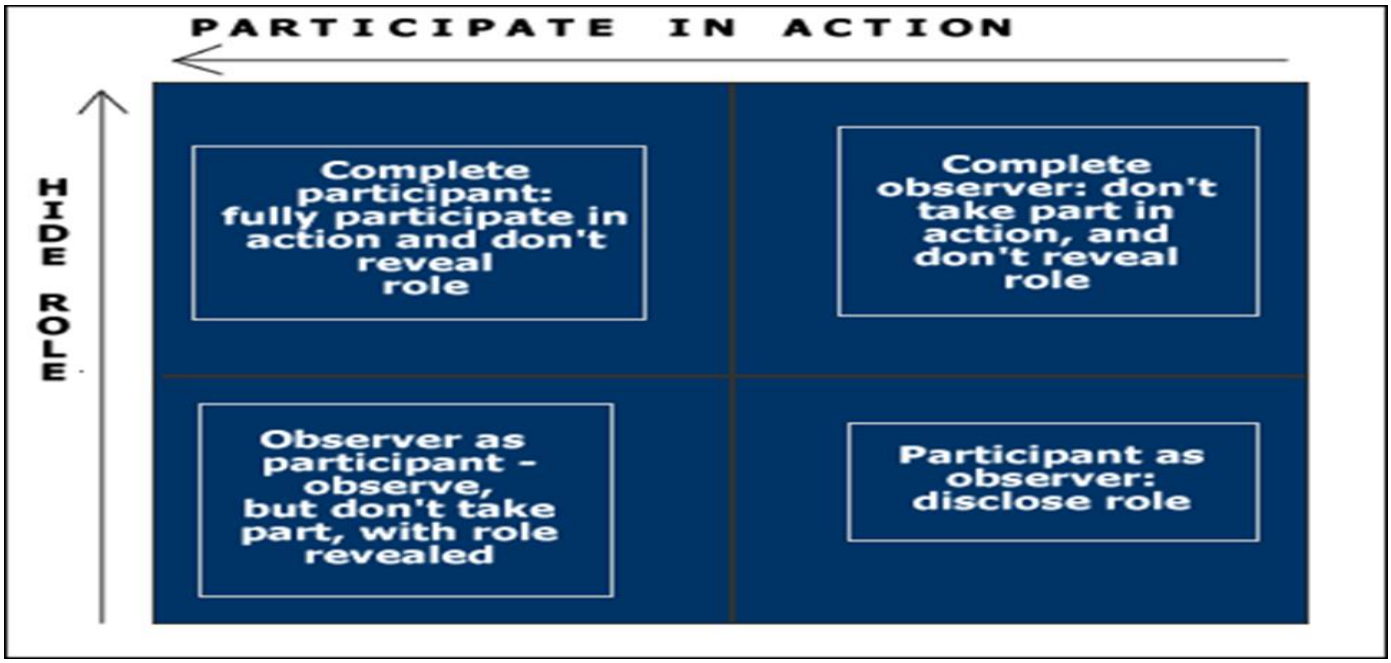


Fig 3: Researcher's spectrum of roles

The researcher must be capable of acknowledging their prejudices, especially when faced with an unfamiliar environment (Creswell, 2009). Limitations of this method include bias resulting from gender, age, ethnicity, theoretical approach, and class. Some situations may lead to the researcher facing challenges in gaining acceptance within the community and encountering potential researcher bias. The researcher can be a complete observer and be concealed from the public glare. At the same time, the target population is unaware of being observed or fully absorbed into the system. Observations by the researcher either took on the observer as a participant or the participant as observer roles. The observation enabled the perception of the phenomenon under study from two perspectives: as an observer and a participant. Complete participation could result in a loss of focus, while comprehensive observation approaches could result in ethnocentrism (Sandiford, 2015).

Participant observation was used as one of the data collection methods when the researcher initially adopted ethnography, which was later changed to phenomenology because of the pandemic, which did not support close interactions with participants because of the spread of the virus. However, it is worth mentioning because the participant observation helped to provide some information about the community and community members' beliefs as they affect the utilisation of maternal healthcare services. The information gathered during the participants' observation helped to

enrich the discussion of the findings of this study. The researcher initially employed the participant as an observer, as Kawulich (2016) suggested, but later changed to the observer as participant role to enable the researcher to relate more closely to these women and establish a trusted relationship with the target groups. This stance is more ethical in its approach. The researcher's observations were known to the group, and she could maintain the primary motive, gathering relevant data rather than partake in the activities under observation (Kawulich, 2016). All observations were noted in the researcher's field notes.

At the maternal centres, participant observation created an avenue for further data collection where the researcher interviewed staff informally. An informal atmosphere is more relaxing and creates an enabling environment for the staff, resulting in better communication. The interview involved a regular discussion with the health workers since they knew the purpose of their interactions. Patients' attendance was noted as they arrived, and the kind of reception offered by the staff and patient's perception of services were also noted. These events were jotted into the researcher's diary to track the process against forgetfulness and ensure all the observed events were included in the journal. This avenue helped the researcher to see healthcare interactions between the health workers and the patients. It helped to get first-hand information about maternal healthcare services in community healthcare centres. The researcher was perceived as one of the community members who came to utilise the health care facility in the community. These discoveries align with the position of Gaille (2020) on the advantages of participant observation, which are as follows:

Researchers and practitioners use participant observation in several fields to get to know a specific group of people in a particular demographic. At the same time, cultural anthropology, occupational, religious, and geographical demographics are frequently considered when used for data collection (Gaille, 2020). A purposeful sampling technique was utilised to observe the participants relevant to this study. Participants who could provide rich information about the use of maternal healthcare services were identified with the help of the key informants. The key informants' identification facilitated access to these women's residences without much hindrance after the key informants had duly informed their husbands of the researcher's intentions. The researcher resided in the target wards and, as a result, got fully immersed in the day-to-day lives of these women as they attended to their homes and received visitors.

Informal discussions between these women, the men, and their children, casual discussions between them and their spouses, and attending ceremonies such as marriages and child naming were essential for gathering data, in which the researcher also participated.

The researcher had to dress in Muslim attire, where all body parts were adequately covered. The Muslim community highly appreciates dressing that covers the female body very well, and the study area was no exception. Society accords respect to people who dress in this way. Hence, the researcher aligned with the dressing of the community, which was a gateway to securing acceptance for data collection. Also, the marital status of the researcher earned her additional benefits of acceptance. The researcher was pregnant during the data collection period. Seeing the researcher being pregnant, the participants welcomed her as a mother and an indigene of one local government area (LGA) in Bauchi state. The participants were able to exchange experiences with the researcher. The researcher opened up to the participants about her pregnancy history, how she managed the situation, and the need for more carefulness as a pregnant woman coming for data collection.

The researcher tried as much as possible to avoid anything that would give her stress and ensured she rested when necessary. She did what was expected of her as a pregnant woman. She confirmed she had obeyed the instructions given to her by the maternal health professionals through regular visits to maternal healthcare. In the seventh month of her pregnancy, the researcher had a terrible experience when she was rushed to the hospital due to high blood pressure. At this point, she could not bend or do anything. This experience affected her baby's heart rate, according to the report from the gynaecologist who attended to her, an experience that almost resulted in death, which necessitated a need for surgery. However, the surgery could not be carried out because of the state of her blood pressure, which was considered too high. The professional healthcare workers could control her BP while the surgery was no longer necessary after normalising her BP. The doctors were able to provide care with modern healthcare equipment, a type of service that may not be possible using traditional healthcare.

The marital status and pregnancy enabled the participants to give listening ears and were willing to participate in the data collection. The participants gave special care to

the researcher, including preparing special meals and drinks made from natural plants to help her successfully push through her pregnancy period. The essence of the meal was to aid her child's development and provide energy for the baby. The special drink was also to help reduce complications during labour, reduce delivery delays, and fast-track the easy removal of dirt from the child during cleaning by the midwives. The researcher obliged the offer as a measure of acceptance and aid for her pregnancy despite her regular attendance at ANC.

The researcher observed the confirmation of the professional healthcare workers of the cleanliness of her baby during delivery. The researcher could not precisely ascertain if the cleanliness of her baby resulted from the local Zobo drink she was given, as explained by the community women. On the other hand, she was aware that these cultural drinks had not been scientifically tested, but it seemed difficult to doubt the efficacy of these local drinks. This dichotomy demands further research by scientists to put some of these cultural drinks to the test to prove their efficacy. Such drinks can be used with doctor's prescriptions if considered valuable and productive.

The researcher spent about two hours daily for four weeks in one of the communities observing pregnant women in their first and second trimesters. These included women who had miscarried, women who had had at least a child or more children, and who did not use maternal health services but preferred other services provided in the community by traditional birth attendants (TBAs). Day-to-day activities at their homes, such as home management and interactions with spouses, were observed. Visits to health centres and the kind of reception received were observed. The researcher observed the nature of their interactions, the process of interactions, and the people that interacted together. The researcher observed how pregnancy-related complications were managed in the community by TBAs while bearing in mind the research aims and objectives.

A further observation was conducted in the community where the researcher was introduced to the TBAs by the religious/traditional leaders. The researcher engaged these women in informal discussions. Those women who utilised maternal health services were also a part of the discussions. The professionals were interviewed in their facilities to share their views on the topic under investigation and to know if they

adhered to the organisation's culture of care, policies, and values in carrying out healthcare duties.

4.5.2: Semi-Structured Interviews

Interviews are phenomenological in grasping the essence of a lived experience regarding the phenomenon being studied (Creswell, 2013). The semi-structured interview begins with an open-ended question to encourage participants to express their thoughts and reveal their perspectives on discussed issues (Reeves *et al.*,2013). It helps to create a more relaxed environment, prompt conversations, and a more detailed response from participants (Jones and Smith, 2017). DiCicco-Bloom and Crabtree (2006) observe the wide use of semi-structured interviews in qualitative research. The semi-structured interview is not as rigid as the structured one, where interviewees are somewhat confined to pre-determined themes. The semi-structured interview enables interviewees to express themselves as much as possible without interruption by the researcher. Hence, detailed information was obtained from the participants. This type of interview was flexible; participants were free to provide information as it occurred. The researcher could ask further questions based on the participants' responses. The inquiry implies participants' responses became a basis for asking additional questions within the study's objectives. Thus, using semi-structured interviews enhances the inductive approach of data coding, which is data-driven, where a researcher can code based on the participants' responses.

4.5.2.1: Interview Questions

Two main questions were asked of the participants based on the interview guide (Appendix 4):

1. What have you experienced regarding maternal healthcare?
2. What conditions have mainly influenced or affected your maternal healthcare experience(s)?

Although other open-ended questions were asked, these main questions were vital in collecting data that would give insight into lived experiences and help answer the research question. In addition, the use of the outcomes of the pilot conducted assisted the researcher with target topics for the semi-structured interviews. Additionally, the participants could divert from areas outside the main issue to elicit details pertinent to the research. It was crucial to record interviews as note-taking might exclude vital points or miss critical comments, especially in focus group discussions. The

researcher concentrated on the interview and ensured that issues were addressed and reflected participants' beliefs or concerns. For example, the researcher decided to discuss personal experiences with maternal healthcare, which helped distinguish the participants' experiences from those of the researcher.

4.5.2.2: The Interview Participants

The observation of potential participants enabled the researcher to sample participants to provide rich information regarding the study purposefully. Participants of choice could relate their experiences with maternal health centres. Semi-structured interviews were utilised to elicit information from participants not in the FGDs. In this study, of the interviewed participants, there were five (5) men, seven (7) women, two (2) healthcare workers (1 male and 1 female), and two (2) TBAs, who were both women. The interview participants were mothers, healthcare professionals working in maternal healthcare centres, and women restricted from leaving their houses without their husbands' permission. The researcher combined semi-structured interviews, non-verbal cues, note-taking, and digital recording to collect participants' information (Appendix 1). Snowball sampling was used to increase the sample size of potential participants, which resulted in the identification of more participants. Snowball sampling is a method of recruiting participants for research in which they are asked to assist researchers in locating additional potential subjects (Oregon, 2023).

Snowball sampling involves using a participant to invite other participants with similar characteristics to the same group (Taherdoost, 2016).

This technique was helpful due to the conservative nature of the communities. In this research, community members who met the inclusion criteria helped connect the researcher to other members with a high likelihood of meeting the inclusion criteria. In other words, some community members helped the researcher get reproductive women, while the reproductive women helped the researcher get other women who also met the inclusion criteria.

4.5.2.2.1: Selection of Pregnant Women Participants

The pregnant women who served as participants in the study were accessed from the clinic, while those who were yet to start attending ante-natal were located through the efforts of the community heads and health workers. Also, by adopting the snowball sampling technique, pregnant women were used to find other women the researcher

could not access directly or quickly. All available pregnant women were used for the study.

4.5.2.2.2: Selection of Male Participants

The male participants, who were husbands and heads of families, were identified with the help of their community heads. This approach was adopted as the heads of the community knew the husbands better than the researcher due to the community's manageable size.

4.5.2.2.3: Selection of Traditional Birth Attendant Participants

Traditional Birth Attendants (TBAs) are older women who assist pregnant women during delivery; they have acquired skills through personal experience or working with other TBAs (Mwangakala, 2016). The TBAs were selected based on their availability and readiness to participate in the study. The community leaders helped provide information on identifying and locating the TBAs. One TBA was interviewed in Two communities each.

4.5.2.2.4: Selection of Traditional Community Health Extension Workers Participants

Skilled birth attendants were included because they were responsible for providing maternal health care for pregnant women. Hence, the two skilled birth attendants were selected because they were primarily connected to maternal health services. They were health workers working in the maternal healthcare centres in the communities.

4.5.2.3: Inclusion and exclusion criteria

Inclusion criteria involve the basis of including some participants in a study, while exclusion criteria imply the exclusion of some participants. It covers both those who can and cannot participate in a study. The inclusion and exclusion criteria for each category of respondents were as follows.

4.5.2.3.1: Pregnant Women

Women who belonged to the age bracket of 15-49 years, pregnant, miscarried, or had at least one or more children were considered suitable for the study. The lower cut-off age of 15 was selected because sometimes females are married as early as 15 years of age in Nigeria (National Bureau of Statistics (NBS) and United Nations Children's Fund (UNICEF), 2018), especially in the Northern part of Nigeria, where 54% of the females are married before the age of 15 (Erulkar and Bello, 2019). Even though

fertility is low at age 49, some women still conceive. These pregnancies are termed high-risk (Kushner, 1979).

4.5.2.3.2: Married Men

Married men aged 20 – 65 were eligible for the study. As it is also evident that Nigeria is a patriarchal society, exploring the opinion of men regarding a factor that influences women in the utilisation of maternal was also considered vital. As such, men were included as the participants in this study. In this study, including married men was strategic because maternal and child health-related issues are often considered to be women's issues (Makin and Forsyth, 2013; Singh, Lample, and Earnest, 2014). Nevertheless, married men have influential roles in their families in making decisions for the family and the use of health maternal health services (Azuh, Fayomi, and Ajayi, 2015a; 2015b; Mcmahon *et al.*, 2016; Vollmer *et al.*, 2021). These researchers conducted 10 focus group discussions, while married men were among the participants, in addition to the selected women. It was believed that evidence generated from these participants would uncover findings that could contribute to the existing strategies or reveal new insights that could be used to plan an intervention to improve the utilisation of maternal healthcare services. Including married men is a form of establishing validity to corroborate the experiences of the reproductive women. Most of the married men were husbands of the reproductive women. They could attest to the experiences shared by these women. The men and women were interviewed separately. Hence, similarities and variations in their responses were another way of establishing the validity of their responses.

4.5.2.3.3: Traditional Birth Attendants

Traditional birth attendants were also considered eligible for interviews. The TBAs were included because they are local health care providers for pregnant women; they serve as an alternative to skilled birth attendants and are most accessible and available to community members even more than trained health staff (Mwangakala, 2016). The TBAs are experienced women in the community. They are considered alternative healthcare service providers. Community members rely heavily on the services of the TBAs because most have been utilising them since time immemorial. Hence, it was worth including them as participants to get information about how they carry out their services and why pregnant women in the community utilise them.

4.5.2.3.4: Skilled Birth Attendants

Skilled birth attendants were included because they were responsible for providing maternal health care for pregnant women. Hence, the two skilled birth attendants were selected because they were primarily connected to maternal health services. They were chosen because they are responsible for health care for pregnant women and maternal health in general.

4.5.3: Focus Group Discussions (FGDs)

FGDs are discussions conducted collectively to acquire information about a topic of interest for study purposes. These discussions were moderated and recorded by the researcher. FGDs assist in generating an in-depth view of the participants' experiences (Gill *et al.*, 2008). According to Nyumba (2018), the researcher aims to make inferences from the participant's beliefs, experiences, opinions, and behaviours during these discussions. Traditionally, Focus Group discussions are not so widely used in phenomenological studies, as some scholars believe using FGD is methodologically incompatible with phenomenology (Kevern and Webb, 2001; Webb, 2003). These scholars further argue that phenomenology requires individuals to describe their experiences uncontaminated. However, using FGD in phenomenology is worthy of note, as Bradbury-Jones, Sambrook, and Irvine (2009) recommended. FGD enables each participant to share their experiences primarily, while others add their valuable and related experiences as the interaction continues. The use of FGD aligns with Spiegelberg's (1975) and Halling, Kunz, and Rowe's (1994) views, who opine that FGD is a type of group interview with individual perspectives. Bradbury-Jones *et al.* (2009) also posit that personal lived experience could be preserved within a group context.

Jasper (1995) employed FGD in her phenomenological study, which she justified by arguing that FGD allows participants to elaborate on the shared issues raised. Jasper added that the participants could reflect when other participants talked before contributing. The interaction of the participants enriched the data collected in such a way that may not be possible in one-on-one interviews. Sharing a participant's experiences was a trigger and a reminder for other participants to share some fading experiences. It can be concluded that using FGD enhances the data collection rather than the long-time belief of incompatibility. FGDs utilise the ability of storytelling to elicit information; as a result, it is a vital tool for communities where literacy levels are low.

Importantly, it provides an avenue for people who are timid and might be intimated through private interviews (van Eeuwijk and Angehrn, 2017).

FGD is useful in phenomenological studies to cross-check participants' perspectives and for clarification (Côté-Arsenault and Morrison-beedy, 2001). Cross-checking and clarification help handle contradictory findings in the FGD (Carey, 1994). In this study, a follow-up study was carried out on the FGD members to get further information. The follow-up implies that FGD provides the foundation for the follow-up interview. The researcher acknowledged that FGD is not the same phenomenon as interviews. However, the researcher could get other information that was perceived not to be shared by the participants and information that needed further clarification. Hence, the combination of Focus Group Discussions (FGD) and interviews yielded enriched data for the study, a depth of knowledge that might not have been achievable through interviews alone. FGD contains different dynamics, influencers, and enablers that aided the findings/input of the study.

4.5.3.1: FGD before Covid-19

The researcher conducted a focus group discussion with 8 women from different families, sharing similar characteristics, such as pregnant women in their first and second trimesters, first-time mothers, and multi-para. The FGD was conducted in the first community before the pandemic. There were two FGD groups with 8 participants in each group, totalling 16 reproductive women. Participation was voluntary, and the researcher experienced a warm disposition from the participants. The researcher allowed participants equal chances to air their views while refreshment was also provided.

Each session lasted for about 90 minutes. The researcher started the session by asking all the participants to introduce themselves, after which she re-emphasised the purpose of the research. The participants were familiar with the researcher because she resided in the community during the data collection, interacted with them, and attended their ceremonies. The introduction section was followed by the discussion session, which lasted for an hour, followed by a break to enable the participants to have their refreshments. Some mothers came with their babies and older children. They handed the babies to their other children to look after till the break time when they could feed them. The venue for discussions was a place agreed upon by the participants and the researcher, a place that was free from interference. Conversations

were recorded on a digital recorder for transcription and analysis purposes. Two very general questions (Appendix 4) were asked to stimulate discussion, with the researcher intervening using other questions generated from the observatory data (Nyumba *et al.*, 2018). The researcher conducted a pilot study in advance to identify potential problems associated with participants to minimise the risk. Envisaged problems were a lack of confidence in the research, autonomy of decision-making regarding participation, and freedom of movement to interview sites. The envisaged problems were covered in the invitation letter, information sheet, and consent form (Nyumba *et al.*, 2018).

44.5.3.2: FGD after Covid-19

Covid-19, which started in December 2019 in China, later spread to other parts of the world. Hence, it was pronounced a pandemic in March 2020. Social distancing was mainly used worldwide to curtail the spread of the disease. Accordingly, some countries, such as the UK, declared a total lockdown while academic activities became virtual. The pandemic affected several human activities, including the data collection stage for this study. The conduct of FGD demands an interaction among discussants, where participants are meant to come together to discuss issues, which is most times moderated by the researcher. The rule of social distancing did not permit gathering people together. Hence, the researcher could not conduct FGD after the second community pandemic, which was planned to be used for data collection.

4.6.5. Field notes

Field notes are coherent with phenomenological design (Frechette *et al.*, 2020). Field notes serve as a link between observations made and the analysis of data from all the methods deployed. Field notes were scribbled during observations, interviews, and storytelling, including descriptions and interpretations during the observation process. While jotting down field notes, descriptions, observations, and interpretations were clearly defined. Note-taking differed from writing down observations or experiences verbatim but served as a means of interpreting and making sense of events that were termed as important and living out the not-so-relevant aspects. These notes served to convert places, people, and events into words.

4.7: Data handling

An enormous amount of data was gathered during the fieldwork; this included interview transcripts, field notes, and analytic and reflexive notes, which required a

discrete storage method to ensure the confidentiality of their contents and data management. The participants were allocated pseudonyms to hide their true identities. Links to their real identities were removed for anonymity before the contents of interviews were transcribed and transferred to word processing files. Audiotapes were transcribed and stored in word processing files with passwords, and annotations were utilised to indicate a change in the speakers' voice tone. Transcribed data were organised according to the groups they represented. NVivo version 12 was used to analyse the Word files (www.EUi.eu, 2019). The researcher adhered to the General Data Protection Regulation Act (GDPR) 2018 by keeping the participants' data from other parties and ensuring that the data were used solely for research purposes.

4.8: Method of Data Analysis

This section involves the technique used to analyse the data collected for the study. It is a process that requires clarification and interpretation of data collected to create meaning from such (Merriam and Tisdell, 2016). Data analysis was described as a continuous process involving breaking data into meaningful aspects for examination (Major and Savin-Baden, 2012). There is a relationship between the choice of a data analysis technique and the research questions raised for a study because of its significant influence on data analysis and findings (Major and Savin-Baden, 2012). Different analytic methods were adopted to analyse the data collected for the study. Colaizzi's (1978)" s descriptive phenomenological data analysis strategy was adopted to analyse the data collected from women's lived experiences. Colaizzi's method of data analysis is a 7-step process for analysing phenomenological data. Also, Thematic Analysis by Braun and Clarke (2006) was used to analyse the data collected on the perspectives of the maternal healthcare stakeholders on women's utilisation of maternal healthcare services in Bauchi State. The next chapter will provide an in-depth data analysis review, while the analytical processes of each method are presented as follows.

4.8.1: Colaizzi (1978)'s Analytical Technique

Phase 1-Transcription and Familiarisation: This is the phase where a researcher reads and re-reads the transcripts from the recorded files until the researcher is immersed in the data collected. Colaizzi (1978) recommends that researchers can also play and replay the recorded audio or video files, depending on the researcher's research objectives. The essence of doing this is to ensure a researcher fully

understands and emphasises that subsequent steps are hinged on this phase. By immersing themselves and gaining a comprehensive understanding of their participants, researchers can significantly enhance the accuracy of the following processes. In this phase, the researcher's bias and experiences that may likely influence the analysis are added to reflexive journals to serve as a guide for a continuous check to avoid influencing the process and to ensure the phenomena, as shared by the participants, are the participants' whole experience (Meyers and Meyers, 2019).

Phase 2-Extraction of Significant Statements: Significant statements are participants' responses considered relevant to the research objectives. The statements are recorded with the participant ID number, type of transcript, page number in the journal entry, and line number.

Phase 3- Formulation of meanings: This is where the meaning of each of the significant statements identified is determined. The researcher codes the primary meaning as a reflection of the description provided by the participants. The coding implies the researcher attaches labels to capture the formulated meaning. Attaching labels is referred to as coding. Coding identifies unique, relevant details when answering research questions (Merriam and Tisdell, 2016).

Phase 4- Clustering Themes: This is where the coded formulated meanings are categorised into clusters of themes and emergent themes. The themes should adequately capture the meaning of the participants' lived experiences. Peer-briefers and external auditors were considered appropriate for reviewing codes, categories, themes, and the meaning of the participants' lived experiences (Meyers and Meyers, 2019).

Phase 5: Creating Exhaustive Description: This is where the findings through the emergent themes generated from the study were integrated into an exhaustive description of the participants' lived experiences.

Phase 6- Producing fundamental structure: Fundamental structures are formulated to describe the phenomenon under study. The formulation implies that misused or oversimplified descriptions are removed from the general structure (Meyers and Meyers, 2019).

Phase 7-Validation of findings: At this stage, researchers return to the participants to ensure the study findings align with their responses, that is, the experiences they shared during the data collection. The results are compared and contrasted with the participants' shared experiences. This phase shows that this method of analysis has an in-built validation technique.

4.8.2: Braun and Clarke's (2006) Analytical Technique

The 6-step method of data analysis was applied as follows.

Phase One: Familiarisation with the data

Braun and Clarke's thematic analysis begins with the first phase, "Familiarization with the data." During this phase, the researchers aim to comprehensively understand the qualitative data by immersing themselves in it. To begin with, researchers read and re-read the entire set of qualitative data, which might include interview transcripts, focus group discussions, or field notes. They take detailed notes on their initial impressions, exciting patterns, key concepts, and any noteworthy aspects of the information. During this phase, researchers may identify preliminary ideas or codes that capture the essence of certain parts of the data. These initial codes are a starting point for the subsequent coding and theme development.

Additionally, researchers may document their initial emotional reactions or personal responses to the data. The familiarisation phase is crucial because it lays the groundwork for the subsequent steps in the thematic analysis. It helps researchers develop a deep familiarity with the data, ensuring that the research is grounded in the specifics of the information collected.

Phase Two: Generating Initial Codes

In Braun and Clarke's thematic analysis, the second phase is called "Generating Initial Codes." Researchers systematically break down the data into meaningful units during this phase and label them with descriptive codes. Researchers start by segmenting the qualitative data into manageable units, which could be individual words, phrases, sentences, or even paragraphs, depending on the nature of the data. The aim is to break down the data into distinct elements for analysis. Codes are labels or tags that capture the essence of a specific idea, concept, or theme within the data. Researchers assign codes to the segmented units based on their content. Generating initial codes is iterative, meaning researchers may revisit and refine codes as they progress through the data. Researchers must establish consistency in their coding approach.

The establishment involves applying codes systematically across the entire dataset to ensure that similar content is labelled consistently.

Phase Three: Searching for Themes"

Researchers systematically sort the generated codes during this phase to identify overarching patterns or themes within the data. The sorting typically involves reviewing the codes and organising them into potential themes based on commonalities. As researchers identify themes, they create descriptive labels or names that best capture the essence of each theme. These labels should be meaningful and representative of the content they encompass. Refining and defining themes is iterative, meaning researchers revisit and revise the themes to ensure that they accurately reflect the data and capture the richness of participants' experiences. Themes may be merged, split, or adjusted as needed to make sense within the context of the research question and objectives.

Phase Four: Reviewing Themes

Researchers thoroughly evaluate the previously identified themes in the "Reviewing Themes" data analysis phase. The aim is to ensure that each theme accurately represents the data and contributes to a coherent and unified meaning. Researchers check for consistency within each theme during this stage, ensuring that all codes align conceptually. They also compare themes to identify potential overlaps, redundancies, or gaps. Researchers explore various ways to conceptualise and name themes, ensuring they are the data's most relevant and accurate representations. They actively seek counterexamples or instances that challenge the identified themes, refining them by considering diverse perspectives and avoiding a single narrative. To assess whether the themes address the research aims and provide meaningful insights into the phenomenon under investigation, researchers evaluate the themes of the research question or objectives. Based on the review process, themes may undergo further refinement and clarification. The refinement could involve merging or splitting themes, rewording theme labels, or adjusting the scope of themes to capture the sub-themes in a better way. Throughout the review process, researchers document the decisions, including any changes to theme names or definitions. This documentation enhances transparency and provides a clear trail of the analytical process.

Phase Five: Defining and Naming Themes

Refining and providing clear descriptions for the identified themes is crucial in the thematic analysis process. To achieve this, researchers carefully examine the codes under each theme and refine and clarify the boundaries of each theme to ensure they accurately capture the underlying patterns and meanings in the data. This process includes developing detailed and comprehensive descriptions for each theme, assigning evocative and descriptive names, and creating clear, specific, and focused definitions. It is essential to name and define themes in a way that directly aligns with the research question or objectives. Each theme should address the study's goals and provide insights into the phenomenon under investigation. Defining and naming themes is an iterative process, and researchers may revisit and revise theme descriptions and names as they continue to deepen their understanding of the data and refine their analytical interpretations. By the end of this phase, researchers should have a set of well-defined, named themes that accurately reflect the patterns and meanings present in the qualitative data. These themes serve as the basis for the final step in Braun and Clarke's thematic analysis: reporting the findings.

Phase Six: Writing the Report

This phase involves synthesising and communicating the research findings coherently and meaningfully. The report should start with an introduction that sets the stage for the research by providing background information, a clear statement of the research question or objective, and the rationale for the study. This introduction contextualises the themes that will be presented. The researchers should then provide an overview of the identified themes, which may include concise descriptions of each theme and the number of associated codes or data extracts. This section offers a snapshot of the main findings before delving into the details. Researchers should include illustrative quotes or examples from the data throughout the report to support each theme. These quotes serve as evidence and help convey the participants' voices and experiences, enhancing the richness and authenticity of the narrative. The report concludes by summarising the key findings and their implications. Researchers may seek peer review or colleague feedback to ensure the report's quality and rigour. This external input can help identify improvement areas and enhance the findings' credibility.

4.9: Equipment

Equipment was included in this study report to explain how the researcher used them. The equipment for the fieldwork included the following:

4.9.1: A laptop computer

The researcher used the laptop computer for different purposes in this study. The laptop was the primary device used for searching the internet for research materials; it was used additionally for typing and formatting the content of the thesis. It was also used to transcribe the audio recordings of the interviews and Focus Group Discussions. Notes were reproduced daily with the laptop on the day they were written to guarantee that the information they conveyed was included in the transcription.

4.9.2: A cabinet

The cabinet was locked to secure the laptop and backup facilities. The backup facilities included batteries for the two recorders, photocopiers for photocopying purposes, and photocopies of the information and consent forms.

4.9.3: Audio recorder

The device was used for recording purposes. The researcher used the device to record the interviews and focus group discussions. It was used to capture the voice of the participants during the interview and Focus Group Discussions. The device helped capture all the conversations to guide against data loss and appropriately capture all matters discussed during the data collection.

4.9.4: A ream of paper

The paper was a rim for printing and photocopying purposes.

4.9.5: NVivo software license and access

The license is a Computer Assisted Qualitative Data Analysis Software, NVIVO, given by the researcher's institution for data analysis. NVivo, version 12, a computer-assisted qualitative data analysis software (CAQDAS), was used to manage transcripts and audio files. This software allowed the researcher to form clusters of information, develop themes, and retain verbatim quotes as highlighters.

4.10: Research Validity and Quality

Reliability and validity in quantitative research have implications in qualitative research in the form of trustworthiness. Trustworthiness is very significant to the integrity of the findings of any study (Cope, 2014). It promotes confidence and quality in the data of a survey (Polit and Beck, 2012). The validity of research is a key yet challenging task

to guarantee. However, researchers have to show the credibility of their work. Techniques for determining validity include peer reviews, triangulation, and external audits. The technique was chosen to prove the validity of the work depending on the researcher's theoretical assumptions and perspectives. For example, the researcher went through notes taken to see whether themes were emerging and if these themes were relevant to the study. Another research validation method deployed was the qualitative paradigm of realism. The method shows the assumption that reality is socially construed and individual-specific. Krefting (1991) describes strategies essential to maintaining the trustworthiness of qualitative research: credibility, transferability, dependability, and conformability. Validity was enhanced because the opinions of people who lived experience of the issue being studied were sought. In other words, this work conformed to the researcher's ontological and epistemological perspectives. The trustworthiness and rigour were carried out in the following ways:

4.10.1 Triangulation

Triangulation tests a study's validity through various data collection sources (Carter *et al.*, 2014). Triangulation has been categorised into four groups: method, investigator, theory and data-sourced triangulation (Denzin, 1978; Patton, 1999). The researcher adopted data source triangulation, namely, participants' observation, focus group discussion, semi-structured interviews, and journal entries, to gain an in-depth understanding of the phenomenon under study. The main barrier to the study's validity was the researcher's tendency to be so absorbed into the participants' lives that it became difficult to separate their experiences from the researchers. However, this was overcome by reflexive analysis. Since the qualitative researcher took a reflexive stance, personal opinions and their influence on the study were constantly reviewed.

4.10.2.1 Reflexivity / Bracketing

Reflexivity refers to how the researcher's views and perspective influence the research. It is pivotal in qualitative research. Interpretive phenomenologists, unlike positivists, hold that researchers cannot be separated from their suppositions, thus cautioning researchers against pretence (Hammersley, 2000). The concept of bracketing is why Mouton and Marais (1988) emphasise that individual researchers hold explicit beliefs while writing their reports. According to Reeves *et al.* (2014), the researcher's stance and opinions about the study should be presented to the readers to give them insight into how these might have impacted the investigation. Different

researchers can approach the same research from different perspectives and arrive at equally acceptable results. The stance a researcher chooses to assume eventually shapes the research. Therefore, the researcher's beliefs, values, views, and opinions form a basis for readers' judgment of research results (Nevid *et al.,* 2011; Robert Wood Johnson Foundation [RWJF],2019).

4.10.2.2 Bracketing before data collection

I am an indigene of Bauchi State, in Northern Nigeria. Consequently, I am familiar with the region's culture and acknowledge the similarity of cultural concepts. I experienced a positive response from the communities during data collection. The positive reaction I experienced could be partly attributed to my cultural background. The positive response came during the conduct of the study and made my acceptance into these gender-sensitive communities less complicated. They are gender-sensitive because of the restrictions placed on the female gender, especially regarding interactions with the opposite gender (Tyoakaa, Amaka, and Nor, 2014). I also visited these localities and was conversant with their traditions and costumes. The visitation assisted in ruling out problems of culture shock.

I made regular entries in my reflexive journal regarding how my beliefs and values have impacted my decisions during the work. I also documented what my values, beliefs, preconceptions, and assumptions may have had on the study in the publication of the findings. In addition, I kept my reflective diary for self-awareness of my prejudices and experiences and to ensure that the data were collected meaningfully. Before data collection, it was vital for me to set aside my personal experiences about utilising maternal health services for women of reproductive age. I kept a diary to help bring my experiences and prejudices to mind and documentation of bracketing techniques to avoid interference with the participants' experiences. I practised the use of non-verbal behaviour, which promotes neutrality. I adequately prepared to use active listening skills to ensure the originality of the description of participants' experiences.

4.10.2.3 Bracketing during data collection

As social beings, researchers are expected to bring their experiences, predispositions, and prejudices to the research environment (Wall, 2004). However, the possibility of setting aside researchers' experiences, preconceptions, and prejudices help to

produce findings that reflect the unaltered experiences of the participants (Wall, 2004). I ensured participants could share their experiences without influencing them during data collection. I allowed participants to clarify where necessary to avoid influencing their responses. The essence was to ensure that the experiences shared by the participants solely originated from them. My experiences or assumptions did not influence such sharing of experiences. I kept an open mind because there was a high tendency for participants to share similar experiences and observations. I avoided giving non-verbal signs like nodding to align with the participants' experiences. I allowed the participants to personally reflect on their experiences with much time allowance to describe their experiences, while I avoided leading inquiries as much as possible.

4.10.2.4 Bracketing after data collection

Bracketing allows constant reviewing of the data available to the researchers (Wall, 2004). To comprehend the participants' descriptions of their experiences, I read and re-read the transcripts. I understood independence and discussed it with my research group, putting aside my experiences and prejudices. I explicitly described the settings and compared the initial data to emerging themes.

4.10.3 Peer Debriefing

Debriefing involves examining the research process and data by people familiar with the study under investigation (Creswell and Miller, 2000). Biases and prejudices can be handled using peer debriefing, and clarifications can be provided for given interpretations (Lincoln and Guba, 2011). Researcher biases can be addressed during peer debriefing, and any explanations given can be clarified (Lincoln and Guba, 2011). This approach was used, as the researcher regularly met with the doctoral committee, who provided co-facilitation for the study.

4.10.4 Member Checks

The practice of trustworthiness in the study was also ensured by using the study participants to assess the findings from the survey. Trustworthiness is a stage where provisional research findings are returned to the field to scrutinise the participants who provided the information (Lincoln and Guba, 2011). After the initial data collection through interviews and focus group discussions, the data collected were analysed, and the findings were presented to the participants for them to check. The essence is to ensure the conclusions accurately represent the experiences shared by the

researchers; that is, the findings accurately represent their stories. The participants were satisfied with the reports of their experiences shared during the data collection.

4.10.5 Audit Trail

The credibility of a study can be affirmed either by people outside or inside a study. Using an audit trail ensured that individuals outside of research work, referred to as auditors, assisted in examining materials and analysis methods (Creswell and Miller, 2000). Documentation of all decisions and actions taken in a study should be made available to the auditors for examination (Creswell and Miller, 2000). In this study, an audit trail was created with data analysis, field notes, and provisional findings of the study provided for assessment by the auditors.

4.10.6 Confirmability

Each researcher's perspective on a study is assumed to be unique in qualitative research; the degree to which other people can confirm or refute the findings from the research is referred to as their "confirmability (William, 2020). A qualitative researcher must establish confirmability as a trustworthiness criterion. The focus of this criterion is the level of confidence that the research study's findings are based on the participants' words and narratives rather than potential researcher biases (Olivia, 2015). In this study, the researcher kept track of steps taken in different aspects of the study and checked and re-checked those steps. Using the researcher's diary helped keep track of other records from data collection to analysis. I also used the audit trail and reflectivity discussed earlier in this chapter.

4.10.7 Transferability

The degree to which qualitative research findings are adaptable to other contexts or settings is their transferability (William, 2020). From a qualitative point of view, the one who is generalising is primarily in charge of transferability by providing a comprehensive description of the research context and the central assumptions (William, 2020). Transferability and "fittingness" refer to the likelihood that the study's findings will be helpful to others in similar situations. (Vilakati, 2009). In this study, the researcher adequately described her data and carried out member checks to increase the likelihood that the findings will have the same significance for other locations in rural northern Nigeria. The researcher in this study ensured that the results were reliable by showing the survey to a colleague and research team for helpful feedback and showing the findings to the participants to ensure it captured the discussion during

the data collection. The researcher also compared the study findings with those from other locations apart from the study area.

4.10.8 Confidentiality

The term "confidentiality" refers to the restriction on disclosing any information by the informants to third parties (Vilakati, 2009). An individual's privacy or foundation is safeguarded by making it challenging to connect parts of data to a particular individual or establishment (Vilakati, 2009). Following Behi and Nolan (1995), confidentiality and anonymity were maintained by ensuring that the data obtained were utilised so that only the researcher was aware of the source; this shows that the data were not identified using the informants' names. In this study, the privacy of the research participants was kept confidential, as promised during the data collection. During the data collection, the participants were assured that their responses were for research and nothing more. They were assured that such answers would be kept confidential without attaching names to the responses used as excerpts to ensure the study's validity. Their names and profiles were not made available for public consumption. The word 'Participant' was used during the presentation of findings, while numbers were also attached to show the number of participants. For instance, "Participant 1" indicates the responses from a participant assigned number one. Sometimes, the gender and the category of participants, such as women, men, TBAs, or health workers, were mentioned during the presentation of findings. However, there was no trace of the identity of the responses to a specific participant in the community. Thus, no one can locate a participant for their answers.

4.10.9: Pilot Study

The researcher conducted a pilot study to identify and address likely problem areas with potential participants. A pilot study minimises the risk associated with the data collection process by testing the data collection methods, assessing research protocols, and any other techniques to be used before the commencement of the main study (Abu *et al.*, 2006). The essence of conducting the pilot study was for feasibility studies and to pre-test the research instrument. The researcher used feasibility studies to assess the practicability or possibility of the leading research study concerning its implementation/application, which included the assessment of resources, such as costs and time, for the main research study. The purpose of conducting the pilot study was not simply to say that it has been undertaken or to justify the methods used without

explicit details. Instead, the focus was on identifying how to modify the questions or the failed procedures for the study.

The problems encountered during the conduct of the pilot study were:

- During the focus group discussion, mothers came to the venue (FGD) with their children, which distracted the process.
- The researcher combined young and older women in the same group during the focus group discussion, and the older women took over the discussion. Unfortunately, the young women were too shy to share their views.
- Conducting interviews in the participants' homes was not ideal. For example, their co-wives who were not part of the discussion were eavesdropping, and the older children in the respective homes stood by the window to hear what the discussion was about.

The researcher learned from the pilot study that the two age differences should not be combined in one group. In addition, interviews should not be conducted at the participants' respective homes, and mothers should come with caregivers who would help look after their babies during interviews. Conducting interviews at participants' homes gave a sense of informal discussion even though they were aware of the purpose of the data collection. However, the sense of home environment somewhat affected their concentration, looking here and there since it is their home. Having mothers with their children affected the mothers' concentration and attention because they needed to breastfeed their babies, sing for the babies to sleep, or not disturb their data collection setting. These have a way of prolonging the scheduled time more than necessary.

4.11: Research Timeline

Before the commencement of the study, the researcher obtained approval from the Institutional (University of Northampton) Ethics Committee on the research and data to be collected. The approval took 96 days, from April 14 to July 9, 2019. Access to the study site and recruitment of key informants and participants took 13 days, from January 26 to February 8, 2020. The researcher resided in the communities and recruited the community leaders as the key informants, who introduced the researcher to the gatekeepers in the community and women who met the inclusion criteria; that is, they have experiences in line with the study's objectives. Subsequently, data

collection took place in two communities. The researcher observed the participants' activities for 2 hours every day for four weeks. In addition, the researcher conducted two Focus groups in the first community, where eight participants participated in each group. The researcher also organised in-depth interviews with the male participants, TBAs, and health workers. The data collection panned 50 days, from February 10 to March 31, 2020.

The data collection was interrupted by the COVID-19 pandemic when the researcher also gave birth. The period of the interruption took 91 days, that is, from April 1 to July 20, 2020. After lifting the lockdown, the researcher returned to the ethics committee to revise the risk assessment and continue with the data collection stage. The revision took 99 days, from July 6 to October 13, 2020. After the lockdown, the researcher interviewed 5 women of reproductive age, 2 TBA, and 3 men. The post covid data collection took 68 days, from November 2 to January 9, 2021. The data collected on women’s lived experiences and maternal healthcare stakeholders were analysed with Braun and Clarke's (2006) thematic analysis and Colaizzi's (1978) analytical technique, and the data analysis period covered 274 days, from January 13 to October 14, 2021. The timeline is outlined in Figure 4 below.

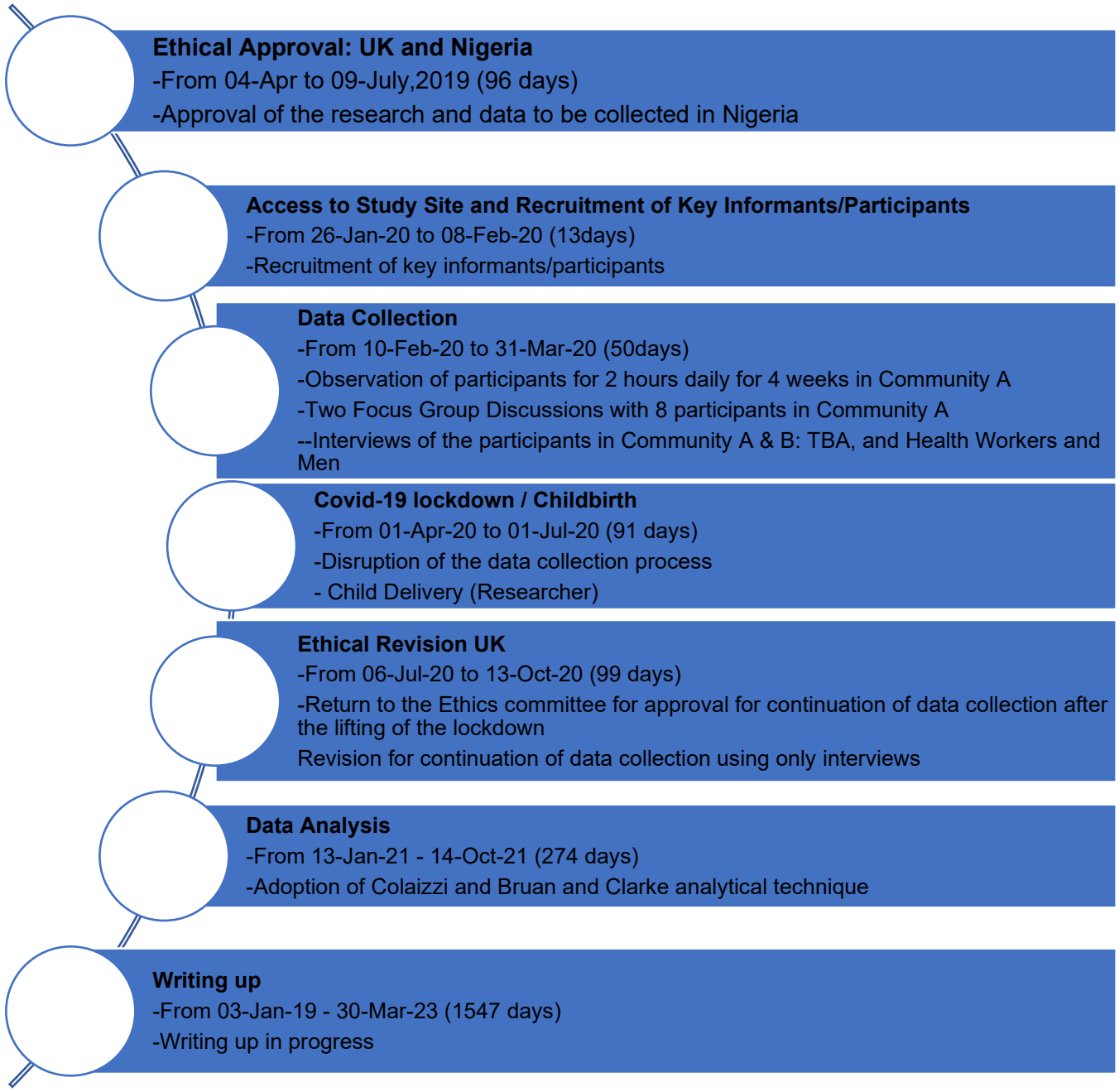


Fig 4. Research timeline

4.12 Ethical considerations

The research study was carried out in a predominantly Muslim community, where access to homes or married women is invariably through the permission of the gatekeepers (husbands). Culturally, in the Muslim tradition, only the married man or his relatives have access to his home, which is the norm in most Muslim-populated

communities (Zakaria *et al.*, 2010). As a result, permission was sought from potential participants' husbands before gaining access to their homes (Sinai *et al.*, 2017b). In addition, the men and their wives were informed about the purpose of the visit and the terms and conditions of participation (Appendix 3).

These terms include:

1.The protection of participants' right to personal autonomy and privacy, which was upheld by providing sufficient information regarding the risks and benefits of the study so that individuals could freely agree to or decline participation.

2. The participants' reserved right to withdraw from the study whenever they choose to or withdraw any data, they have provided within 30 days of participation.

3. The participant's right to decline to answer sensitive questions

4 Participation would not attract any form of remuneration

5 Findings from the research would be published, the identity of the participant would be protected

Participants were informed about the research aims and methods through the participant information sheet (Appendix 1). Translating the sheet's contents and an invitation letter (Appendix 2) into the local dialect was necessary because of the need for clarity. The information sheet accompanied the invitation letter. Informed consent involved filling out the consent form (Appendix 3) and seeking the voluntary participation of suitable participants after all aspects of the study related to their involvement had been disclosed to them (Manti and Licari, 2018). Consequently, the researcher ensured the continuous enlightenment engagement/information of the participants regarding the research, which was aimed at sustaining participation in the study if they decided to participate. Furthermore, the consent form was translated into the local dialect and avoided using coercive language (Manti and Licari, 2018).

The women's autonomy to participate in the study and their right to withdraw within 30 days was clearly stated to their spouses. However, a female participant's autonomy to decide depended solely on whether her husband wanted her to participate in the study. Interestingly, some men involved in the study were the husbands of these women.

Thus, the researcher appreciated the participants' time by providing light refreshments.

4.12.3 Ethical methods (Location and access)

This study was conducted in Birshi and Dan Iya wards of Bauchi Local Government Area in Bauchi state, north-eastern Nigeria. Ethical approval was also gained from the University of Northampton (UoN). Ethical issues are paramount regarding planning, designing, and conducting the research (Tabatabaei, 2016). Also, ethical clearance was obtained from the Bauchi State Health Research Ethics Committee (BASHREC) to access the study sites. After submitting all the necessary documents for ethical clearance, BASHREC granted the researcher clearance approval to proceed with the data collection. Ethical approval from the University of Northampton was gained in full. The UK process assisted with generating a participant information sheet (PIS) and a consent form to be utilised by the researcher to conduct this study. Permission from the community leaders in these wards was gained through the gatekeepers. Gatekeepers assist in controlling access to communities or institutions. They guarantee that researchers adhere to professional ethics while ensuring that the motives of the research will in no way affect the community negatively (Singh and Wassenaar, 2016)). These religious/traditional leaders introduced the researcher to the spouses of participating women to raise awareness and seek their consent and cooperation before establishing networks with likely participants by word of mouth. Potential participants were given an invitation letter (Appendix 2) inviting them to participate in the interviews.

Permission from the local governing council and religious or traditional leaders permitted engagement with the inhabitants of the target regions. The following measures were taken to ensure that ethical issues were addressed:

- Participants were appropriately informed about the study by an agreement based on understanding all relevant details about the research.
- Participants were required to complete a consent form stating they understood the whole process and their willingness to participate in the research. The participants signed the document to record their informed consent to participate.

- Confidentiality and anonymity surrounding all the participants in the study were maintained by eliminating all markers of personal identification, such as names and contact addresses.
- Participants were informed beforehand that they were not obligated to recollect upsetting events. However, the interviewer organised support groups comprising other women with similar experiences and possible relations to help them overcome the trauma they had had to undergo.
- Measures were taken to ensure the interviewer maintained a neutral stance on all issues discussed by avoiding coercion and inciting language (Voltaren *et al.*, 2018).
- A schedule of travel plans with dates and emergency contact details was made available to the supervisory team and significant others (husband, parents).
- The researcher had the right to withdraw from studying or interviewing in the event of an unjustifiable risk of psychological or physical harm since she was working alone without direct supervision.
- Verbal and ongoing consent was sought from participants during participant observation because data collection requires many visits to the community.

On agreeing to participate in this study, the participants were informed that the summary of the research findings would be made available publicly for easy access in academic journals and conference papers. The necessary procedures observed and permissions obtained were attached (Appendices 1,2,3).

Data collected for this study were stored in the university's One Drive. Additionally, participants were informed that their details would be coded to ensure confidentiality during the analysis and writing stage, and all data would be destroyed 5 years after completing the project. For future use of the data, such as publications, codes were used to represent names to ensure anonymity and confidentiality. To maintain privacy and disclosure in a focus group, the researcher provided participants with the procedures by asking them to sign a confidentiality statement to affirm that they would not communicate or disclose the information discussed in the group. They were guaranteed that this procedure was not meant to intimidate or pressurise them but to psychologically commit them to respect confidentiality, especially when discussing sensitive topics. Issues of concern or evidence of past, present, or probable harm or malpractice were not envisaged to arise during the research. However, if it did happen,

participants were informed that such cases would be reported by following the locally laid down policy to handle such issues in the following ways:

- There was a reassuring of participants' confidentiality.
- There was reporting to the local ethical committee or Ministry of Health, which oversees the health status of the community. For instance, the researcher reports to the community leader, who reports to the Ministry of Health to handle the issues accordingly.
- Support groups were organised for those who have suffered abuse or misconduct at the hands of unscrupulous health staff.
- Enlightenment campaigns about the importance of maternal health care were organised with the permission of the community heads. The process was explained to the participants via the participant information sheet and word of mouth before and on the day of the focus group discussions and interviews.

4.13: Summary of the chapter

The details of the research methods concerning the concept, study population, description of the participants, and selection of the participants were discussed in this chapter. Purposive sampling and snowballing techniques were used for the selection of research participants. Purposive sampling enables the researcher to select appropriate study samples for the study. Key informants helped provide necessary, helpful, and detailed information about the community and community members for the researcher. Snowballing helped to connect other samples that were relevant to the study. Participants' observations provided helpful information for different parts of the study. The methods of data collection were focus group discussions and semi-structured interviews. FGDs were conducted before and after the Covid-19 break. The study's inclusion and exclusion criteria, validity and reliability, ethical channel, and data analysis methods are all discussed in this chapter.

CHAPTER FIVE

FINDINGS

5.0 Introduction

This chapter presents the analysis of lived experiences shared by the women and perspectives shared by married men and healthcare workers concerning women's utilisation of maternal healthcare services in Bauchi State, Nigeria. The participants were women of reproductive age, men (husbands), skilled health workers, and Traditional Birth Attendants (TBAs). The chapter includes the details of the participants' demographic and the study's findings. Also, emerging themes with significant statements from the lived experiences shared by the participants are presented in this chapter. Similarly, themes and sub-themes with corresponding excerpts from the perspectives shared by the maternal healthcare stakeholders are presented in this chapter. The details regarding applying Colaizzi's analytic method for phenomenological study data (1978) and Braun and Clarke's (2006) analytical method are also included.

Research Question One: What are the women's experiences of the factors influencing their utilisation of maternal health services in Bauchi State, Nigeria?

Colaizzi's method of data analysis was used to analyse the data collected for the study, and the results are presented in the subsequent section.

5.1 Application of Colaizzi's Method of Data Analysis

The analysis of phenomenological data demands that a researcher provides a comprehensive, insightful, and thorough examination of the experience of the study's participants (Carpenter and Suto, 2008). Colaizzi's (1978) analytical technique demands the immersion of researchers investing quality time in data collected from the study participants until meaningful units and themes emerge (Todres, 2005). The findings should arise from the study participants' experience without alteration by the researchers. Phenomenological researchers use the Colaizzi method of data analysis because of its clarity, logic, and sequence of steps, which makes a study's results highly reliable and dependable (Wirihana *et al.*, 2018). This healthcare-based study explored the participants' experiences concerning maternal services in Bauchi State, Nigeria.

This study aimed to ascertain the state of maternal healthcare services in the study population. The findings helped to conclude several factors that hindered the utilisation of maternal services in the study population. The researcher observed that people quickly shared their feelings, views, and opinions from personal experiences without much ado. The findings were based on the cumulative experiences shared by the participants. Hence, the importance of experiences cannot be overemphasised. This assertion aligns with Colaizzi's view, 'to believe that my experience does not count amounts to believing that my existence does not count.' Colaizzi equated peoples' experiences with their existence because experiences are gathered over some time. The alignment between Husserl's approach to phenomenological studies and Colaizzi's analytical technique promotes essential healthcare values by capturing participants' experiences as a consideration (Wirihana *et al.*, 2018). Thus, Colaizzi's method of data analysis is very relevant to this study as it was used to analyse the data collected from women, men (husbands), healthcare workers, and traditional birth attendants concerning maternal healthcare services in Bauchi State, Nigeria. The subsequent section shows how Colaizzi's analytical technique was utilised in this study.

5.1.1-Transcription and Familiarisation with the Data

The files recorded during data collection were converted into text verbatim, that is, word for word. Different forms of transcription, manual, and machine, are available for researchers' use. Machine transcription involves taking technological advantage through Artificial Intelligence (AI). Researchers must meet several requirements before using Artificial Intelligence to convert recorded files during interviews or Focus Group Discussion Groups into transcripts. There should be as little background noise as possible. The participants' accent is a key issue in using machine transcription. The AI should be able to pick the participants' voices for transcription without much difficulty. In this study, I used manual transcription since the interaction with the participants in the Focus Group Discussions and most of the interview sessions were in the Hausa Language. The study was conducted in rural areas where the Hausa language is the community's dialect. Interacting with the participants in their local dialect enabled them to share their experiences freely, comfortably, and in detail. I researched the phenomenon under study regarding utilising maternal healthcare services in their community. I was able to have their detailed responses on such

experiences. Hence, using machine transcription was impossible because it was difficult for artificial intelligence to recognise participants' voices in the Hausa language. Also, there was no Artificial Intelligence powered machine in the Hausa language during the transcription. Using AI to transcribe local dialects in Nigeria could be a welcome invention.

In addition, the researcher afterward manually translated the transcripts from Hausa to English. I did the translation initially and then engaged the service of experts in English to ensure the translation was in line with the rules guiding language translations. The experts understood both Hausa and English languages and were versatile in their understanding of both languages. The essence of seeking the service of the experts in the field was to ensure that the experiences shared by the participants were not altered, nor inappropriately modified or misinterpreted. The transcripts from the FGD and semi-structured interviews were imported for data analysis into NVIVO (version 12), a Computer-Assisted Qualitative Data Analysis Software (CAQDAS). Importing files into the software allowed me to have all the data available in the software. In other words, I did not have to go back and forth to the transcripts because they were all imported into the software. I read and re-read the transcripts several times within the software environment. Reading and re-reading interview transcripts helps researchers to have a comprehensive view of the phenomenon shared by the participants (Tappen, 2011). I could understand the participants' different perspectives in detail regarding their experiences of healthcare services in their communities. I could align the participants' reactions, including their non-verbal feedback, with their transcripts. A keen and careful following through this phase ensures that the experiences the participants share stand as the focus of the data analysis (Wirihana *et al.*, 2018).

I also imported the audio files from the interview and the Focus Group Discussions. I could listen as often as I wanted and align the transcripts with the audio files to refresh my memory of the data collection period and confirm the transcripts' content. This process helped me to immerse myself in the experiences of the participants. I found some insightful and relevant statements made by the participants in line with my research objectives. I took note of some segments that were not understandable at first reading, which I had to re-read for deeper understanding. I made notes on some emerging concepts from the participants' shared experiences. At this stage, NVIVO

helped to take note of the insightful words and add comments using 'memo, one of the powerful features in NVIVO. Memo helps researchers put down their thoughts concerning observations, likely codes, and themes. Memo helps to have lists of possible codes from the relevant statements made by the participants. The codes in the memo in the NVIVO software included tradition, religion, transportation, and preference of the participants for female healthcare workers, among others. The memo in the NVIVO software is an electronic version of the researchers' diary. It helps to house all researchers' observations and can be viewed at a glance. Both hard and soft memo versions can be exported into NVIVO for use.

5.1.2 - Extraction of Significant Statements:

This aspect focuses on bringing some sets of important responses out of the participants' responses. There were quite a lot of experiences shared by the participants during data collection. However, only phrases and sentences found relevant to the research questions were extracted from the participants' responses. These statements were the exact words of the participants and an excerpt of their reactions during data collection. The extraction of the significant statements was discovered through reading and re-reading the transcripts to capture the description of the experiences regarding utilising maternal health care services. I also took notes alongside the extraction of the statements. Hence, all the transcripts were read line by line. The significant statements were highlighted and coded in the NVIVO software with the page and line numbers. Researchers should be careful when extracting significant statements from the participants' experiences; the essence is to preserve the context where the statements were extracted (Tappen, 2011). Every statement was properly given identification with page and paragraph number from the transcript of each of the participants, as depicted in Table 3 below. The page and line numbers were helpful for reference and an easy trace of the data when the need arose.

Table 3: Example of Significant statements

Significant Statements	Transcript No	Page No	Lines
In fact, women believe that God has blessed every woman with all the needed strength and some natural solutions (mostly in the form of herbs) to keep their pregnancy without the need for any artificial support from any healthcare facility.	14	3	53-57
Many of us believe that God Almighty has endowed us with a good and reliable traditional caregiving system that is sufficient to help us manage our illnesses. Since this caregiving system has not failed us in any way, and it is something that was passed on to us by our parents, we felt it would not be fair to play with the age-long tradition, but we would continue to uphold this in our time.	15	2-3	56-60

Take, for instance, the first statement:

> *In fact, women believe that God has blessed every woman with all the needed strength and some natural solutions (mostly in the form of herbs) to keep their pregnancy without the need for any artificial support from any healthcare facility*

The significant statement was extracted from the statement made by the 14th participant, as the statement can be found on the 3rd page of the participant transcripts, lines 53-57.

5.1.3-Formulating meanings

Formulated meanings involve attributing meanings to the significant statements generated from the participants' responses. The participants described their experiences as applicable to them. However, there is a need to transform the description of participants' experiences into clarified terms relevant to scientific inquiry (Giorgi, 1997). Hence, the significant statements were rewritten as formulated meanings to capture extracted significant statements. Meanings were attached to the significant statements as codes in NVIVO software. Researchers have the advantage of generating codes and groups of codes using NVIVO software. A thorough study of the significant statements and deep thinking preceded discovering appropriately formulated meanings that would capture the significant statements. The formulated meanings are not expected to deviate from the data. The formulated meanings were compared with the original transcripts to represent the experiences the participants shared accurately. The formulated meanings were discussed with some friends and

colleagues who are qualitative researchers and experts in qualitative research. The essence was to promote the validity of the findings by engaging various experts' perspectives and to ensure participants' experiences were not altered.

My fellow researchers checked the significant statements and the formulated meanings and gave some suggestions. My research team also reviewed all the formulated meanings with the corresponding significant statements while suggestions were provided to improve the formulated meanings. Bracketing is a major concept in the descriptive phenomenological study. I activated my bracketing plan to ensure the validity and rigour of the study, as discussed in the methods chapter. Setting aside my prior experience, biases, and preconceptions was somewhat difficult because the experiences have been acquired over the years. However, discipline and determination were the major tools in achieving this purpose. I maintained the design requirements because this was my first time taking the phenomenological route. Bracketing is essential in this phase as it helps to guide against misinterpreting the views shared by the participants (Praveena and Sasikumar, 2021). The use of bracketing had its challenges. I had to put aside my experiences and preconceptions to protect the research process. I did, however, keep reminding myself of the importance of bracketing. Examples of the formulated meanings from the significant statement are presented in Table 4. below.

Table 4: Example of formulated meanings from significant statements

Significant Statements	**Formulated Meanings**
In fact, women believe that God has blessed every woman with all the needed strength and some natural solutions (mostly in the form of herbs) to keep their pregnancy without the need for any artificial support from any healthcare facility. (Transcript 14, page 3, lines 53-57)	Every woman can naturally carry their pregnancy without artificial support.
Many of us believe that God Almighty has endowed us with a good and reliable traditional caregiving system that is sufficient to help us manage our illnesses. Since this caregiving system has not failed us in any way and was passed on to us by our parents, we felt it would not be fair to play with the age-long tradition, but we would continue to uphold this in our time. (Transcript 15, pages 2- 3, lines 56-60)	Herbs have been traditionally sufficient in managing all forms of known illnesses.

5.1.4- Organising the formulated meanings into a cluster of themes and themes

This phase is also known as the clustering of themes and the emergence of themes. It follows the pattern of collecting like terms in mathematics. The formulated meanings generated from the significant statements are categorised into clusters, while the clusters are arranged into themes (Praveena and Sasikumar, 2021). I organised the formulated meanings into themes and emergent themes, as depicted in Table 5 below.

Table 5: Examples of Cluster of themes and themes from formulated meanings

Formulated Meanings	Theme Cluster	Theme
Every woman can naturally carry their pregnancy without artificial support	Masculinity in pregnancy	Communal Belief
Herbs have been traditionally sufficient in managing all forms of known illnesses.	Efficacy of Traditional Healthcare	

The formulated meanings were classified based on similarities of concept. The formulated meanings were reviewed with friends who are qualitative researchers and experts in qualitative data analysis to ensure the re-organisation and re-categorisation of clustered and emergent themes. I created a concept map in NVIVO software to represent the themes' clusters and emergent themes. Notably, it was challenging to accurately and appropriately organise the formulated meanings into themes. I eventually arrived at the final clustering of the themes after some drafts. I did a lot of reflections on the themes and their meanings to ensure genuineness and appropriateness. Colaizzi emphasised theme validation by comparing the themes generated with the original transcripts of the participants. The theme validation was achieved by reading the transcripts repeatedly to ensure their authenticity. The cluster of themes and themes alongside the formulated meanings were shared with my peers, qualitative researchers, and research team. Their feedback helped me create the final draft of the cluster of themes and emergence themes.

5.1.5-Creating Exhaustive Description

An Exhaustive description is a detailed description of experiences expressed by the participants (Edward and Welch, 2011). In this phase, the researcher comprehensively describes the phenomenon by integrating cluster themes and themes produced in the previous step (Morrow *et al.*, 2015). To create a complete structure, researchers

should combine the cluster of themes, the themes, and the formulated meanings into descriptions (Praveena and Sasikumar, 2021).

I checked the formulated meanings linked with clustering themes aligned with Colaizzi's stand. The essence is to discover the participant's experiences for a detailed account of their maternal health care services descriptions. To get the best out of this phase, researchers should re-check their participants' transcripts and theme clustering and ensure thoroughness as they carry out the comprehensive description (Wirihana *et al.*, 2018). Afterward, I engaged in a detailed description of the experiences, checking the formulated meanings and clustered themes. This analytical phase provided a detailed description of the participants' lived experiences with excerpts from participants' shared experiences to develop exhaustive reports. An example of exhaustive description is presented thereby:

5.1.6- Producing fundamental structure

This phase's essence is focused on removing redundant or misused descriptions (Colaizzi, 1978; Shosha, 2012). Reduction of the findings was carried out at this stage. Hence, misused or distorted descriptions were removed from the overall structure. A basic structure was developed to capture the described phenomena.

5.1.7-Validation of findings

After the analysis, I conducted a follow-up analysis to ascertain the participants' views to ensure the findings represented the experiences shared during the interview and Focus Group Discussions. In other words, I sent the participants a copy of some coded transcripts for cross-checking and confirmation of their lived experiences. I engaged a translator who helped translate findings into the Hausa language since the discussion with the participants was in the Hausa language, a language they understood better. The participants' responses were noted in their local language. Moreover, all the participants agreed that the transcripts' content accurately represented their lived experiences and perspectives shared during the data collection. The participants were happy to get feedback after a long time from the data collection period.

5.2: Description of the Demographic of the Participants

Each participant filled out the Demographic Data Form before the commencement of the interview sessions and Focus Group Discussion. The essence of the form was to capture their bio-data, which may serve as factors that may influence their lived

experiences. The information on the form includes participants' names, gender, level of education, age, religion, family size, and pregnancy status.

Table 6: Demographic of Participants' Characteristics

Demographic	**Reproductive women**	**Health Workers**	**TBAs**	**Male Participants (Husbands)**	**Total**
Gender					
Male	0	1	0	5	**6**
Female	23	1	2	0	**26**
Total	**23**	**2**	**2**	**5**	**32**
Religion:					
Christianity	3	0	0	0	**3**
Islam	20	2	2	5	**29**
Total	**23**	**2**	**2**	**5**	**32**
Education Qualification:					
Primary Education	3	0	0	2	**5**
Secondary Education	3	0	0	0	**3**
Tertiary Education	0	2	0	0	**2**
Islamic Education	10	0	2	3	**15**
No Education	7	0	0	0	**7**
Total	**23**	**2**	**2**	**5**	**32**
Age group:					
15-30 years	8	0	0	0	8
31-45 years	15	2	0	0	17
46-60 years	0	0	1	3	4
61-75 years	0	0	1	2	3
Total	**23**	**2**	**2**	**5**	**32**
Family size:					
Less than 5	1	1	0	0	2
6-10	12	1	0	0	13
11-15	10	0	0	0	10
16-20	0	0	0	2	2
21-25	0	0	0	2	2
26-30	0	0	2	1	3
Total	**23**	**2**	**2**	**5**	**32**
Women Pregnancy Status					
Primigravida	1	**-**	**-**	**-**	**-**
Pregnant	6	**-**	**-**	**-**	**-**
Multigravida	16	**-**	**-**	**-**	**-**
Total	**23**	**-**	**-**	**-**	**-**

Table 6 shows the 32 participants who participated in the data collection in Focus Group Discussions and Interview sessions. From the Table, 6 participants were males, while 26 were females. Hence, most of the participants were females. Of the 6 male

participants, 1 was a skilled health worker, while 5 were husbands of some of the reproductive women who were participants also. Also, of the 26 female participants, 23 were women of reproductive age, 1 was a health worker, and 2 were TBAs. All sampled TBAs and women of reproductive age were females. Also, the information concerning the religious status of the participants shows that 3 were Christians, while 29 were Muslims. Therefore, most of the participants were Muslims, and it was shown that 3 of the women of reproductive age were Christians, while none of the health workers, TBAS, and male participants were Christians. Of the 29 participants who were Muslims, 20 were women, 2 were health workers, 2 were TBAS, and 5 were male participants. It shows that all the participants, except 3 women, were Muslims.

The information concerning the educational qualifications of the participants shows that 5 participants had primary education, 3 participants had secondary education, 2 participants had tertiary education, and 15 participants had informal education, that is, Islamic education. In comparison, 7 participants had no education at all. Thus, most of the participants had Islamic educational qualifications. Of the 5 participants that had primary education, 3 of them were women, while 2 of them were male participants; all the 3 participants that had secondary education were women; all the 2 participants that had tertiary education were health workers; 10 women, 2 TBAs hand 3 male participants had Islamic education the 7 participants that indicated no education at all were women. Hence, only the health workers had tertiary education; the women participants had primary, secondary, and Islamic education and no education. So, none of the female participants had had tertiary education.

Out of the total participants for the study, the information from Table 5.1 above also shows that 8 were in the 15-30 years age group, 17 were in the 31-45 years age group, 4 were in the 46-60 years age group, and 3 were in the 61-75 years age group. Hence, most participants were in the 31-45 age group. Furthermore, the information concerning the women participants shows that 8 of them belonged to the 15-30 years age group while 15 of them belonged to the 31-45 years age group; all the health workers belonged to the 31-45 years age group, 1 TBA belonged to the 46-60 years age, while the other TBA belonged to 61-75 years age group; 3 male participants ed to the 46-60 years age group, while 2 of them belonged to the 61-75 years age group. Hence, most female participants and health workers belong to the 31-45 age group, and most male participants belong to the 46-60 age group.

The description of the family size of the participants shows that 2 of the participants had a family size of less than 5, 13 participants had a family size between 6-10, 10 participants had a family size between 11 and 15, 2 had a family size between 16 and 20, 2 had a family size between 21-25, and 3 had one between 26-30. Hence, the family size of most of the part participants was between 6 and 10. Furthermore, 1 female participant had a family size below 5, 12 participants had between 6 and 10 family members, and 10 female participants had families between 11 and 15. The family sizes of the 2 TBAs were between 26-30; the family sizes of the 2 male participants were between 16-20. Another 2 male participants had their family sizes between 21-25, while the other male participant had his family size between 26-30. Thus, all the TBAS and male participants, followed by the women participants, had large families, unlike the 2 health workers, who had small ones. From the table above, 1 woman participant was a primigravida 6 was pregnant at the time of the data collection, with 4 in their 2nd trimester and two in their first trimester. In contrast, the majority, 16 female participants, were multigravida.

5.3: Overview of the Findings

Colaizzi's method for phenomenological data analysis produced four emergent themes and fifteen (15) clusters. The quotations associated with each piece were presented based on suitability and compatibility with each theme. The essence is to allow participants' voices to be heard correspondingly, equitably, and appropriately. This section aims to report the findings by analysing the transcripts of the FGD and interview sessions. The study's objective was to explore the lived experiences of women of reproductive age on utilising maternal health care in Bauchi State. The essence was to identify factors responsible for the underutilisation of formal healthcare centres in the study population. Colaizzi's analytical technique of phenomenological data was used to analyse the study's data.

The transcripts were read repeatedly to deduce the lived experiences the participants shared. The significant statement, in line with the research objectives, was extracted from multiple times readings of the transcripts. Meanings were formulated from the significant statements and formed into themes. The clustered themes were arranged into emergent themes. A rich and exhaustive description of the participants' lived experiences was based on the study results. The study participants validated the exhaustive description. This section focuses on the themes from the participants'

narratives and what underpinned their experiences concerning utilising maternal health care services. Significant statements were extracted from the FGD and interview transcripts; formulated meanings were extracted from the significant statement, while cluster themes were formed and further categorised into 4 emergent themes. The emergent themes (Fig. 5 below) were described with corresponding excerpts from the participants' transcripts that supported each theme.

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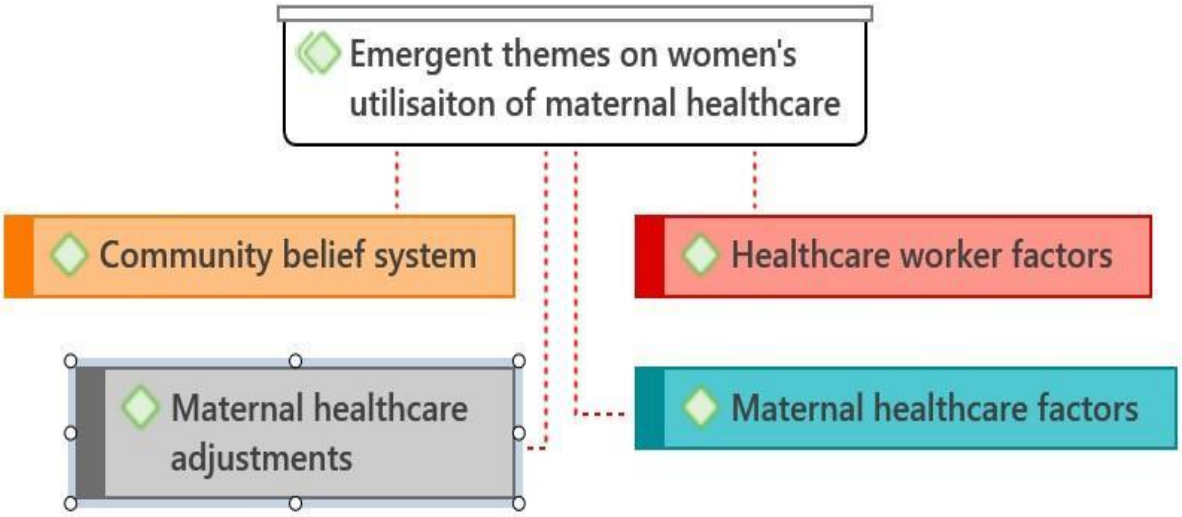

Fig. 5: Networks showing emergent themes for utilisation of maternal health care services

5.4. Communal Belief

The theme refers to the accepted traditions, customs, rituals, and social behaviours that shape the experience of women seeking healthcare in maternal healthcare centres. Seven themes emerged from analysing the women's lived experiences (Figure 6).

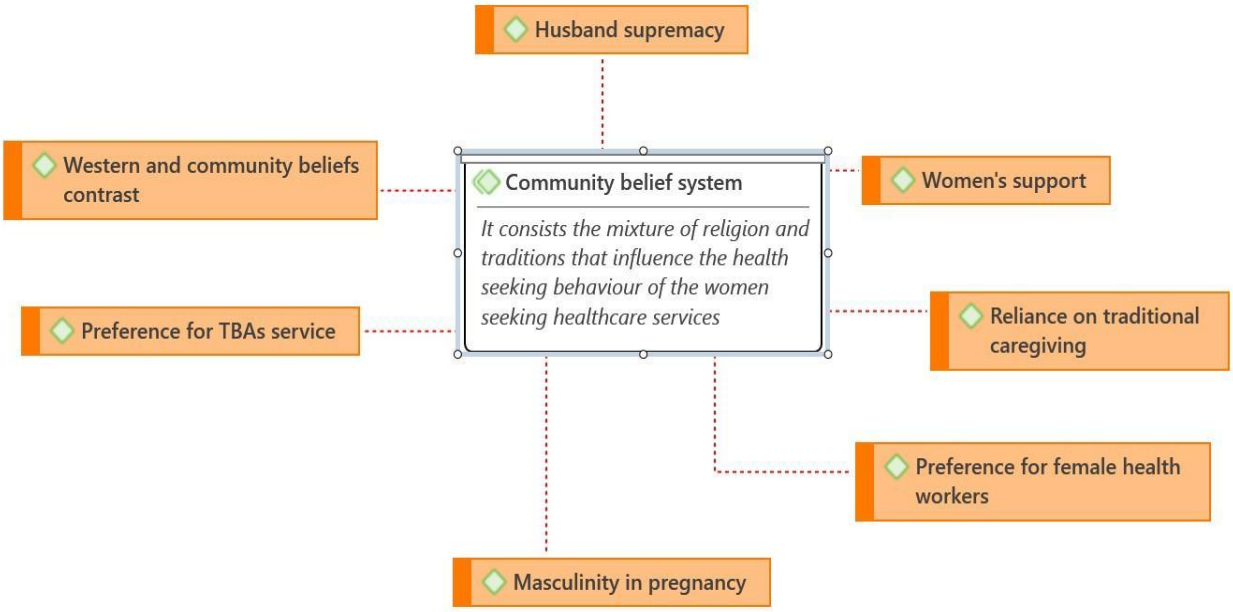

Fig. 6: Thematic network of community belief system

5.4.1: Preference for female health workers

It is noteworthy that societies have different emphases on different subject matter, an attribute that distinguishes the dimensions of value celebrated in one culture from another. This theme pertains to women opting for healthcare workers of the same gender. This inclination is shaped by a belief deeply embedded in a blend of cultural and religious influences. One of the participants described the cultural taboo around women exposing sensitive body parts to males, highlighting the prevalence of male healthcare workers in the maternal healthcare centre and the corresponding discomfort it causes:

> *It is taboo for a woman to open her private part or any sensitive part of her body before any male for any reason whatsoever. Most of the healthcare workers at the health centres are male. Most of the maternal health services require interaction with male personnel and will demand that you open certain sensitive areas of your body for inspection. This is quite strange and totally against the provisions of our shared culture (Participant Efgd1)*

Similarly, another participant emphasised the Islamic and cultural aspects, highlighting the religious prohibition of male health workers examining women without their husbands present. Also, the participant spoke about the challenges women faced when their husbands are not available during ANC:

In terms of my religion and culture (tradition), you see, coming from a Muslim background, a married woman is not supposed to be seen by a male health worker who is not her husband. It is forbidden Islamically to see sensitive parts of a woman who is not your wife. If a male health worker must see a woman's sensitive parts because of ANC and generally, that woman's husband must be present, and you see, most of our husbands do not avail themselves during ANC (Participant Zfgd2)

In addition, the participant highlighted a cultural perspective on pregnancy, delivery, and postnatal care, that these aspects of reproductive health are traditionally viewed as the domain of older women within the family, which is a subtle means of preventing the women from utilising the healthcare services:

Culturally, it is believed that pregnancy, delivery, and postnatal care are meant for older women in the family to handle. Therefore, these men tend to prohibit us from attending ANC (Participant Zfgd2)

A participant shared a complex set of dynamics and coping mechanisms that women employ when faced with instances of mistreatment or abuse within the healthcare system. She spoke about the experiences of women who, when faced with significant incidents of mistreatment or abuse by male healthcare professionals, choose to keep such occurrences hidden from their husbands:

When something of this magnitude happens, we often keep it from our husbands to stay married and for our self-worth (dignity) in the community. There are instances I have discussed with my fellow women what I had gone through at the hands of these so-called male nurses and doctors (Participant Afgd2)

To corroborate the statements earlier made by the participants, another woman shared a personal experience of harassment by a male health worker during ANC, underscoring the cultural and religious taboos against such examinations. She expressed the dilemma of modest dressing and adherence to norms not preventing mistreatment:

During one of my visits to the hospital for ANC, the male health worker made advances on me during an examination. He said, "I am beautiful. And that of all

the women he examined, he has not come across such beauty". I felt embarrassed and wondered if it was my dressing, but it was not. I dressed modestly and covered myself with a veil (Gelle) as a complete Muslim woman. Culturally and religious-wise, it is taboo for women to be examined by male health workers (Participant Ffgd2).

A participant shared experiences of advances and inappropriate touching by a male health staff during the examination, expressing frustration at the lack of consequences for such actions of the male health worker by the hospital management:

A male health staff made advances on me. He was touching sensitive parts he was not supposed to touch during the examination. I know this because it was not my first pregnancy. What connection is there between my breast and pregnancy? Some of these male health professionals take advantage of every slightest opportunity they get, and the most annoying part is that they get away with it (Interview Participant 7)

A traumatic incident involving sexual assault during a hospital visit, leading to significant personal and societal consequences, was narrated by a participant. She illustrated her experience during her first pregnancy, particularly her encounter during an antenatal care (ANC):

I conceived with my first pregnancy. My husband encouraged me to go to the hospital for ANC registration, which I did. I started my ANC in my fourth month because I was shy about the pregnancy. I got to the hospital on the day of my appointment. I gave my urine for a test, and all my vital signs were checked, and everything seemed perfect… The doctor asked me to undress and lay down, and I took off my wrapper and underpants. He gave me a piece of clothing to cover my waist to my knees… He then pulled off the piece of clothing and poured a liquid below my abdomen to carry out a scan (FGD 2, Participant 4)

The participant shared the concluding part of the profoundly distressing and abusive experience during the medical examination: an account of a grave violation of trust, ethical standards, and the patient's rights:

He said that he wanted to see how my child was doing. After the scan, he said he would have to examine my vagina. I did not object because I had no idea how the examination was done. However, I believed it was part of it. He inserted his finger in my vagina. I just lay there on my back, staring at the ceiling. He kept saying "yauwa, yauwa" (meaning oh yes, yes) with his finger in my vagina. So, I assumed that my baby was growing fine. Before I realised it, his penis was inside my vagina. I started screaming; he immediately used the clothing he gave me to cover myself and closed my mouth with it so that I would not yell. I don't want to talk about this painful experience (FGD 2, Participant 4)

The participant spoke about the distressing aftermath of the abusive incident and its impact on her. She expressed reluctance to blame men who prevent their wives from seeking healthcare due to the widespread mistreatment by male health workers. She strongly opposed using maternal health services due to fear of losing marriage, dignity, and reputation:

My husband did not pursue the case to maintain his reputation; he said it happened with my consent. He divorced me afterward because my presence disgusted him. The shame did not allow me to stay in that community after the birth of my child. I don't blame those men who refuse their wives' permission to go to the hospital. However, many women are molested by male health workers in one way or another but dare not say for fear of losing their marriage, dignity, and reputation. For example, I could not explain what I experienced due to the utilisation of MHSs during the group discussion because of shame and how these women would look at me. Therefore, I am strongly against using these services or going to the hospital for medical assistance.

Similarly, another participant described personal consequences, including divorce, due to the cultural and societal implications of mistreatment. She mentioned the significant impact on individuals, leading to community disapproval and relocation:

I am a victim of such that led to my husband divorcing me. I could not bear the shame that I had to leave that community and remarried in another community (Participant Zfgd2)

On the other hand, a participant described the internal struggle faced when asked to open certain body parts during hospital visits. She posited the gradual acceptance over time, even with male nurses inspecting her without complaints:

> *Sometimes, you are asked to open certain parts of your body for inspection, sometimes at the hospital. This was the most challenging battle I struggled to overcome. I remember the first time I was asked to open my cervix for inspection during delivery. I refused because that was insane; I wondered about opening my cervix to someone I had never met. Gradually, I overcame that. Today, even male nurses inspect me without complaining (Interview Participant 6)*

The findings showed that cultural and religious factors deeply influence women's preference for female health workers. Instances of mistreatment, harassment and assault, traumatic incidents and systemic failures, violations of trust and patient's rights, and personal and societal consequences of sexual harassment underscore the reason for opposition to maternal health services.

5.4.2: Husband Supremacy

Husbands occupy a significant role in every family. Husband supremacy is the belief that husbands are placed in authority or dominance within a marriage or family structure. The theme implies a hierarchical relationship where the husband is considered superior and holds more power than the wife. One of the participants talked about their deeply ingrained cultural norms and expectations regarding married women's autonomy, particularly concerning seeking permission before leaving their homes. The participant's statement reveals a cultural framework where women are expected to seek approval from their husbands before leaving homes, with potentially significant consequences for non-compliance:

> *No reasonable woman would leave her house without her husband's consent if she is married or any elderly male relation from her family or her husband's family. Any attempt to do so without proper permission would spell disaster for her marriage or her relationship with her siblings. Therefore, seeking approval in our community is necessary (Participant Zfgd1)*

In addition, the participant narrated a multifaceted scenario where cultural, religious, and gendered norms intersect, posing significant challenges to women's autonomy

and healthcare access, a response that highlights the importance of addressing deeply ingrained sociocultural factors to promote gender equity and improve women's health outcomes in the community:

> *In my case, women do not go out without the permission of their husbands; husbands, on the other hand, hate to see their wives go out of their houses because of the religious beliefs which prevent women from going out. This is a serious hindrance to accessing the healthcare service because when the woman insists on accessing it, she will be labelled a flirt who wants to start going out with men other than her husband.*

A participant shared a personal experience that provided insight into multifaceted challenges faced by women due to restrictions on their mobility, rooted in cultural and religious norms. The participant was of the view that these barriers extend beyond physical access to healthcare, encompassing social perceptions and potential stigmatisation for women who assert their autonomy in seeking essential services:

> *I take permission before I go anywhere. I came back from the farm when I was pregnant with my younger child. I did not know what had happened, and there was a sharp pain. Then, I was bleeding and lost the pregnancy because I could not go to the hospital. This happened because my husband was not at home (Participant Ffgd2)*

Similarly, another participant shed light on the profound consequences of restrictions on women's mobility, emphasising the direct link between such limitations and adverse health outcomes. The participant delved into the intricate web of factors that sustain these restrictions, highlighting the need for comprehensive efforts to address socio-cultural norms, economic disparities, and beliefs to improve health equity and outcomes:

> *Some women cannot go out without the immediate consent of their husbands, and it has led to the death of many children and some mothers. Some fathers will not approve because they believe in tradition or lack of money or because of fear that their poverty will be exposed, and when a patient dies, they will say it was the person's time to die no matter what they would have done, it would not have been enough to save their life. This belief has led many people to their*

early graves, though the practice has started changing recently (Interview Participant 4)

A participant's statement provided insight into the influence of husband's supremacy in alignment with traditional beliefs on healthcare decisions, particularly related to maternal health. The participant's narrative unveils the complex interplay between traditional values, financial constraints, and individual agency in healthcare decisions. The participant's silent coping strategy underscores how some women navigate traditional norms to address their maternal health needs, shedding light on the multifaceted challenges in achieving reproductive healthcare equity:

Hmm! My husband is someone who holds the tradition in high esteem. He sees other practices like maternal health services or going to the hospital for any help as an aligned culture. For this reason, I decided not to tell him. Of the pregnancies, I delivered at home with the help of the TBA to avoid problems with my husband. I had no financial support from my husband for drugs, scans, and other services, so I had to sell my wrappers and jewellery to afford these services (Interview Participant 5)

The findings from this theme depict a cultural context where women's mobility and access to healthcare are heavily regulated by husband supremacy rooted in traditional norms, impacting their health outcomes and perpetuating gender inequalities. The reluctance to challenge these norms suggests a complex interplay of cultural, economic, and social factors that shape women's experiences in the community.

5.4.3: Masculinity in Pregnancy

The term '*masculinity'* refers to the quality of women having and using their natural strength to deliver their baby without visiting any maternal health care for delivery. In Africa, especially in Northern Nigeria, pregnancy is a pride for married women and a desire of young women looking forward to a blissful marital state. It is the joy of every pregnant woman and their loved ones to give birth safely. So, many reasons are attributed to patients' high reliance on traditional healthcare systems. The cultural system seemed to prioritise women delivering their babies at home, not having any reason to visit formal maternal health care centres. Pregnant women who held this cultural view and were ready to imbibe the culture were not expected to visit maternal

healthcare for assistance. The belief system promoted pregnant women giving birth at home, not using either formal or traditional healthcare for delivery.

A participant outlined a cultural perspective regarding childbirth within their clan. The participant highlighted the intersection of cultural beliefs, social stigma, and individual decision-making regarding maternal health practices within the specific cultural context of her clan:

> *It is common in our clan that every woman is strong enough to give birth without assistance. Any effort to seek help will mean weakness on the woman's side, making other community members look down on her. For that reason, every woman tries to keep her faith and stay away from going to the healthcare centre (Participant Sfgd2)*

A pregnant woman interviewed emphasised her belief that there is no need for formal maternal healthcare services. She attributed the reason to her faith in God and the use of solutions nature has provided to help her a successful pregnancy period:

> *'In fact, women believe that God has blessed every woman with all the needed strength and some natural solutions (mainly in the form of herbs) to keep their pregnancy without the need for any artificial support from any healthcare facility* (Interview Participant 10)

Another participant expressed her view on the sufficiency of women's strength to endure various experiences during pregnancy. The participant mentioned some available natural herbs and the recommended pattern of using the herbs for an effective outcome. According to the participant, these natural herbs support community resources to ensure pregnant women give birth without attending formal maternal care for child delivery. According to the participant:

> *'We believe that every woman on earth is blessed with sufficient strength to endure everything that comes with pregnancy, and we are also blessed with natural herbs to serve as a medicine when we utilise them well. We have herb experts in this community who are skilled and have the needed experience in utilising these herbs. We use those people as a guide on how to make the most of the abundant natural herbs we are endowed with'* (Interview Participant 9)

Following the other participants' responses, a participant spoke regarding a set of cultural beliefs within certain families regarding women's health and seeking healthcare support. The participant illustrated a cultural framework that placed a strong emphasis on self-sufficiency, divine endowment, and a stigma against women seeking external healthcare support:

> *Other families believe it is a sheer weakness or lack of bravery for a woman to take herself to any healthcare centre for any health support. They believe God has equipped every woman with every resource and strength she needs to keep herself and her baby from conception to delivery. Therefore, women from such families do not go to the healthcare centre for any help (Participant Rfgd1)*

A participant explained the reason for the common practice of self and home delivery among pregnant women in the community. The participant provided a glimpse into a society where cultural and traditional methods play a significant role in shaping the experiences of pregnant women, the nature of some traditional practices, and the continuity of these practices throughout the pregnancy stage:

> *People like me and most other women about twenty years of age and above will have two experiences. First, the tradition provides that once a woman is two months pregnant, she has to start observing specific rules and taking some concoctions to help her and the child she is carrying. I can sometimes remember the TBAs would push some powdered leaves through a woman's cervix, believing that it would help her during delivery. The practice continues up to delivery. Those women who believe so much in the tradition still use this type of service (Interview Participant 4)*

The findings showed the community's cultural perspectives strongly influenced women's maternal health practices, promoting self-sufficiency and reliance on traditional methods, beliefs in divine endowment, and the use of natural resources contribute to a community-wide preference for home-based, traditional practices during pregnancy and childbirth, and the stigma associated with seeking external healthcare support.

5.4.4: Reliance on Traditional Healthcare

Traditional healthcare is an informal healthcare system where unskilled health workers provide healthcare services for some members of the community who find such services worthwhile. Reliance on traditional healthcare" refers to seeking and relying on healthcare methods, treatments, and practices rooted in cultural traditions, indigenous knowledge, and historical practices. A participant expressed a strong belief in a traditional caregiving system, attributing it to a divine endowment from God Almighty. She adjudged the system, passed down by parents, reliable and effective with a commitment to upholding the tradition:

> *Many believe that God Almighty has endowed us with a good and reliable traditional caregiving system to help us manage our illnesses. Since this caregiving system has not failed us in any way, and it is something that was passed on to us by our parents, we feel it would not be fair to play with the age-long tradition, but we would continue to uphold this in our time (Interview Participant 9)*

A participant mentioned the belief in sufficient traditional medication within some clans for known illnesses. Members of the clan prioritise traditional medicine over modern healthcare, showcasing a strong attachment to inherited healing practices.

> *Some clans believe they have developed sufficient traditional medication for all the known illnesses within the clan. No members of the clan will neglect their inherited means of medicine to access modern medication by going to the healthcare centre. In some tribes, pregnant women do not go out because people will see the pregnancy and know that they were somehow involved in sexual intercourse. For this reason, a pregnant woman will remain indoors throughout her pregnancy days up to delivery. It, therefore, means they cannot go out to access healthcare services (Interview Participant 10)*

A participant highlighted the community's belief in the power of prayers, especially before seeking medical help. She said the idea is that God's intervention, rather than the actual medicine, leads to healing; scepticism about the blessings of modern medicine, with the belief that it may lead to abrupt deaths:

> *We also believe in prayers. Although traditionally, our people pray before issuing medical help, we don't find this in modern medical practices, which is*

why our parents don't use these modern medical services. They say, 'There are no blessings in modern medicine. That is why people die abruptly.' it is believed that when our elders pray over any medicine to be taken, God sees what the needs are. He cures the ailment, not because of the actual drug that the patient takes, but because God has intervened (Interview Participant 3)

Also, the participant mentioned that some illnesses are connected with wrongdoings and that healing is believed to require seeking forgiveness or making peace with the gods of ancestors, a belief that influenced a shift from healthcare centres to traditional caregivers when sickness persists:

We also believe that some illnesses are connected with our wrongdoings. So, before you can be healed of any ailment, you have to seek forgiveness or make peace with the gods of your ancestors; otherwise, whatever you do, whatever medicine you take, will not heal you. So that is why when sickness persists, the village elders would call the patient's relatives and ask them to withdraw the treatment from healthcare centres to traditional caregivers where the gods and the ancestors would be appeased.

A participant noted the limited patronage of community healthcare services by most of the women due to reasons connected to their cultural way of living, a signal that cultural norms significantly impact healthcare-seeking behaviour: “Most of the women in this community do not utilise these healthcare services; this is attributed to numerous reasons, most of which are connected to the cultural way of living.” Similarly, a participant mentioned cultural factors as chief hindrances to healthcare utilisation. The participant emphasised the need for education to address these cultural barriers and enhance awareness about healthcare services: *“I feel most of the hindrances to utilising the healthcare services are culture-related; as such, there is a need for education about the subject matter for everyone that is affected in one way or the other” (Interview Participant 10).*

The findings showed a community deeply rooted in traditional beliefs and practices, where cultural norms, religious beliefs, and a reliance on traditional healing methods significantly influence healthcare decisions and utilisation. The inadequate or lack of utilisation of maternal healthcare services was traceable to community members' dependence on traditional caregiving, which they considered a better alternative to

modern healthcare services. Hence, the availability of orthodox health care affected patients' decisions and attitudes toward patronising the formal health care systems. The participants emphasised a complete reliance on traditional caregiving due to a high level of trust.

5.4.5: Preference for TBAs Service

Traditional Birth Attendants' support implies the healthcare services rendered by the Traditional Birth Attendants (TBAs) in their community. TBAs were considered assets to their communities, and their services were deemed worth patronising because of the track records of their effectiveness. They were regarded not just as traditional healthcare service providers but also as spiritual people who knew how to switch to the spiritual dimension in cases of complications that physical means could not handle.

A participant ‘s statement touches upon the preference for Traditional Birth Attendants (TBAs), particularly women, and the interesting choice made by some men or husbands in favour of having their wives attended by these TBAs, even in the presence of complications that require urgent medical attention. Also, the participant underscored the preference for TBAs over health professionals, involving considerations of accessibility, community integration, affordability, and perceptions of cultural respect. According to the participant:

> *Most of the TBAs are women, and some of the men/husbands prefer their wives to be attended to by them even if there are complications that need urgent medical attention. Most families opt for the use of TBAs because they are easily accessible. They can be reached at all times without travelling long distances. The TBAs live within the community, know the culture and traditions of the community, and respect them. They are affordable. Sometimes, the services are free of charge. The negative attitudes of the health professionals also contribute to why some women prefer the TBAs (Interview Participant 5)*

A participant mentioned an early marriage, pregnancy, and complications after giving birth with the assistance of a TBA. She narrated the consequences of early marriage, including health risks and complications during childbirth:

> *I was married at 15 to a far older man than me. Our culture and tradition say that once a woman reaches puberty, she is to marry before she gets impregnated out of wedlock. I was naive and did not know what marriage or*

pregnancy was. It was 12 weeks before I realised that I was pregnant, even when I was constantly told that I was pregnant. I gave birth at home with the help of a TBA but had complications after delivery (Participant Afgd2)

The participant shared a distressing experience of constant urination, smelling, and social isolation, and the stigma and challenges faced by young mothers ultimately resolved by a TBA using herbal remedies:

I found out that I was constantly urinating uncontrollably and smelling. I did not know what it was, but my husband and co-wives were running away. No one wanted to come close to me and kept calling me names. As a child, I became frustrated and depressed that I wanted to take my own life. People kept saying that it was a curse from the gods for wrongdoing. I believed all that was said because I believe in culture and tradition. It was the TBA that cured me of the problem. She boiled the bark of a tree with some roots and asked me to sit in it for 15-20 minutes.

Another woman narrated experiences of miscarriages, seeking help from a spiritualist, and later hospitalisation for spotting during pregnancy; her experience of a mix of traditional and modern healthcare approaches, seeking help from a spiritualist and subsequent visit to the hospital:

In my case, I experienced miscarriages. The 1st miscarriage was at age 15 years, the same year I got married. I was three weeks pregnant. The second miscarriage was a few months after the first, but the second was 6weeks. My mother was worried about it and took me to see a spiritualist who prepared some concoctions and told me how to take them. Finally, at age 16 years, I took in again, but this time around, the pregnancy stayed. I was spotting during the 3rd pregnancy. I told my mother; she discussed it with my husband to allow her for a couple of weeks until the bleeding stopped. He agreed, so my mother took me to the hospital, where I was given bed rest for a month and was discharged with strict instructions to rest. (Participant Zfgd2)

A participant who gave birth at home with TBAs acknowledged their imperfections but expressed satisfaction with their services. She attributed illnesses to ancestral spirits attempting to inhabit the child's body, leading to diseases when resisted.

In my case, I gave birth to most of my children at home using the TBAs. I have never had a problem with the TBAs. Though they are not imperfect, they have their lapses, which could sometimes be fatal in managing maternal and child health. The terrifying issue is that everybody believes that these illnesses are associated with some ancestral spirit trying to inhabit the child's body. When the body resists them, that is what leads to such diseases (Interview Participant 3)

Supporting the statements made by other participants, a participant acknowledged TBA's use of chants with a lack of scientific basis. She noted that some women fully embrace tradition, hindering their willingness to seek modern healthcare, a signpost of a deep commitment to traditional practices, possibly rooted in cultural beliefs and familiarity:

Most of the time, the TBAs do some chants to help the pregnant woman. However, it is a practice with no scientific bearing and will not be approved medically. Those women who enjoy the services will never go to the modern healthcare centre for any help because they seem to give their whole self to the tradition too much that they cannot find any fault with the traditional practice (Interview Participant 4)

The findings show a complex interplay between cultural beliefs, traditional practices, and the challenges faced by women in seeking maternal and child healthcare. Factors beyond medical considerations influence the preference for TBAs, emphasising the need for a comprehensive understanding of cultural contexts in healthcare interventions.

5.4.6: Women's support

The pregnant women's lack of financial capability was found to be a limiting factor in utilising maternal healthcare since the service was not without cost. A participant highlighted financial constraints, coupled with a lack of support from husbands' fear of embarrassment due to an inability to pay for healthcare services as factors that deter women from accessing healthcare services:

Most of us women are poor, and we don't enjoy financial support from our husbands. This deters us from patronising the services provided by the healthcare centres around us. You know the services are not free, and if you

go there without money, you can be embarrassed' (Interview Participant 9, TBA)

Also, the financial barrier faced by pregnant women, with husbands' lack of financial support, was adjudged a critical factor, while the inability to afford transportation and services underscores the multifaceted challenges:

> *In other cases, the husbands do not give their pregnant women any money to pay for the services they will get at the healthcare centres, and the women are too poor to afford the transportation and the services at the healthcare centres* (Interview Participant 9, TBA)

Similarly, a participant highlighted the role of husbands in actively discouraging women from seeking healthcare by withholding financial support, a factor that significantly influences women's healthcare-seeking decisions:

> *The other issue is that we do not have the support of our husbands when we want to go to healthcare centres. The husbands discourage us by refusing to give us transport money and some extra funds to help cater to the other medical bills we may incur at the healthcare centres (Participant Rfgd1)*

A participant provided a broader perspective on the challenges, linking poverty, lack of economic opportunities, and spousal support issues to healthcare access. At the same time, dissatisfaction with the quality of treatment adds another layer to the barriers.

> *The other problem we face is problems related to poverty. Women do not go out to do any business; hence, they are poor; the husbands do not give their wives money to go to the hospital, located some distance from this community. This lack of support hinders pregnant women from accessing these healthcare facilities* (Participant Rfgd1)

A lack of autonomy for women without formal employment, relying on husbands' permission for healthcare decisions, was underscored by a participant:

> *I have realised that those of us who do not have white-collar jobs or any business tend to do everything our husbands tell us. We take permission before going for ANC. We take permission before visiting our friends and relatives or*

attending any festivity (for example, marriage or naming ceremony) [Participant Kfgd2]

A participant pointed out the disparity in decision-making power based on employment status, emphasising financial autonomy as a key factor influencing women's access to healthcare:

At the same time, working-class women have the right to go out without proper permission. They have the upper hand in utilising maternal health services because they do not have to wait for their husbands to give them the money to go to the hospital or buy drugs or money for a scan. Sometimes, they even have the money to visit the private hospitals. The services in private hospitals are costly; only those who are financially buoyant go there for ANC and delivery (Participant Kfgd2)

A participant provided a contrasting scenario where spousal support positively impacts healthcare-seeking behaviour, indicating that not all women face the same challenges, and an indication of positive experiences on health-seeking behaviour: *"My husband always supports other family members and me in healthcare because we have tested it over the years and found it worth the effort" (Interview Participant 6).* The findings show a range of challenges faced by women in accessing healthcare services, with financial constraints and lack of spousal support being prominent barriers. Additionally, power dynamics within households and variations in experiences further contribute to the situation's complexity.

5.4.7: Western and communal beliefs contrast

The theme shows the dichotomy and the conflicts between Western and traditional healthcare services. It shows the reasons many women did not utilise maternal healthcare services. Some participants (Interview Participant 3 and Participant Efgd1) believed that modern healthcare services contrast their traditional values and beliefs. A participant provided insights into a specific clan's perspective, describing it as an abomination to consider health services rendered by outsiders. She emphasised a solid adherence to local traditional medical caregivers, and violating this tradition may lead to severe consequences, including spiritual attacks:

In my clan, it is an abomination to consider other health services rendered by outsiders to the detriment of our local traditional medical caregivers. This will

be seen as a great crime against the existence of our people, and the consequences can be severe; sometimes, it can even lead to death. In most cases, if the spiritual leaders identify you, they can attack and kill you spiritually for breaking the tradition (Afgd1)

Another participant highlighted a cultural practice within their clan where pregnant women are not allowed to go out. She explained the rationale behind this restriction to societal judgments, associating pregnancy with sexual intercourse. Going out during pregnancy is seen as shameful, and the community members may stigmatise the woman:

Pregnant women in our clan do not go out. The reason is that pregnant women who go out are considered shameless women because pregnancy is associated with sexual intercourse. Therefore, seeing the woman with her pregnancy outside will make the community members see her as used to prostitution and can go out even if everybody knows that she has had sexual intercourse with her husband. For that reason, once a woman is pregnant, she does not go out until after delivery (Participant Rfgd1)

A participant highlighted various cultural practices that impact healthcare access, such as certain clans not taking children to hospitals due to a belief in strange diseases being found there."

Other clans within the community don't take their children to the hospital for any reason. They believe that strange diseases are found at the hospital. Therefore, they prefer managing all their illnesses within the community to avoid introducing strange conditions to their community (Participant Efgd1)

A participant emphasised reliance on spiritual consultations for problem-solving, consulting the spirits ahead of any action, and avoiding visits to the hospital:

In our family, for instance, we believe everything is spiritual whenever there is a problem of whatever type, and at whatever level, the spirits are consulted ahead of any action. The spirits decide what to do and when to do it to get the problem solved. We do not go to the hospital (Participant Nfgd1)

Some Participants expressed a belief that death and sickness are inevitable, regardless of modern medical services, a belief that might contribute to scepticism about the effectiveness of healthcare practices:

> *Some of us in this community believe so much that death and sicknesses are inevitable. There is no modern medical service or facility that one can use to either prevent you from dying or delay your death for some time. The belief is that whatever you do, local or international, cannot prevent someone from contracting any disease or stop anyone from dying.*

A participant provided insights into a specific cultural practice where there is a clash between modern medical practices and traditional cultural beliefs regarding pregnancy:

> *Modern medical practice desires that a woman be visiting maternal healthcare facilities from the first few months of pregnancy. The practice is totally against our culture. When a woman is pregnant, she is to remain indoors for the entire pregnancy. Anyone who sees her in the community will call her names, defiling the sacred order that forbids the woman from going out during pregnancy (Interview Participant 4)*

A participant highlighted specific traditional rituals, such as blessing a newborn before cutting the umbilical cord, which is not found in modern medical practice, an absence that leads to resistance from community members, especially husbands:

> *One of these values is when a woman gives birth to a new baby before the umbilical cord is cut, the father and the fetish priest bless the baby and read some incantations before the cord is cut off. Unfortunately, this is not found in modern medical practice. Because this is missing, our husbands feel any child who misses this opportunity has missed their legitimate right in the family and cannot inherit or be chosen to represent the community. For this reason, our husbands don't want us to utilise maternal healthcare facilities (Interview Participant 7)*

The participant discussed some dangerous consequences, such as killing a twin to prevent disaster, and suggested that bringing a twin from the hospital to the community

could result in harm to the mother. She underscored a perceived safety in utilising the traditional system of health caregiving despite its potentially harmful practices:

> *In our culture, when a woman gives birth to twins, one is immediately killed to allow the other to grow. Suppose the two children are allowed to live for up to six hours. In that case, this would spell disaster on the land, and plaques would come on the community until every community member offered big sacrifices to our ancestors and the gods of the land before the plaque would stop. I know the modern medical system would not do that or encourage anybody to do that. If a woman brings a twin from the hospital to this community, honestly, the woman will be killed either physically or spiritually. Can you see how tricky this is, especially for us women? We from this village are exposed to many dangers from using modern health facilities. We feel safer utilising the traditional system of health caregiving (Interview Participant 7)*

The result showed that the community's healthcare practices are deeply rooted in cultural traditions, strongly emphasising local and traditional approaches. Spiritual beliefs, societal judgments, and a sense of cultural identity influence the reluctance to embrace modern medical practices.

5.7: Maternal healthcare factors

The theme refers to various elements and characteristics associated with healthcare centres or facilities like effectiveness, quality of service, accessibility, and overall impact on women’s health-seeking behaviour. These factors encompass many components, including infrastructure, staffing, resources, management, and the ability to provide comprehensive and timely healthcare services. Four themes emerged under this theme (Fig. 7).

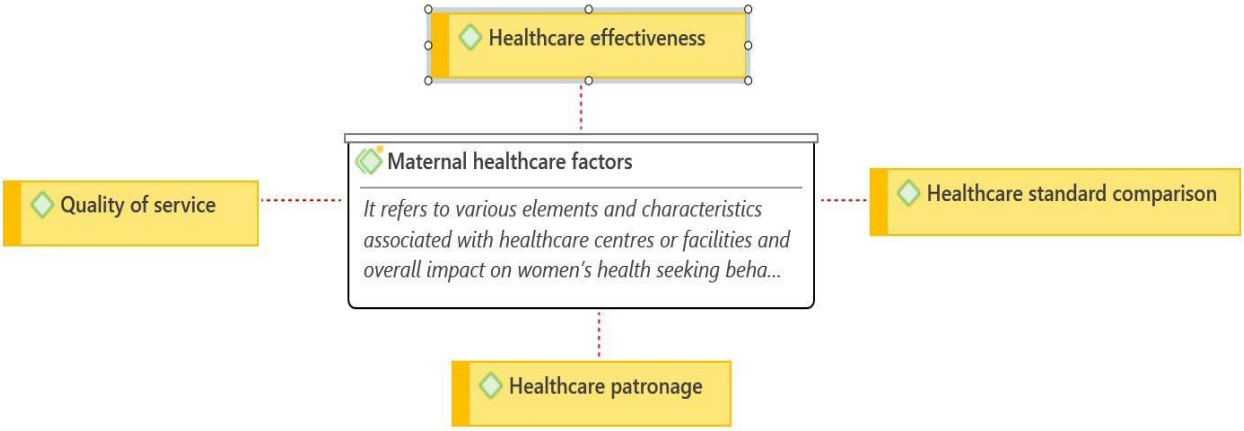

Fig. 7: Thematic networks showing maternal healthcare factors

5.7.1: Quality of service

The theme refers to how well the service provided by the healthcare workers met the needs of the women patronising the healthcare centres. A participant described the maternal healthcare services as inadequate and not easily accessible, attributing this to traditional practices, cultural values, or religious beliefs:

> *Let me speak the minds of those born, raised, and married here or around this community. The services here are bad and inaccessible to most of us in this community. We do not access the facilities because of certain traditional practices, cultural or religious values (Participant Sfgd1)*

A participant shared negative experiences with maternal healthcare services, expressing dissatisfaction and attributing it to bad encounters:

> *Hmmm! Your question is funny. Most of us here have had bad experiences at some point in our lives, so why would we want to use these services? The bad encounter I had in one of my pregnancies made me never return to use these services with my subsequent pregnancies, which I believe most of us would agree with (Participant Mfgd2)*

Similarly, a participant expressed a subjective view based on personal experience, stating that maternal health services in their area are not good, though acknowledging potential variations. *"Based on my experience, the MH Services in my area are not good, but they may be good for some women seated here" (Participant Afgd2).*

A personal journey from an optimistic view of healthcare services to a negative realisation based on a bad experience was relayed by a participant. *“Hamm! I would say the services are not helpful. At first, I thought it was, but my bad experience made me realise that the services are not helpful “(FGD2, Participant 1).* Another participant highlighted a critical viewpoint on the local healthcare services, emphasising concerns about the limited access to severe medical help, doubts about the healthcare centre’s purpose, and a perception of political influence on healthcare decisions:

> *If you need severe medical help, you must rush to the cities. Otherwise, you will die without any serious care here. So, I think this centre is only there to satisfy specific political points. But not to meet our health needs. This is my opinion, and I also think many of us in this community share the same idea (Interview Participant 3)*

The participant added a perspective on the perceived absence of maternal health services in the community, shedding light on the community's attitudes towards modern medical management in maternal healthcare:

> *We should say there are no maternal health services in this community. This is why people don't pay much attention to modern medical management for maternal health care compared to traditional services we used before the government introduced modern medical services to us.*

A vivid picture of the challenges faced by a participant in accessing maternal health services, including financial constraints, practical difficulties related to distance, and the impact of these challenges on healthcare attendance, was underscored:

> *I have to spend a lot of money to go where I can access health services, a situation I am not comfortable with. Sometimes, I would skip an appointment because I have no money to travel distances for maternal health services. I could not ask my husband because he was not aware of me visiting the healthcare (Interview Participant 5)*

Likewise, a participant illustrated the impact of the absence of local healthcare infrastructure in the community, leading to a reliance on a distant healthcare centre and, subsequently, a return to traditional practices, factors that have influenced healthcare access and choices within the community.

We don't have any healthcare centre in this village. The one we utilise is situated in Bizallo, a village some distance from us. This has affected the medical services so much that many of us have given up on the system and switched back to what our parents left for us (Interview Participant 7)

A complex narrative of healthcare evolution within the community, marked by an initial positive shift towards modern medicine, followed by challenges and dissatisfaction with the current state of healthcare services, was shared by a participant. She mentioned the financial burden associated with accessing modern facilities in another location as a significant concern expressed in the statement:

The services are scanty, no longer available the way they were when they started. You know most of us were using traditional medicine before the introduction of modern medicine. After some time, most of us became convinced that modern medicine is good. We abandoned the traditional medical system for the modern system and then became regular users of the health facilities. Now that we are obsessed with the system, everything then falls apart to our disadvantage. We had to spend a lot of money to go to where we could access the facilities, a situation we didn't want (Interview Participant 4).

On the other hand, the participant appreciated the presence of the healthcare service centre with a strong call for improvement, coupled with a sense of disappointment in the perceived neglect by the government and an assessment of the centre falling short of its original objectives.

We thank God it is okay. At least we are better than many others who don't have anything like this. However, we cry for improvement because the health centre seems to have been forgotten by the government. So far, the aim of establishing the centre has been defeated as far as I can assess (Interview Participant 4).

The findings showed inadequacy and accessibility issues of maternal healthcare, women's negative experiences and dissatisfaction with the centre, expression of critical viewpoints on local healthcare, challenges in accessing healthcare, initial positive shifts towards modern medicine and a subsequent return to traditional practices, and a call for improvement of the maternal healthcare.

5.7.2: Healthcare Effectiveness

The theme refers to how the community healthcare centre meets its intended goals and objectives in promoting health and delivering medical care to women needing such care. A participant provided a historical perspective on the healthcare services, expressing satisfaction with the initial services when the health centre was introduced. She highlighted positive aspects such as good health personnel and sufficient drugs. However, she noted a decline in service quality over time:

> *I am quite familiar with the services because we have experience. We are the end-users, and I have accessed the services, especially when introduced in the community. Then everything was working; the health personnel were good, and the drugs were enough for us. After some time, the workers took the drugs to some medical stores and sold them off to owners of pharmaceutical stores. All these things were happening while we were here in this community. We don't know why, and we don't know who to complain to (Interview Participant 3)*

Participant 4 reflected on the past effectiveness of the health centre, stating that it was performing well when first established. However, she observed a decline in its current state, criticised the limited range of services, and referred to a significant reduction in the scope and quality of services over time:

> *The centre was doing very well when it was newly established, but today, we see an image of its past. It only manages pain by giving some pain relievers, and some few lucky days, you can find drugs for the treatment of malaria, typhoid, ulcers, some few other infections, and drugs for antenatal care (Interview Participant 4)*

Participant 6 contrasted her experience with traditional birth attendants before the health centre's establishment with the initial positive phase of the health centre. She acknowledged the early effectiveness of maternal services at the health centre but noted a subsequent decline in performance, reaching a point where she opted for the nearest location:

> *I had used the traditional birth attendants from the early days of my marriage to when this health centre was established in this community. Since I have been using the centre for my medical needs, the maternal services were very good at the inception of the health centre. Later, its performance began to depreciate*

to such an extent that we had to go to the nearest city centre for maternal services (Interview Participant 6)

Also, another participant described a timeline of effectiveness concerning the health centre: a positive phase when the services were good, but they later deteriorated. She said the services were worse, indicating a continuous decline, available for some particular class of people:

I had used it well before things went wrong. There was a time when the services were good, but later, they turned bad; now, it is worse. The users tell us everything about the modern medical system. Today, the services are for the rich and the educated who can travel long distances and speak English (Interview Participant 7)

The findings showed a narrative of diminishing effectiveness and satisfaction over time. Participants expressed concerns about the limited service and a shift toward serving a more privileged demographic.

5.7.3: Healthcare Patronage

The theme describes a significant factor that motivated the community women to utilise the Western healthcare centre service. A participant highlighted that healthcare centres are better suited for less severe cases and may not be the first choice for serious illnesses. The participant shared a personal history of utilising the healthcare services more often in the past but less frequently afterwards, especially for minor illnesses:

These centres are only good for treating uncomplicated malaria, some injuries, and other simple forms of fever. The patient can walk to the centre on their feet smiling and explain everything himself; otherwise, we don't dare take somebody with severe illness to this centre. I have used that often, but I use it occasionally today, especially for minor illnesses. However, as I said earlier, some of us still enjoy the services and patronise them very well, except in cases of severe disease (Interview Participant 3)

Participant 9 indicated that women tend to seek formal healthcare services when TBAs are unable to manage complications, suggesting a hierarchy of care. The participant Illustrated the range of complications handled by TBAs and the collaborative approach they adopt when facing challenges beyond their expertise:

Women utilise these healthcare facilities only when there are complications that the TBAs cannot manage complications, such as swelling, sitting position during pregnancy, and the like. We reduce body temperature, or if it is associated with low blood, we give her a remedy, which replenishes and provides sufficient blood within three days. Sometimes, we tell these women to reduce salt intake. In the case of the baby's sitting position, we do not have the skill to change the seating position of the baby, but there are other TBAs in the neighbouring communities that do that. When there is a need, we call their attention to assist (Interview Participant 3, TBA)

A participant discussed the experiences of a few women in the community, emphasising that only a limited number have given birth at healthcare centres, often due to complications:

It is worth noting that these few women are the only ones with such experience among the entire community, with over two hundred homemakers. The first woman has six children. She gave birth to her third child at a health facility due to prolonged labour, and the second woman has ten children with one delivery at a health facility. Few of these women who gave birth at the health care centre were due to complications (Participant Mfgd1)

Participant 5 described transitioning from using natural herbs provided by TBAs and native doctors to embracing modern medicine after realizing its benefits. However, the participant regretted her decision to choose modern healthcare, while she also emphasised a perceived advantage of contemporary healthcare to include preventing and addressing complications during pregnancy:

I used natural herbs given to me by the TBA and native doctor before I decided to use modern medicine. After some time, I became convinced that modern medicine is good and that I would lie to my husband that I was visiting my parent to permit me. I abandoned the traditional medical system for the modern system and became a regular health facility user. Now, everything has fallen apart to our disadvantage. The most important advantage of modern maternal health services is that they help to rule out unforeseen complications to the unborn child and the mother (Interview Participant 5)

These findings reflect an approach to healthcare decision-making within the community, considering factors such as the severity of the illness, the effectiveness of traditional practices, and the perceived benefits of modern medicine. The primary role of Traditional Birth Attendants (TBAs) in providing care for less severe cases, coupled with the community's predominant dependence on informal healthcare centres for childbirth, particularly in instances of complications

5.7.4: Healthcare standard comparison

One of the women interviewed mentioned the absence of a healthcare centre in her community, leading them to use a facility located in a distant community: *"We don't have any healthcare centres in this village. The one we utilise is situated in Bizallo; a village located some distance from us" (Interview Participant 7).* Participant 6 mentioned the underutilisation of the village health centre. She chose to travel to the nearest city for maternal services. Despite potential higher costs, the participant believed the services were worth the expense:

> *Now that the health centre in our village is not functioning to capacity, we go to the nearest city centre for our maternal services and never regret it. We always patronise the services no matter how expensive they are. It is worth the cost (Interview Participant 6).*

The participant acknowledged continuous patronage of the local health centre over ten years but pointed out the limitations of the services compared to those in city health centres. She also highlighted a common issue in rural areas, though she acknowledged the state of healthcare services to some extent. She posited the limitation of women in the village to access the complete package of maternal health services available in urban areas:

> *As far as I am concerned, the health centre here is okay. I have never stopped patronising it since its inception ten years ago. However, the services are not as good as those of city health centres. This is a simple fact that you can deduce by merely looking at the structures. I am quite aware of it. However, women enjoy only limited access to complete maternal health services provided elsewhere in the cities. As a matter of fact, the services are good, but we don't have the complete package of maternal health services (Interview Participant 6)*

Similarly, a participant expressed satisfaction with maternal healthcare services from her former residence before relocation, describing them as suitable, accessible, and accompanied by informative sessions for women. This participant also mentioned delivering children at the healthcare centre in her former location and home with the assistance of a Traditional Birth Attendant (TBA):

> *Some of us are quite familiar with maternal healthcare services. In my case, I came from Yelwa, one of the suburbs in the metropolis where the healthcare facilities are good, not like what I see here after my husband has been transferred to this community. I gave birth to three children, all delivered at the healthcare centre in Yelwa and others at home with the help of a TBA, where I used to be. The services are good and accessible, and more information is given to women every day before the services is provided (Participant Rfgd1)*

A participant shared a positive experience with maternal healthcare services in private hospitals: “In my case, I would say that using these services in a private hospital is helpful. You get all the care from ANC to delivery and even after delivery” (Participant Kfgd2). A participant emphasised the importance of health, stating a willingness to sell belongings if necessary to access good medical services, a signal of the value placed on health and a determination to seek quality healthcare regardless of cost or distance:

> *As I said earlier, I have never relented in using the services ever since I started using the facilities. Though the patronage is not for the health centre in this village, I go where I can access any good medical services no matter the distance, no matter the cost. If I can sell any of my belongings to access the services, I will do it because health is wealth (Interview Participant 4)*

The findings from the participants' statements collectively highlighted variations in experiences and access to maternal healthcare services. Factors such as the quality of services, accessibility, cost considerations, and the absence of healthcare facilities in some villages contributed to the participants' diverse perspectives on maternal healthcare.

5.8: Health Worker’s Factors

Health workers' factors refer to the various elements and characteristics of health workers working in community healthcare centres. The factors encompass a wide range of factors traced to the health workers providing medical services that can

influence the health-seeking behaviour of the community women. Three themes emerged under this theme (Fig. 8).

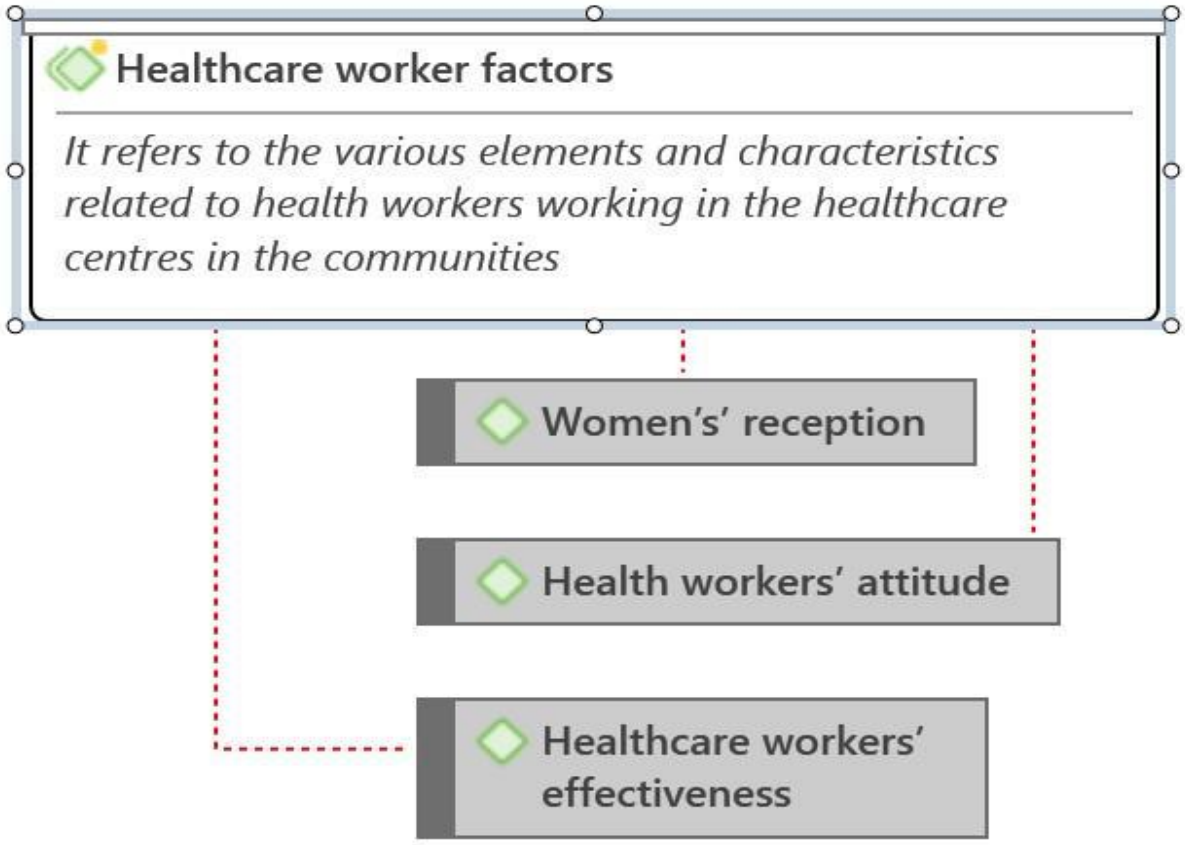

Fig 8: Thematic network for healthcare worker factors

5.8.1: Health Workers' Attitude

The theme refers to the behaviour exhibited by healthcare workers in their interactions with the women who came for healthcare service. The attitude of health workers can significantly impact the overall patient experience, satisfaction, and the effectiveness of healthcare delivery. A participant raised concerns about favouritism and unfair treatment at hospitals, leading to a reluctance to seek healthcare due to perceived disparities in service provision:

> *I see no reason why some of us will leave our homes very early to go to the hospital, but we end up coming late or not seeing a nurse or a doctor because some are influential or know one or two persons working there. These women come in when they like and are seen before some of us who left our homes as early as possible to queue for numbers. These experiences make us stay away from going to the hospital (Participant Afgd2)*

Similarly, a participant expressed dissatisfaction with the lack of respect shown to pregnant women by medical workers, highlighting a perception that healthcare workers do not share the same sense of urgency regarding deliveries:

> *Besides, these medical workers do not treat pregnant women with respect. While we feel this delivery is a life and death-issue and must be treated with respect, they do not feel the same. As such, we consider going to the hospital as a last resort (Participant Hfgd1)*

A participant expressed fear of judgment from healthcare workers based on cleanliness, leading to avoidance of healthcare centres to prevent embarrassment:

> *We find it difficult to connect with the medical staff at the healthcare centres for various reasons. For example, they say we don't clean our bodies or even bathe that we smell most of them. We fear this type of embarrassing statement from the health workers. So sometimes we go with our children who support us. So, to avoid this or anything that may cause chaos, we decide to keep off and let them be (Interview Participant 7)*

Participant 5 echoed her concerns about disrespectful behaviour from healthcare workers, emphasising the need for respectful communication in healthcare settings:

> *When I was pregnant with my third child, I went to the hospital for ANC, and the health worker was not respectful at all. Instead, she spoke to me as if she was talking to her child. Sometimes, they ask us to do something, and when we tell them we do not understand, they shout or scream at us. Apart from male health workers in the facility, some nurses are mean. They do not respect us (Interview Participant 5)*

In the same view, a participant pointed out a cultural clash, citing a lack of respect among healthcare professionals compared to traditional values in the community:

> *In our culture, there is great respect between you and someone older than you. In the cities or among medical staff, we don't see this type of respect exhibited. A young nurse will be passing without saying hello to anybody as if she doesn't have parents (Interview Participant 3)*

One of the women shared a distressing experience of maltreatment during labour, emphasising the emotional impact of negative encounters with healthcare workers and the subsequent decision to opt for traditional birth attendants for the next deliveries:

> *My bad experience was in the labour room. The nurse asked me to push so that the baby would come out. Hmmm! Instead of the baby coming out, I mistakenly passed out the stool. The nurse gave me a dirty slap and rendered all manner of curses on me. I cried like a little child whose mother had punished her because of what she did. The incident made me furious because this nurse was not my age-mate. I think she should be in her late 20s. Some of the maltreatment we receive in hospitals (government hospitals) is heartbreaking. My subsequent children were delivered at home with the help of TBAs (Participant Nfgd2)*

Similarly, another participant described a postpartum health issue that was poorly addressed by a healthcare worker, leading to severe pain and negative consequences for both the mother and the newborn:

> *My experience was after delivering my third child at a government hospital. The doctor discharged me from the hospital after a day of delivery. After one week, I developed severe pain in my neck that I could not eat or swallow anything. I went back to see a doctor, and after a long waiting period, I succeeded in seeing a doctor (they are called family doctors). I came back home with severe pain. The pain kept me awake at night, and I could not eat. The severity of my condition affected the health of my newborn baby because he was not feeding well. The pain worsened that my husband had to look for money to go to a private hospital (Participant Hfgd2)*

In another view, a participant shared a mixed perspective highlighted a shift from initial problems to a more positive relationship with healthcare workers, even engaging in friendly exchanges:

> *We had problems with the medical workers early when we learned how to use modern medical services. After some time, we became conversant with the procedures. We end up making friends with health workers such that when we come, they ask us to buy certain farm produce from our villages and pay us*

back after delivery with some interest. So far, the reception is good. We all know the procedures and the general process (Interview Participant 6)

The findings, based on the attitude of the health workers, showed women experience a lack of respect, fear of judgment and embarrassment, disrespectful behaviour and communication, cultural clashes and lack of care, negative encounters during labour, poorly addressed postpartum health issues, mixed perspectives and changing relationships, favouritism, and unfair treatment.

5.8.2: Women's' Reception

A participant highlighted a poor reception and the lack of regard for women's treatment in healthcare centres. "This is a terrifying experience we all had. Reception at the healthcare centre is very poor, and women are treated without regard" (Participant Hfgd1). A participant highlighted the contrast between private and government hospital experiences. She shared a positive reception at a private hospital, mentioned cordial appointments and excellent health workers, and spoke of the capital-intensive nature of personal care. On the other hand, she described a hostile reception at a government hospital:

As for me, the reception at the private hospital I attended during my first pregnancy was okay. My appointments were cordial. The health workers were nice and explained what we needed to know about these services. The only issue with using a private hospital is that it is capital-intensive. I paid money for ANC, drugs, scans, and tests for every appointment. This is all thanks to my mother, who decided to help out. My second pregnancy was at a government hospital. The reception was not friendly at all. We had to queue for long hours for numbers before seeing a nurse or a doctor. The nurses always yelled at us as if this was not enough (Participant Kfgd2).

Similarly, a participant expressed discomfort and recalled a negative delivery experience. She emphasised health workers' lack of conscience, shared an instance of false labour diagnosis, and described unresponsiveness during a critical moment:

Hmmm! I would not like to recall the reception I received when I went for delivery. These health workers have no conscience at all. My labour started at about noon on a Wednesday, and I was taken to the hospital. On my arrival at the hospital, the nurse told me to return home and that it was false labour. I

tried explaining to her, but she would not listen, so I decided to return home. At about 2 00 pm, my water broke, and I was taken back to the hospital. I leaned beside the vehicle outside the premises because I could not walk into the hospital. The people that took me kept calling for help, but no one responded (Participant Afgd2)

In addition, the participant pointed out issues with time wastage and inadequate attention to patient history. Hence, she suggested doctors and nurses should adhere to official office hours to address time wastage and prevent preferential treatments.

Most of us have experienced time wastage in the hospital; nurses and doctors do not give ample time to take the complete patient history, doctors refer patients from government hospitals to their private hospitals, preferential treatments, etc. In terms of time wastage, doctors and nurses should report to the office during official office hours to see patients booked for that day. In so doing, our coming to the hospital as early as 5:30 am will not be in vain.

Another participant conveyed a negative childbirth experience, leading to a vow to avoid hospitals for delivery. She described a rude nurse who witnessed a tragic incident of a pregnant woman's death due to negligence, leading to a decision to give birth at home with the help of a Traditional Birth Attendant (TBA):

I would have thought so myself, but the way and manner she said it came out wrong. She was rude when she made the statement as if she wanted something to go wrong. After cleaning up, I left the labour room and went to the other room to wait for the second nurse to clean my child. While waiting for my baby, another pregnant woman came in. I think she was in labour. None of the nurses attended to her because she did not come with her husband or relatives. This poor woman died with her unborn child in her womb. With the reception I received, and what I saw in the hospital, I vowed never to go to the hospital for delivery again. I gave birth to my second child at home with the help of a retired nurse who serves as a trained TBA in my community (Pfgd2)

One of the women interviewed highlighted the marginalized status of village women in healthcare centres. She expressed a feeling of being disrespected and not regarded as indigenous people, indicating a lack of equality in healthcare services:

In the health care centres, village women don't feel like they are also entitled to health care services. As such, we are not given the same treatment. We are not regarded as indigenous people but as aliens from another world. We are disrespected by the way the health professionals talk to us (Interview Participant 3)

Nevertheless, a participant had no issue with reception but problems with medical workers and the process. She indicated a lack of understanding of the medical process, leading to conflicts with medical workers, especially in cities:

We don't have a problem with the reception at any healthcare centre, whether in villages or cities. However, we had issues with the medical workers because we didn't know the process then. So, we take offence at how they show us the process, which brings some hitches between the medical workers and us, especially those in the cities (Interview Participant 4)

Also, a participant described mixed experiences in healthcare centres. She believed that some encounters were cordial, while others were disrespectful, suggesting inconsistency in the reception quality. “Sometimes the reception in the healthcare centres I visited was cordial, while some encounters were disrespectful” (Interview Participant 5). The findings showed a range of negative experiences within the reception of women in healthcare settings involving issues such as disrespect, inadequate attention to patients, and systemic problems in the healthcare system.

5.8.3: Healthcare workers’ effectiveness

Healthcare workers' effectiveness refers to the effectiveness, efficiency, and quality of work exhibited by the healthcare workers in the community healthcare centre. A participant raised concerns about the lack of qualified medical workers, struggle with machines, and discomfort with the reliability of the results issued by those who have to deal with the results of our belief. She attributed these reasons, among others, to why some women prefer traditional medical care over modern methods:

There are numerous issues like lack of good medical facilities and the medical workers not being qualified. We could see how they struggled to operate some machines before getting results. At some point, we are not comfortable with the results they issue to us, so we take them home and never use them (Interview Participant 7)

She further highlighted a lack of proficiency of some healthcare professionals in using modern medical equipment, leading to a preference for the traditional medical care system. She emphasised mastery, precision, and a return to trusted practices, which showed a complex interplay of factors, including trust, familiarity, and cultural beliefs, influencing healthcare choices:

> *When we see somebody asking his partner or colleague how to use a particular machine, we know that such a person is a novice and cannot use the device to get any reliable result. From there, we went back to the traditional medical care system that uses people who have mastered the art and know what to do and how to do it.*

Similarly, a participant expressed concern about the qualifications of healthcare personnel, suggesting that they may not be adequately trained to handle complications associated with delivery: "Most healthcare personnel do not seem to be qualified enough to handle most of the complications associated with delivery" (Participant Hfgd1).

Another participant pointed out a failure in antenatal care, with a situation where a problem was not detected earlier, leading to the loss of babies. In contrast, the participant placed the blame on the health facility's failure to meet such expectations:

> *The woman attended complete antenatal, yet this problem was not detected earlier. We blamed the health facility for not meeting up to expectations. The woman later lost the babies. Honestly, these services are very poor; we use them with great caution (Participant Hfgd1*)

A participant criticised doctors for being in a hurry, leading to incomplete medical histories and missed diagnoses. She gave an example of a child born with a cleft palate, which might have been identified with a more thorough examination:

> *These doctors are in a hurry to go to their private hospitals. They fail to make time to take the patient's complete history; in so doing, they tend to give the wrong medications or fail to see if the child in the womb has a defect during scanning. One of my children has a condition called a cleft palate. If the doctor had taken his time to do a thorough check, he would have seen the condition and prepared our minds for such a child (Participant Mfgd2)*

A participant who had earlier spoken raised a concern about a lack of thorough diagnostic procedures. She expressed discomfort with the drugs prescribed without any tests, relying solely on symptoms:

> *We feel even more uncomfortable with the medicines they prescribe without any tests. They use symptoms to prescribe. Though we are not educated, we have the instinct that helps us make a good judgment about certain conditions (Interview Participant 7)*

A participant described a distressing incident where a patient had to deliver on the ground due to a lack of assistance from hospital staff. She reported the response from the nurses as inadequate and included yelling. The incident led the participant to vow against returning to the hospital for subsequent pregnancies:

> *I had my child on the ground, so one of the hospital attendants rushed into the hospital to speak to the chief nurse in charge, and he came and yelled at the nurses before they all rushed outside to help me. I was so furious that I left my baby on the hospital grounds and started walking away with a retained placenta. Then, one of the nurses came after me, pleading to return to the hospital. She said that I should thank God for having a healthy baby. What about the trauma I experienced at birth? I refused, and then the attendant who reported the nurses to the chief nurse came and pleaded with me to return so that the baby and I could be looked after. From that day, I vowed never to go to the hospital with my subsequent pregnancies (Participant Afgd2)*

Along the same line of experience, a participant shared a negative experience during labour at a government hospital, highlighting issues such as inadequate facilities, lack of guidance, and poor reception. The participant had to deliver with minimal assistance and without proper advice on positioning:

> *I am a mother of two. I gave birth to my first child at a government hospital, and the reception was bad. My labour started at home, and I was taken to the hospital. The first nurse examined my cervix to track how my labour was progressing. After the examination, she told me she would check back after 5 hours.*

Meanwhile, there was no empty bed to admit me. Therefore, I managed to see an empty chair to sit on. After a while, I was in serious pain, so I went to the toilet to urinate. I passed out blood, and the pain kept progressing (cervix dilation with regular, painful contractions). I returned and complained to the first nurse that the baby was coming. The first nurse said I should push there on the plastic chair where I sat, and she went out. As I was seated in the pool of blood, I had the urge to push; there was an empty bed in the labour room, so I quickly got on it (Participant Pfgd2)

The participant highlighted the emotional and cultural aspects of her birthing experience, emphasising the need for sensitive and patient-centred care to ensure a positive and safe delivery process and the importance of effective communication, guidance, and timely interventions during childbirth:

Hmmm! Being a first-time mum, I had no idea how to position my legs for the baby to come out, coupled with the fact that there was no nurse to guide me on what to do, so I held my legs anyhow. After my second push, the baby came out and was about to fall on the floor when the second nurse rushed from nowhere to rescue the baby from falling on the floor. The first nurse who examined my cervix then returned to attend to me. She cleaned me up and said that I should thank God for having a good birth canal. I did not know what she meant by her statement because I was already angry at her, and then in my response, I told her that God is more than man (Participant Pfgd2)

The participants collectively highlighted various challenges within the healthcare system, including personnel qualifications, antenatal care, prompt assistance during delivery, infrastructure, rushed medical care, and concerns about the reliability of results and prescriptions. These issues collectively pointed to a need for improvements in healthcare infrastructure, training, and patient care practices.

5.9: Maternal Healthcare Adjustments

The theme refers to modifications and changes women must undergo before utilising maternal healthcare centres. Four themes emerged under this theme (Fig. 8).

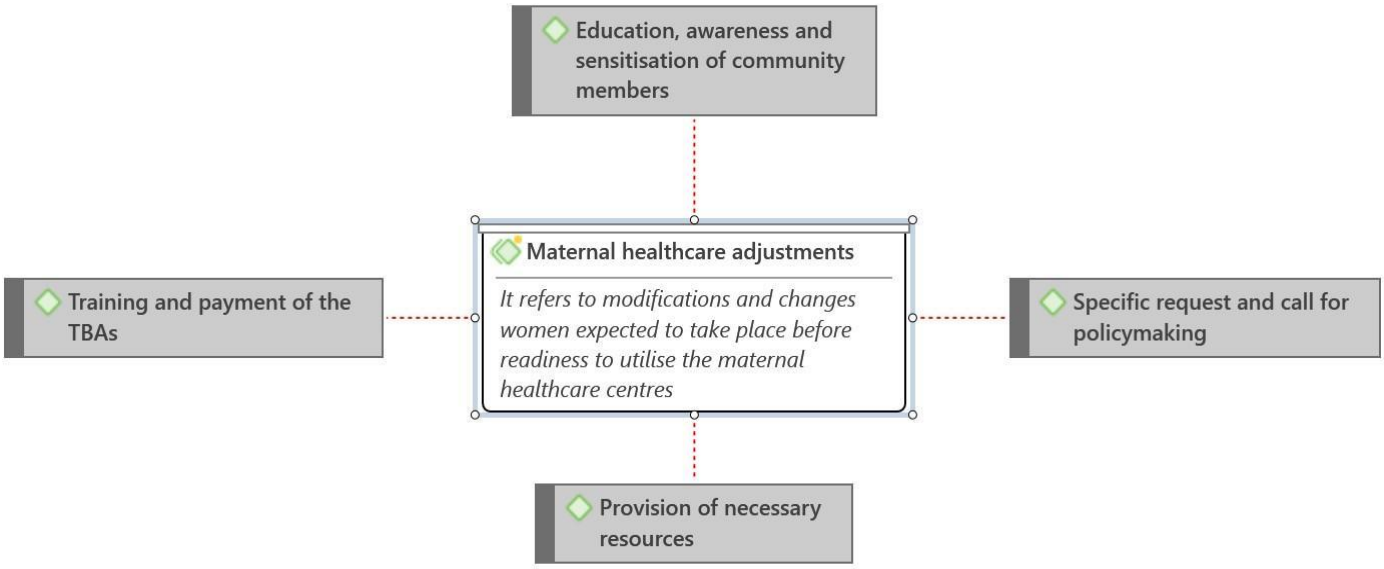

Fig. 9: Thematic network showing maternal healthcare adjustments

5.9.1: Training and payment of the TBAs

Training and payment of the TBAs refers to providing education, skills development, and financial compensation for individuals traditionally involved in assisting women during childbirth and providing maternal and newborn care. A participant highlighted the impact of cultural factors on hindering healthcare service utilisation. She underscored the need for training to address these cultural barriers, suggesting that raising awareness can help bridge the gap between cultural beliefs and modern healthcare practices:

> *I feel most of the hindrances to utilising healthcare services are culture-related; as such, there is a need for education about the subject matter for everyone who is affected in one way or another (Interview Participant 9)*

Similarly, a participant advocated for providing comprehensive training to Traditional Birth Attendants (TBAs) to enhance their skills in managing child delivery in a modern way:

> *TBAs should be given all the needed training on how best to manage child delivery in a modern way. I feel we would do better than all the nurses and most other health workers at the healthcare centres. This is because we would do everything respecting our cultural norms and values.*

A participant suggests that TBAs should be included in the state government's payroll due to the significant number of women who rely on their services for childbirth; a proposal aims to acknowledge the role of TBAs in the community and formalise their contributions:

> *I feel we, the traditional birth attendants, need to come into the payroll of the state government because the number of women that are delivered using TBA's is far more than those that go to the healthcare centres (Interview Participant 9)*

The findings highlight the influence of cultural factors on healthcare utilisation and the participants' suggestions for addressing this challenge. The recommendations include education to raise awareness, comprehensive training for TBAs to align their practices with modern healthcare, and the formal recognition of TBAs through inclusion in the state government's payroll. These insights underscore the importance of culturally sensitive approaches and community involvement in shaping healthcare policies and practices.

5.9.2: Provision of necessary resources

A participant who highlighted the community's struggles with water issues, poor road conditions, and challenges faced by women, particularly in accessing antenatal services, suggested a solution by advising the management on the provision of human resources:

> *In this community, we have problems with water and bad roads. Some of the women who kept quiet have faced this difficulty many times. They could not attend antenatal services because of the prevailing problem. Therefore, I wish to advise the management of the Ministry of Health to combine fresh graduates with experienced ones to minimise the many problems women face with the healthcare personnel (Participant Mfgd1)*

Another participant who highlighted concerns about the healthcare centre’s structure requested particular intervention regarding the importance of a visually appealing and well-maintained healthcare facility. She advocated for a good-looking structure and properly stocked drugs to create a positive first impression for patients and provide relief to them:

The centre needs special intervention because you can see how the structure is standing, some houses in the village look better than the unusual centre. Good-looking structure and well-stocked drugs kept in good condition help give relief to the patient, and I think that is the first impression a patient can get (Interview Participant 4)

A participant, who had concern for the overall well-being and development of the community, suggested the need for the provision of essential social amenities, with a focus on water, roads, and education, and increased awareness "*I feel we need social amenities like schools, good sources of water, good roads, and good enlightenment on the need to patronise the healthcare facilities, especially for maternal health services" (Interview Participant 6)*

In addition, the participant highlighted the potential benefits of having community members involved in healthcare professions, especially women, to address cultural and gender-related concerns within the community.

Bringing more women to serve as nurses and midwives will help reduce the fear of opening our private parts to men or groups of medical workers that may include men (Interview Participant 6)

A participant advocated for a specific intervention in the form of excluding men from the maternity unit to create a more women-friendly environment for maternal health services and to increase utilisation of these services by women who might be avoiding them due to the presence of men*: "Men should be removed from the maternity unit. With these in place, I think women who do not use maternal health services will see the need to use them (Interview Participant 5)*

A participant made a heartfelt plea for the government to address the critical issue of inadequate medical services in rural areas, emphasising their suffering, mortality, and economic consequences associated with their situation:

Please tell the government that people in the villages are suffering from poor medical services. So please encourage the government to do more because people are dying, and sometimes illness lingers for a long time in the individual's life, which makes them unproductive (Interview Participant 3)

The findings highlight various challenges in healthcare accessibility, infrastructure, and the need for essential social amenities and education. Participants also suggested specific interventions and emphasised the role of community involvement and gender-sensitive measures in improving healthcare services. The overall finding centres on addressing multifaceted challenges to enhance healthcare delivery in the community.

5.9.3: Education, awareness, and sensitisation of community members

A participant advocated for education as a means of enlightenment, focusing on the importance of healthcare facilities, maternal health services, and cultural sensitivity. She highlighted the potential benefits of having community members involved in healthcare professions, especially women, to address cultural and gender-related concerns within the community.

> *I feel we need enlightenment on the need to patronise healthcare facilities, especially for maternal health services. The school will help us become more enlightened on the modern way of doing things. If we are adequately educated, we can liberate ourselves from illiteracy, and one day, the medical workers will be people from our community. They would respect our cultural values and beliefs. Bringing more women to serve as nurses and midwives will help reduce the fear of opening our private parts to men or groups of medical workers that may include men (Interview Participant 6)*

A participant desired modern healthcare services among community members while acknowledging the existing cultural and religious barriers. She suggested the sensitisation of men, especially religious and community leaders, as a strategic approach to address and overcome these barriers, emphasising the importance of their influence in shaping community attitudes toward healthcare:

> *So many of us want to utilise modern healthcare services, but cultural and religious beliefs prohibit most of us. Our men, religious/community leaders, should be sensitized about the importance of healthcare services (Interview Participant 5)*

A participant who alluded to her educational background advocated for extended education, empowerment through knowledge, and a plea for improving healthcare facilities in the community. She shared a holistic perspective on the

interconnectedness of education and healthcare and appealed to the government for support:

> *I attended only primary school. For this reason, I believe educating people beyond primary school in this community and other communities would go a long way to have a different orientation and perspective on modern medicine. It would also give us a voice in our homes when it has to do with our health. I am pleading with the government that the health centre in this village should be improved because the number of people needing the services is more than the number of health staff. At the same time, the facilities are inadequate and insufficient. Thank you so much for your time. I am still around. If you remember anything that you think is relevant to the research, please do let me know (Interview Participant 6)*

A participant advocated for education to align the community with the global trend of modern medical practices. She acknowledged potential challenges stemming from cultural and traditional influences and emphasised the importance of addressing these challenges to ensure women's access to modern healthcare:

> *We, like all other people, want growth and development. If it is true that modern medical practice is the new normal practice used by everyone in the world as it is being put by the government in the media. Then, the government needs to educate our elders and community leaders, the fetish priest, and every stakeholder to reduce the dangers they pose to women who want to access the modern healthcare system (Interview Participant 7)*

A participant posited the community's aspirations for local education, particularly in the form of primary and secondary schools, to produce healthcare professionals. She underscored the belief that education is key to improving individual and community outcomes. She has a desire for self-sufficiency and a recognition of the transformative potential of education in enhancing the overall well-being of the community:

> *We also need primary and secondary schools around us to be educated and be the doctors and nurses who would work in our healthcare centres. The educated do things better and enjoy the dividend much more than the illiterate. Thank you so much for your time. If you remember anything, let me know (Interview Participant 3)*

In addition, participant 3 underscored the importance of health education in shaping the community's understanding of modern health practices and managing contemporary diseases. She highlighted the transformative potential of education in changing perspectives and encouraging the utilisation of modern healthcare services, ultimately leading to the enjoyment of associated benefits:

> *There is also the need for health education and the relevance of modern health practices in managing today's diseases. A proper education would change people's perspective on modern health care, and they will be able to patronise the services and enjoy their benefits as expected.*

The findings underscored the community's recognition of the transformative power of education in shaping attitudes toward healthcare. The results showed cultural sensitivity, gender-related concerns, and the integration of education and healthcare as central to the participants' perspectives.

5.9.4: Specific request and call for policymaking

A participant made a heartfelt plea for assistance, emphasising the urgent need for intervention to free women from traditional bondage. She also underscored the awareness of the potential impact that policymakers, especially on a global scale, could have in addressing these issues and bringing about positive change for the affected women:

> *I want to tell you and anyone who can help that many women in the villages desperately need help. If you are among the policymakers here in Nigeria or elsewhere in the world, please make an effort to free women like us who are in traditional severe bondage and need liberation from such. Please help and tell the world about our plight (Interview Participant 7).*

A participant expressed dissatisfaction with the health system but proposed a gender-specific approach as a potential solution to improve acceptance, particularly among men:

> *Well! I am no longer a fan of the health system, but if female health staff can see or handle cases that concern women and men handle that of men, then men may allow their wives to use these services (Interview Participant 8)*

A participant advocated for a legal solution to address what they perceive as a problem of medical personnel, especially doctors, leaving their duty posts during government working hours. She emphasised accountability and a commitment to professionalism within the healthcare system:

> *Doctors should not leave their duty posts. The government should put a law for all medical personnel operating their hospitals during government working hours to stop or be dismissed when caught (Participant Hfgd2)*

A participant advocated for a fair and impartial approach to healthcare services for pregnant women, emphasising the principles of equality, meritocracy, and patient-centred care*: "The doctors and nurses should treat all pregnant women equally. It should be on a first-come, first-served basis, not about who you know" (Participant Ffgd2).*

The findings highlight various concerns and proposed solutions related to healthcare, traditional practices, and gender dynamics. The participants' perspectives underscored the need for interventions at multiple levels, including legal measures, gender-sensitive healthcare practices, and a commitment to fairness and professionalism within the healthcare system.

Research Question Two: What are the perspectives of maternal healthcare stakeholders (husbands and healthcare workers) on women's utilisation of maternal healthcare?

The second research question was analysed with Thematic Analysis, using data collected from maternal healthcare stakeholders, the husbands, and the healthcare workers.

Application of Braun and Clarke (2006)'s Thematic Analysis

Phase One: Familiarisation with the data

As I began the initial phase of familiarisation, I focused on delving into the data and immersing myself in the rich and diverse narratives shared by the participants. I read and re-read the transcripts to allow the respondents' voices to resonate with me. This process helped me to grasp different perspectives shared by the participants. This process enabled me to gain a deeper understanding of the perspectives shared as contained in the transcripts. I highlighted the statements I considered relevant to the objective of the research. It was crucial to absorb the essence of each participant's

perspective, appreciating the unique aspects of their responses. This immersion facilitated a connection with the data and laid the foundation for identifying potential themes and patterns that would later emerge during the analysis.

> *The Major area of great concern to us is the practice where somebody you don't know would take your wife inside a particular room and undress her in the name of investigating or observing a specific aspect of her body. This is a great taboo in our beliefs and culture in this community; whenever my wife comes back from the healthcare centre, I always feel she must have opened the sensitive part of her body to be observed by an unknown person, which implies that that person has defiled her. This makes me begin to feel a kind of hatred in my mind and perhaps jealousy (Interview with Male Participant, M1)*
>
> *Certain medical practices conflict with our values, especially when a male health worker would ask my wife to undress to allow him to investigate certain parts of her body. This practice is an abomination for any reasonable man in my community. As such, I cannot encourage my wives to go to any healthcare centre for any treatment (Interview with Male Participant, M3)*
>
> *A woman cannot leave home without her husband's full knowledge and consent. This is a serious problem because when women ask permission from their husbands, they have the right to either accept or decline. On the other hand, wives do not have the right to request either why they refused her permission or make an effort to explain to their husbands why they need to go out to any healthcare centre for healthcare services (Interview with Health Worker 1)*
>
> *There was a certain woman. She was the second wife in the house, and it was her first pregnancy. She came for her first ANC when she was in her second trimester, and she was told that her child was normal. I encouraged her to come for a follow-up until delivery, but she never showed up again. Due to natural causes, her child's position later changed, and she did not know. Her labour started mid-afternoon; she was not taken to the hospital because her husband was not home to give her permission. When he later came back in the evening, she was rushed to a nearby primary health care facility, but the child was already dead. I later discussed this with her and asked her why she had never*

returned to the clinic. She said her husband was not home to grant her permission (Interview with Health Worker 2)

Phase Two: Generating Initial Codes

I began generating initial codes as I progressed into the second phase of Braun and Clarke's thematic analysis. The process involved breaking down the data into meaningful segments, identifying key concepts, and labelling them with descriptive codes. For instance, when exploring participants' responses, I started coding phrases such as “Preference for female health workers” and “Husband’s Supremacy.” Each code represented a distinctive aspect of the participants' perspectives. Other codes, as presented in this study, also emerged.

Preference for female health workers:

The Major area of great concern to us is the practice where somebody you don't know would take your wife inside a particular room and undress her in the name of investigating or observing a specific aspect of her body. This is a great taboo in our beliefs and culture in this community; whenever my wife comes back from the healthcare centre, I always feel she must have opened the sensitive part of her body to be observed by an unknown person, which implies that that person has defiled her. This makes me begin to feel a kind of hatred in my mind and perhaps jealousy (Interview with Male Participant, M1)

Certain medical practices conflict with our values, especially when a male health worker would ask my wife to undress to allow him to investigate certain parts of her body. This practice is an abomination for any reasonable man in my community. As such, I cannot encourage my wives to go to any healthcare centre for any treatment (Interview with Male Participants, M3)

Husband’s Supremacy:

A woman cannot leave home without her husband's full knowledge and consent. This is a serious problem because when women ask permission from their husbands, they have the right to either accept or decline. On the other hand, wives do not have the right to request either why they refused her permission or make an effort to explain to their husbands why they need to go out to any healthcare centre for healthcare services (Interview with Health Worker 1)

There was a certain woman. She was the second wife in the house, and it was her first pregnancy. She came for her first ANC when she was in her second trimester, and she was told that her child was normal. I encouraged her to come for a follow-up until delivery, but she never showed up again. Due to natural causes, her child's position later changed, and she did not know. Her labour started mid-afternoon; she was not taken to the hospital because her husband was not home to give her permission. When he later came back in the evening, she was rushed to a nearby primary health care facility, but the child was already dead. I later discussed with her why she never returned to the clinic. She said her husband was not home to grant her permission (Interview with Health Worker 2)

This initial coding process acted as a foundation for the subsequent stages of analysis, providing a systematic way to organise and interpret the data.

Phase Three: Searching for Themes

I systematically searched for themes within the coded data during the third phase of Braun and Clarke's thematic analysis. This phase involved closely examining the generated codes, looking for patterns, connections, and recurring concepts that could be grouped into overarching themes. For example, I studied the coded segments related to participants' concerns about the gender status of the health workers and husbands' roles in the women's health-seeking behaviours. Searching for themes was iterative, involving multiple rounds of reviewing, refining, and revisiting the data. It required a balance between staying close to the participants' voices and generating meaningful, abstract themes that could encapsulate the depth and diversity of their experiences.

Phase Four: Reviewing Themes

I reviewed and refined the identified themes in the fourth phase of Braun and Clarke's thematic analysis. To do this, I carefully examined the themes in relation to the coded extracts and the entire dataset, ensuring they accurately represented the participants' experiences. For example, when reviewing the "Community Belief System" theme, I looked back at the coded segments related to preference for female health workers and husband supremacy. I carefully checked each code to confirm that it aligned with the broader theme, making adjustments and modifications where necessary to

enhance the coherence and clarity of the thematic structure. This process involved assessing the internal consistency of each theme and the external differences between themes. I considered whether each theme was internally consistent and distinct from other themes. This iterative review helped to refine the themes, ensuring they portray participants' narratives while avoiding redundancy or overlap. Throughout this phase, I remained reflective, acknowledging any potential biases or assumptions that might influence the interpretation of themes. This thoughtful process enhanced the rigour and trustworthiness of the analysis.

Phase Five: Defining and Naming Themes

During the fifth phase of Braun and Clarke's thematic analysis, I had to name and define the themes that had been identified. This process was an essential step that required me to articulate the meaning and significance of each theme concisely and clearly, capturing the essence of the patterns observed within the data. For instance, while defining the theme ‘Community Belief System,' I crafted a description that encapsulated the recurrent codes related to participants' concerns about maintaining cultural norms, gender-specific boundaries, husbands’ related supremacy roles, and privacy during healthcare interactions. At the same time, I named each theme thoughtfully to ensure it succinctly conveyed the content and significance. For example, ‘Preference for female healthcare' was selected to encapsulate the essence of the participants' shared perspectives and concerns related to the gender of the healthcare workers that attend to the women who utilise maternal healthcare services. The naming process involved selecting the language that resonated with the participants' voices, fostering a connection between the themes and the lived experiences they represented. Through this process of defining and naming themes, the analysis moved closer to a cohesive and meaningful representation of the participants' narratives, providing a foundation for the subsequent stages of interpretation and reporting.

Phase Six: Writing the Report

As I progressed toward the final phase of my thematic analysis using Braun and Clarke's approach, I shifted my focus toward writing a report that could effectively communicate the identified themes, their meanings, and their implications. I ensured that the information provided a faithful representation of the participants' narratives in a clear, coherent, and structured manner. To begin with, I structured the report around

the emergent themes, starting with a brief introduction that provided the necessary context and background information. I then explored each theme in detail by combining the relevant coded extracts and interpretations, substantiating my findings.

For instance, in the “Preference for female health workers” section, I included key quotes from the participants that reflected their concerns about maintaining cultural norms and gender-specific boundaries during healthcare interactions. I supplemented these quotes with my analytical reflections, linking to the codes and offering a deeper understanding of each theme. Below is an example of the reporting for ‘Preference for female health workers”:

Preference for female health workers

This theme refers to husbands' choice of having medical care for their wives, precise healthcare procedures or examinations, specially provided by female healthcare professionals. This factor influenced the husband’s decision to allow their wives to seek healthcare services in the community’s maternal healthcare. A male participant expressed deep concern about a practice that occurs in his community, where strangers are allowed to take their spouses into a room and undress them to observe their bodies. The participant said the practice goes against their beliefs and culture, causing the participant to feel that their spouse has been violated and defiled, an action that resulted in negative emotions such as hatred and jealousy:

> *The Major area of great concern to us is the practice where somebody you don't know would take your wife inside a particular room and undress her in the name of investigating or observing a specific aspect of her body. This is a great taboo in our beliefs and culture in this community; whenever my wife comes back from the healthcare centre, I always feel she must have opened the sensitive part of her body to be observed by an unknown person, which implies that that person has defiled her. This makes me begin to feel a kind of hatred in my mind and perhaps jealousy (Interview with Male Participants, M1)*

Throughout the report, I strived to balance providing rich, descriptive accounts of the themes and offering interpretative insights. I carefully avoided imposing my interpretation. Finally, as I concluded the report, I summarised the main findings. This reflective closure aimed to enhance the transparency and credibility of the analysis,

contributing to a comprehensive and authentic representation of the participants' perspectives shared. Below is an example of the summary of findings of the theme:

“The findings showed a clash between Western medical practices and deeply rooted cultural norms, with concerns ranging from gender sensitivity and privacy issues to instances of alleged sexual abuse. These conflicts have tangible consequences, leading to a reluctance to engage with Western healthcare services in the community. Addressing these issues requires careful consideration of cultural values and implementing measures to ensure respectful and culturally sensitive healthcare practices.”

Five themes emerged from the analysis of the data gathered from the husbands and healthcare workers on the reasons women don't utilise maternal healthcare (Figure 10).

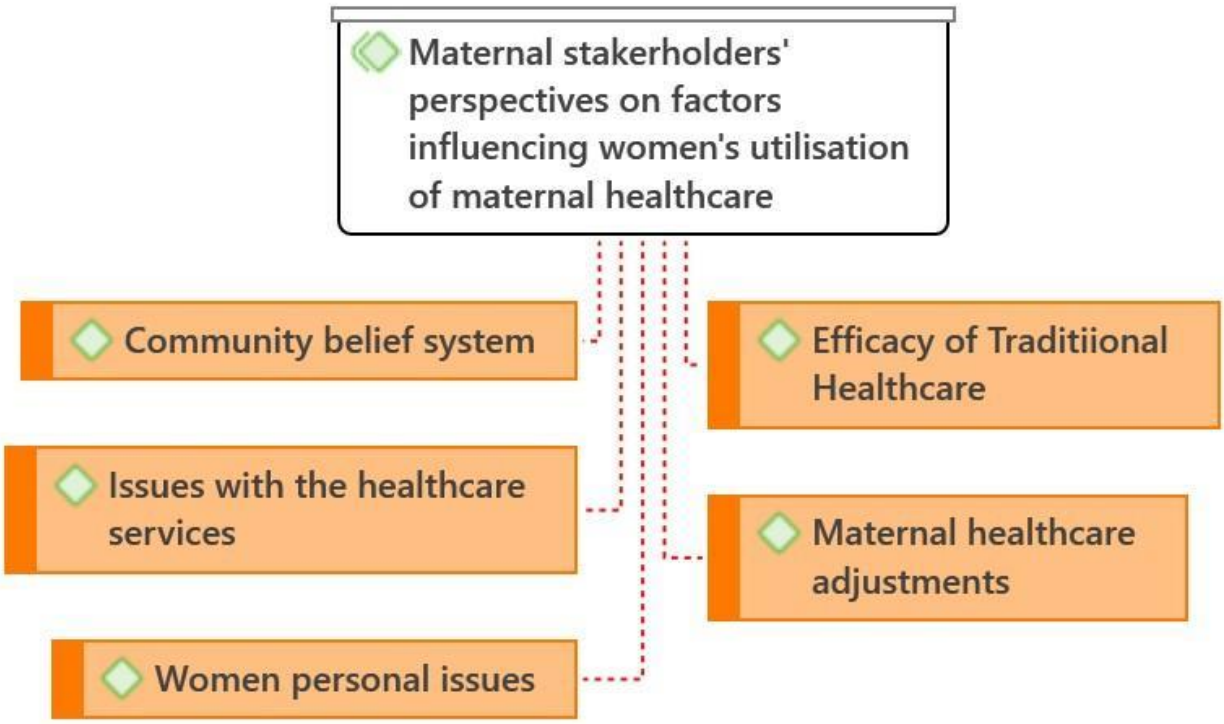

Figure 10: Thematic network showing factors influencing women's utilisation of maternal healthcare

5.10: Communal Belief

The theme refers to the participants' interconnected beliefs or convictions about life, the world, and existence. The belief systems comprised the cultural, religious,

philosophical, cultural, or ideological perspectives of the participants' worldviews. Three themes emerged under this theme (Figure 11).

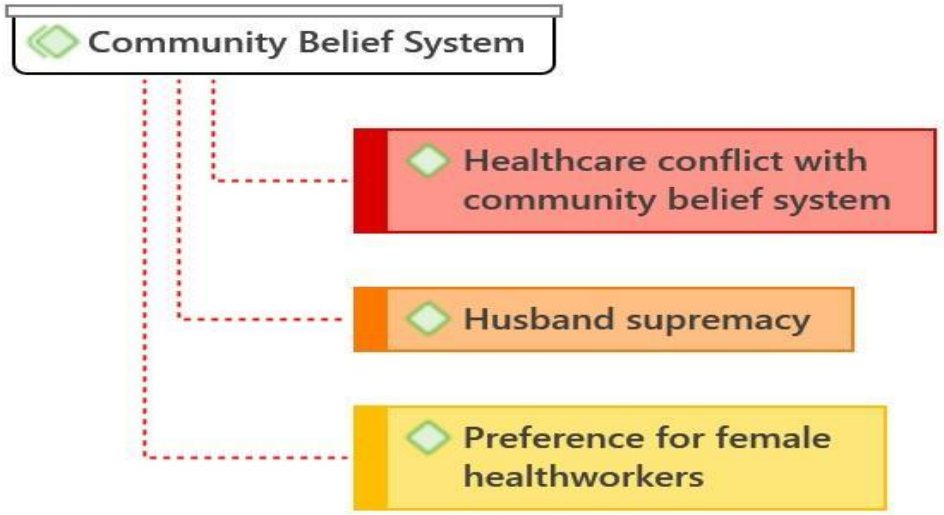

Figure 11: Thematic network showing community belief system

5.10.1: Husband Supremacy

The theme refers to the socio-cultural dynamic in the Northern part of Nigeria in which husbands are considered the authority figure or have a dominant role within a marital relationship, where most decisions require the approval or permission of the husband. One of the skilled health workers interviewed shared a scenario where women's mobility is heavily controlled by their husbands, impacting their ability to access healthcare services independently, and that the lack of open communication and the requirement for permission create challenges for women in expressing their health needs and seeking timely medical attention:

> *A woman cannot leave home without her husband's full knowledge and consent. This is a serious problem because when women ask permission from their husbands, they have the right to either accept or decline. On the other hand, wives do not have the right to request either why they refused her permission or make an effort to explain to the husband why she needs to go out to any healthcare centre for healthcare services (Interview with Health Worker 1)*

In addition, the health worker underscored a cultural context where traditional gender roles and communication patterns are strictly adhered to, leading to a hierarchical and segregated approach to decision-making within a marital relationship, segregation that

is seen as a potential barrier to improving healthcare access, as the wife's influence in decision-making is constrained by cultural expectations:

> *The other problem is that seeing a man and his wife sitting together to discuss any issue is an abomination. The wife's work is to report any problem to her husband while the husband decides how the problem is handled without her contribution. In such a situation, educating the women will have little or no effect on the family's access to healthcare services since the wife does not influence the husband.*

The participant highlighted some concerns regarding the pattern where patients, particularly women, in the community were discarding prescribed medication out of fear that it may harm their fertility, where their husbands heavily influenced them and tended to follow their wishes. The speaker reiterated that the husbands, who prefer traditional healthcare practices, do not support their wives in utilising modern healthcare facilities and instead direct them to conventional healthcare providers:

> *I have had many cases of patients diagnosed with a different ailment, and after giving them the relevant drugs, they go home and throw the pills away because of the fear that it may destroy their fertility. The women in this community are like slaves to their husbands, and they follow everything their husbands ask them to do. The husbands don't like modern healthcare facilities; thus, they do not support their wives when they want to utilise them. Instead, the husbands refer them to the traditional healthcare givers*.

Another health worker shared an experience that highlighted the complex interplay of cultural, communication, and gender-related factors that can impact maternal healthcare outcomes. It underscores the importance of holistic approaches to maternal care, encompassing education, communication strategies, and cultural sensitivity to address barriers and improve overall maternal and child health:

> *There was a certain woman. She was the second wife in the house, and it was her first pregnancy. She came for her first ANC when she was in her second trimester, and she was told that her child was normal. I encouraged her to come for a follow-up until delivery, but she never showed up again. Due to natural causes, her child's position later changed, and she did not know. Her labour started mid-afternoon; she was not taken to the hospital because her husband*

was not home to give her permission. When he later came back in the evening, she was rushed to a nearby primary health care facility, but the child was already dead. I later discussed with her why she never returned to the clinic. She said her husband was not home to grant her permission (interview Health worker 2).

The findings showed limited autonomy for women in accessing healthcare independently, limits the women's influence and involvement in decisions related to healthcare, the misconception that modern healthcare drugs, and the woman's inability to secure permission led to delayed intervention and tragic consequences.

5.10.2: Preference for female health workers

This theme refers to husbands' choice of medical care for their wives, particularly certain healthcare procedures or examinations, specially provided by female healthcare professionals. This factor influenced the husband's decision to allow their wives to seek healthcare services in the community's maternal healthcare. A male participant who emphasised the variance between traditional and Western maternal healthcare also spoke of his belief in maintaining gender-specific boundaries in healthcare settings; thus, he questioned the necessity of having a male staff member perform the specific medical investigation involving exposure of the body of his wife:

There are certain aspects of Western medicine that conflict with our norms, values, and beliefs. The one that concerns me the most is the situation where a male staff carried out an investigation on my wife, asking her to expose certain parts of her body. This is not acceptable. Why must a male staff carry out the investigation? Couldn't a female health staff carry out the investigation? (Interview with Male Participant, M2)

Similarly, another male participant expressed deep concern about a practice that occurs in his community, where strangers are allowed to take their spouses into a room and undress them to observe their bodies. The participant said the practice goes against their beliefs and culture, causing the participant to feel that their spouse has been violated and defiled, an action that resulted in negative emotions such as hatred and jealousy:

The Major area of great concern to us is the practice where somebody you don't know would take your wife inside a particular room and undress her in the name

of investigating or observing a specific aspect of her body. This is a great taboo in our beliefs and culture in this community; whenever my wife comes back from the healthcare centre, I always feel she must have opened the sensitive part of her body to be observed by an unknown person, which implies that that person has defiled her. This makes me begin to feel a kind of hatred in my mind and perhaps jealous (Interview with Male Participant, M1)

Based on his long-term interactions with the community members, one of the health workers highlighted a strong preference for gender segregation in medical contexts. The participant raised an issue regarding female patients receiving healthcare from male health workers, as against the cultural norms, which demand that women should only be in the presence of men who are their husbands. Any interaction or examination of a woman's body for medical purposes should be conducted solely by female medical personnel. In contrast, the participant suggested female medical personnel should be assigned to diagnose or examine female patients to ensure respect for cultural values:

Another issue is that of male health workers attending to a female patient in the community, which they hate. In their culture, no woman should be seen with any man other than her husband for whatever reason, not to talk about observing any part of her body for medical diagnosis or any reason. If need be, the woman must be diagnosed or examined by female medical personnel (Interview with Health Worker, Participant 1)

Another health worker interviewed shared a story of one of his patients, a pregnant woman who was unaware of her pregnancy, visited a hospital for a check-up when she felt unwell. He spoke on how she was sexually assaulted by a male doctor who took advantage of her vulnerability during her examination and incidence that goes against the principles of medical ethics:

There is another instance where a particular pregnant woman decided not to go to the hospital because she was molested (sexually abused) by a male doctor. The pregnancy was at an early stage, and she did not know that she was pregnant because she was always sick. Therefore, she came to the hospital for a check-up. The doctor asked to examine her ignorantly; she complied, but the doctor had a different plan unknown to her. The doctor raped

her. She screamed for help, but it was too late. This is against medical ethics (Interview with Health Worker, Participant 2)

In addition, the participant underscored concerns about perceived shortcomings in the emotional control of some male health personnel, leading to specific cultural practices among women aimed at maintaining modesty and privacy:

Some of the male health personnel are so loose and emotional when it comes to sex. Some male personnel can hardly control their emotion; that is why you see Muslim women cover every part of their bodies to maintain modesty and privacy from unrelated males (males who are not their husbands) whenever they leave their husbands' houses for any outing. Some men cannot hold themselves if they see any sensitive part of a woman.

Moreover, a male participant strongly disapproved of medical practices that involve a male health worker asking his wife to undress for examination, with the belief that such practices go against their community's values. At the same time, he considered such abominable. Hence, he refused to support or encourage his wives to seek any medical treatment at the Western healthcare centres:

Certain medical practices conflict with our values, especially when a male health worker would ask my wife to undress to allow him to investigate certain parts of her body. This practice is an abomination for any reasonable man in my community. As such, I cannot encourage my wives to go to any healthcare centre for any treatment (Interview with Male Participant, M3)

The findings showed a clash between Western medical practices and deeply rooted cultural norms, with concerns ranging from gender sensitivity and privacy issues to instances of alleged sexual abuse. These conflicts have tangible consequences, leading to a reluctance to engage with Western healthcare services in the community. Addressing these issues requires careful consideration of cultural values and implementing measures to ensure respectful and culturally sensitive healthcare practices.

5.10.3: Healthcare and communal belief contrast

This theme refers to a fundamental misalignment or clash between the healthcare services and the deeply ingrained belief system of the participants interviewed. One

of the health workers interviewed spoke on the resistance of the community members in accessing modern medicine and healthcare facilities due to the perception that the services are not aligned with their cultural practices and may put their cultural heritage at risk or dilute the traditions they value, a mindset that can lead to potential health disparities and challenges in providing healthcare to specific populations:

> Another reason is that modern medicine and healthcare facility services are foreign to their culture. As such, they feel that associating with such services will jeopardise their cultural practices, which is their duty to keep and protect so that it is passed from generation to generation (Interview with Health Worker, Participant 1)

Similarly, another health worker interviewed corroborated the earlier view raised by the first health worker interviewed on the non-alignment of Western healthcare with their traditional belief system:

> The services provided in this centre in any way conflict with their beliefs, values, and norms. I stated earlier why the women of this community do not utilise the services provided in the clinic (Interview with Health Worker, Participant 2)

The statement made by a male participant aligns with the responses of the healthcare workers. The participant, who affirmed his non-patronage of the healthcare centre, adjudged belief system as the greatest hindrance to accessing the healthcare facilities:

> *I also have those who do not patronise the facility because of certain beliefs they hold fast. This has been the greatest hindrance to accessing these facilities (Interview with Male Participant, M5)*

Similarly, another male participant analysed his personal belief regarding taking their wives to the hospital for delivery while also acknowledging the contrasting practices of their relatives. He further emphasised the cultural conflict that arose due to the differing values, beliefs, and norms held by the speaker and their relatives:

> *It is not in my belief to take my wives to the hospital for delivery. Still, I have relatives who utilise these services, especially those living in cities, and have attended some form of formal education. These services conflict with our beliefs, values, and norms, which are passed to us from our parents (Interview with Male Participant, M2*)

Also, another male participant provided an insight into the varying behaviours of his relatives towards the utilisation of maternal healthcare centres; while some relatives have benefited from these facilities, others refrain from utilising them due to certain beliefs they hold. The participant was of the view that the discrepancy poses a significant hindrance in accessing quality healthcare, potentially leading to adverse health outcomes for pregnant women and their children:

> *I have relatives, including wives (wife), who have utilised the maternal healthcare centres, but I also have others who do not patronise the facility at the healthcare centre because of certain beliefs they hold fast to, and this has been the greatest hindrance to accessing these facilities (Interview with Male Participant, M4)*

A health worker interviewed emphasised that women who do not seek medical care during pregnancy and instead rely on traditional methods or herbal remedies may be at a higher risk of experiencing complications or adverse outcomes. The participant highlighted the consequences of a woman not receiving proper medical care during her pregnancy, as she gave birth to a malformed child who subsequently died. The statement made by the participant suggests that if the woman had attended antenatal care (ANC), any potential issues would have been detected. Appropriate medical interventions could have been taken, but he was of the view that the involvement of a male herbal doctor and the mention of cultural issues indicate that cultural beliefs and practices may influence women's decisions to avoid healthcare facilities:

> *For instance, a woman had nine children; these children were all delivered at home without a trained health worker. She conceived again, but this time around, there were complications. Instead of going to the hospital, they consulted an herbal doctor for the herbal solution, and Quranic prayers were rendered. She gave birth to a malformed child who died after three days. They all believed it was a punishment of some kind from the gods, but if this woman had attended ANC, it would have been detected, and medical majors would have been taken. The herbal doctor is a male. Therefore, it is more of a cultural issue when these women do not patronise the health facility (Interview with Health Workers, Participant 1).*

Moreover, a health worker highlighted the significance of religious and cultural beliefs in Nigeria, focusing on the northern part. He emphasised how these beliefs impact their perception and approach towards health issues, favouring spiritual explanations rather than purely medical ones:

> *I think it is beyond just being a male health worker. In Nigeria, especially in northern Nigeria, religion/culture is valued even more than one's health. Anything that happens to an individual is attributed to a spiritual attack or punishment from the gods for wrongdoing (Interview with Health Worker, Participant 1).*

The findings showed a complex interplay between cultural values, beliefs, and healthcare services. The fear of cultural jeopardy, conflicts with deeply rooted norms, and strong beliefs are significant barriers, leading to a reluctance to engage with modern medical practices. Understanding and addressing these cultural considerations are crucial for designing effective and culturally sensitive healthcare interventions in the community

5.11: Efficacy of Traditional Healthcare

The theme refers to the effectiveness and success of traditional medical treatments, therapies, and practices in improving patient health outcomes and the overall well-being of community members. Two sub-themes emerged under this theme (Figure 12)

Figure 12: Thematic network showing the efficacy of traditional healthcare

5.11.1: Preference for TBAs' Service

A male participant spoke regarding a community where the roles of TBAs and experienced mothers are integral to maternal healthcare, with a preference for home deliveries despite ANC visits. The participant emphasised financial support,

highlighting a communal approach to supporting women during pregnancy and childbirth within the cultural and traditional context:

> *We have the TBAs who look after our women during pregnancy and delivery. The TBAs also look after them after delivery if there are complications. Apart from the TBAs, we have our mothers who have experience in this area, so we leave everything for the women to handle. My attention is only needed when there is a need to provide anything regarding money. Sometimes, they go for ANC, but delivery is done at home (Interview with Male Participant, M5)*

Similarly, another male participant underscored the complex interplay between traditional, spiritual, and modern healthcare practices in the context of maternal care provided by TBAs. He was of the view that the incorporation of cultural and religious elements in healthcare practices should be considered when designing interventions for improved maternal healthcare outcomes:

> *These TBAs give them herbs and prayers or recite the Quran for Allah (God) to avert the situation. If Allah's wills, these women survive. At times, the TBAs resort to sending these women to the hospital for a further check-up if there are complications (Interview with Male Participants, M4)*

In the same vein, another male participant highlighted the historical healthcare practices of his community, emphasised their reliance on traditional methods and the ongoing use of Traditional Birth Attendants even after the establishment of a health centre:

> *Before establishing the health centre, the People of the Zullum community depended solely on traditional herbs, consultation of native doctors for cure of diseases, and TBAs in terms of pregnancy and delivery, which they still do (Interview with Male Participant, M2)*

Another male participant highlighted the community's positive perception of the traditional medical healthcare service providers, emphasising their effectiveness and the community's self-sufficiency in meeting medical needs locally. However, the participant also raised considerations about the need for a comprehensive understanding of the types of healthcare services provided and the potential limitations of the traditional healthcare system:

People naturally seek help when they cannot provide it. In our case, in this community, the traditional medical healthcare service providers have been doing so well that we do not need to go elsewhere to seek any assistance whatsoever. We rely entirely on them for our medical needs (Interview with Male Participant, M3)

Corroborating the views shared by the male participants, one of the health workers interviewed highlighted a preference for TBAs among some women due to their gender, convenience, and accessibility, especially in situations where the husband's permission may be required. The participant responses suggest that cultural, logistical, and gender-related factors play a role in shaping women's choices in maternal healthcare:

Some prefer TBAs because they are women. Sometimes, their husbands may not be around for them to get permission to go to the hospital, but they can call the TBA to their houses because they are women (Interview with Health Worker, Participant 2).

In addition, the participant sheds light on the preference for Traditional Birth Attendants (TBAs) in the context of maternal healthcare in the northern part of Nigeria, and it raises concerns about the practices employed by TBAs. The participant shared a complex scenario where the preference for TBAs coexists with fears of their rules and also the realisation that the TBAs' training needs improvement, especially regarding recognising and managing complications:

When it comes to MHSs in the northern part of Nigeria, most women prefer to use the TBAs. They should be trained to know the delivery complications, especially in the third trimester. They need to know when to induce labour. When the dilation is 5-7cm, the TBAs tend to give these women a concoction to make them deliver before it reaches 10cm. This complicates the third stage, which is supposed to be observed (Interview with Health Worker, Participant 2).

Another health worker shared progress he observed in healthcare utilisation, particularly among pregnant women, but also highlighted a challenge in the form of a preference for traditional birth attendants, whereas addressing this Challenge and

continuing efforts to improve healthcare services could contribute to more comprehensive and effective healthcare delivery in the community:

> *There is a slight improvement in patronage, especially among pregnant women, because this is the only healthcare facility around here. We see pregnant women around the community coming to the facility for services; this has been encouraging. However, most pregnant women tend to stay away or prefer other services like traditional birth attendants (TBA) (Interview with Health Worker, Participant* 1)

The findings showed reliance on the role of Traditional Birth Attendants (TBAs) in the community, providing care to women during pregnancy, delivery, and post-delivery complications, the existence of Traditional medical service providers in meeting the community's healthcare needs before Western healthcare, Preference for TBAs Over Hospitals, the comfort of having female attendants, and the need to train TBAs to recognise complications and handle deliveries responsibly.

5.11.2: Herbs Efficacy

This theme refers to relying on herbal remedies for medicinal purposes and the accompanying belief in the effectiveness of these natural substances. A male participant spoke regarding a sense of discouragement from accessing modern healthcare services within the community, with a preference for traditional herbal medicines that have been used for an extended period. He spoke on how the community's reliance on conventional practices reflects a cultural and historical dimension to their healthcare choices:

> *Finally, when specific ailments escalate from the locals, we will likely be referred to the city for treatment even if we go to the healthcare centre. These issues discourage us from accessing healthcare services; to a greater extent, members of this community are satisfied with the herbal medicines that have been in use for ages (Interview with Male Participant, M2)*

Another male participant shared a historical and cultural perspective on healthcare practices in the community. He believed that the use of traditional herbs is deeply rooted in the community's history, passed down through generations, and continues to be valued for its perceived efficacy in addressing health needs. At the same time,

the statement suggests a connection between cultural heritage and the community's approach to healthcare. According to the participant:

> *Before Western medicine came, our forefathers used traditional herbs for treating ailments and diseases. They depended on conventional medication for their primary health needs. This has been passed down from generation to generation. These herbs are gotten from the roots of plants and offer the active ingredients of, if not all, our traditional medicines then most of it (Interview with Male Participant, M3)*

In addition, the participant provided insights into traditional healers' qualifications, practices, and beliefs, emphasising the plant-based nature of traditional medicine, the significance of specific natural environments, and the importance of adhering to prescribed rules to avoid serious complications. In contrast, he emphasised the cultural and spiritual dimensions of traditional healing:

> *To be a traditional healer, you must have some form of foresight to commune with the environment (plants) to understand it. Traditional medicine is plant-based, with prayers and invocations to activate its effect. Plants from the deep forest are more productive and powerful than those that grow close and are more appropriate for treating severe complications. When mixed with Western medicine, it results in serious problems. As a result, specific instructions are given on how and when to administer these herbs. If these laid down rules are not followed, the woman in question may end up losing her life or that of her newborn.*

Participant Four discussed a holistic approach to childbirth by TBAs, involving traditional herbal remedies, prayers, and Quranic recitation. He mentioned the community's belief in the interplay between divine will and healthcare practices is evident, along with a pragmatic approach to seeking hospital assistance in case of complications; hence, the integration of cultural, religious, and modern healthcare elements is a vital aspect of the community's maternal healthcare practices. According to the participant:

> *These TBAs give them herbs and prayers or recite the Quran for Allah (God) to avert the situation. If Allah's wills, these women survive. At times, the TBAs*

resort to sending these women to the hospital for a further check-up if there are complications (Interview with Male Participant, M4).

Another male participant highlighted the enduring influence of traditional healthcare practices in the community, focusing on spiritual attributions for ailments and a continued reliance on traditional healers. The participant mentioned the coexistence of traditional and modern healthcare practices poses challenges for healthcare integration and utilisation of government-provided health services:

Before establishing the health centre, People of this community depended solely on traditional herbs, consultation of native doctors for cure of diseases, and TBAs in terms of pregnancy and delivery, which they still do. For instance, someone with a particular ailment is considered spiritual, so they consult native doctors and traditional healers for a cure. As such, very few use the health facilities provided by the government (Interview with Male Participant, M1).

A male participant underscored the strong influence of cultural and spiritual factors on healthcare practices within the community. He emphasised the prevalence of attributing ailments to spiritual causes and the preference for traditional healing methods shape the community's healthcare-seeking behaviour, leading to limited utilisation of government health facilities and scepticism toward modern medicine:

For instance, someone with a particular ailment is considered spiritual, so they consult native doctors and traditional healers for a cure. As such, very few use the health facilities provided by the government. At the same time, others did not believe in modern medicine (Interview with Male Participant, M2).

A participant, a health worker, spoke on the spread of disinformation within the community regarding medications at the healthcare facility, which has led to a decline in healthcare utilisation. The narrative, suggesting intentional harm to fertility and population control, reflects trust erosion in the healthcare system. His statement showed that addressing and correcting these false narratives is essential to rebuilding community trust and ensuring access to necessary healthcare services. According to the participant:

Another doctored story is going around the community that most of the medications given to people at the healthcare facility are deliberately made with

some chemicals aimed at destroying their fertility and eventually destroying or greatly reducing their population. This disinformation makes many of the community members stay away from patronising the healthcare facility (Interview with Health Worker, Participant 1)

The findings showed that the community has a firm reliance on traditional medicine, mainly herbal remedies. TBAs play a significant role in managing complications during pregnancy and delivery, employing a combination of herbs and prayers. Prevalent distrust in Western medicine, fuelled by misconceptions and reluctance to access healthcare services with the belief that specific ailments are attributed to spiritual causes, leads many to consult traditional healers, attribution of diseases to spiritual reasons, and a spread of disinformation suggesting healthcare facility medications are intentionally harmful.

5.12: Maternal Healthcare Factors

The theme refers to the healthcare system's challenges, problems, or shortcomings that hinder women's effectiveness in utilising maternal healthcare centres. Four sub-themes emerged under the theme (Figure 13).

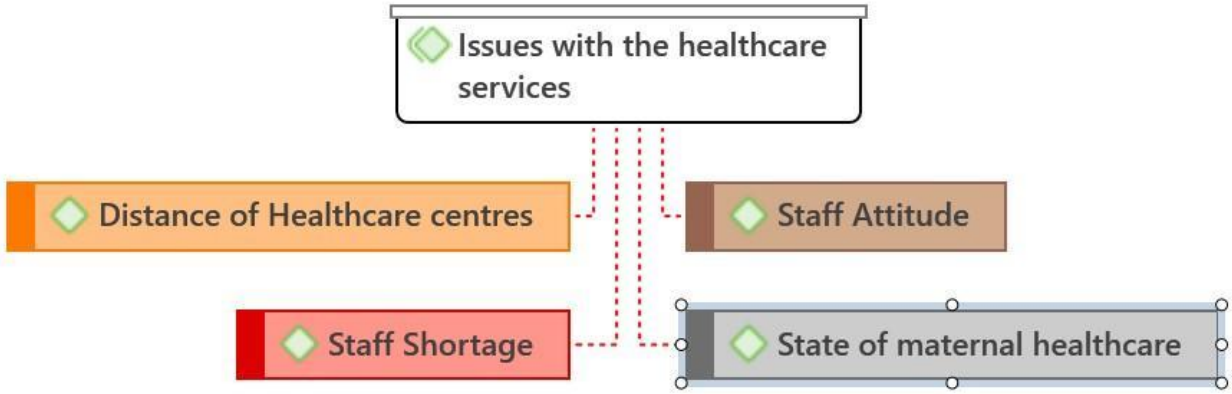

Figure 13: Thematic network showing issues with the healthcare services

5.12.1: Staff Shortage

The theme shows the inadequate number of appropriate health workers available for work in healthcare centres. A health worker expressed his dissatisfaction with the healthcare services in the rural area, highlighting challenges related to limited staffing and its impact on service efficiency, a statement that suggests potential implications

for the community's access to quality healthcare and may serve as a call for attention to address staffing issues in the rural healthcare setting. According to the participant:

> *To be candid with you, the services in the rural area are boring. This is because we get two or three health personnel in the clinic, and it runs all the services to meet the health needs of the entire community with few or limited staff. It makes it difficult for the staff to work efficiently (Interview with Health Worker, Participant 1)*

In addition, the participant emphasised the shortage of human resources in different levels of hospitals and advocates for training Traditional Birth Attendants as a community-centric solution to address gaps in maternal healthcare:

> There is a shortage of human resources in tertiary, secondary, and primary hospitals. Therefore, it is essential to train the TBAs because they play a key role in our communities.

Similarly, another healthcare worker revealed significant gaps in personnel and expertise needed to cater to the medical requirements of the community. He pointed out the absence of medical professionals alongside the limited support from a security guard and cleaner, emphasises the urgent need for additional human resources in the facility to address the medical needs effectively:

> *We lack the human resources to meet this community's medical needs or demands. As you can see, only three are working here: the security guard, the cleaner, and myself. The security guard keeps watch of the facility at night while the cleaner comes three times a week to clean the facility (Interview with Health Worker, Participant 2)*

Buttressing the response above, the participant sheds light on the challenging circumstances he faced as a single health worker responsible for the medical care of an entire community, "I am the only trained health worker providing medical care to the community's entire population." A male participant highlighted the challenges and potential limitations of healthcare services, particularly in terms of resource shortages and referral systems for complex cases, in connection with the emotional toll and significant loss associated with the death of a newborn child:

Have you had relatives, including wives, that have to utilise the health centre? *My wife has given birth to about five children now, though one was given birth at the healthcare centre but not in this community. We were referred to another health facility because of the shortage of human resources and referral services in case of complications. The only child she gave birth to at the hospital came with some difficulties, which made it necessary for us to take her to the hospital. My wife delivered the baby after about a day of painful labour at the healthcare centre. The child only lived for six hours, after which he sadly gave up the ghost (Interview with Male Participant, M2).*

The participant underscored the general problem of a shortage of human resources in healthcare facilities, using the specific example of a health centre that experienced declining staffing levels over the years. He highlighted the impact on maternal health services and emphasised the need for attention to staffing issues to improve healthcare delivery in the community:

The shortage of human resources is a general problem for most of the facilities in this area and neighbouring villages. After establishing the health centre 12 years ago, it was functional. It had sufficient health workers, availability of drugs, and provision of referral services. Our wives need not travel long distances for delivery except in special cases. But as I am speaking, we have only one male health worker who is not always on the seat.

A health worker mentioned the challenges in the healthcare sector, emphasising the impact of understaffing on patient experiences and the workload of healthcare professionals. The participant called for government action to bridge the gap between training and employment, highlighting the need for a systemic change to address these persistent challenges in the healthcare system:

Yes, most hospital and clinic patients complain about waiting time, rebooking, etc. We have a small number of health personnel to meet the daily health needs of patients. Some are retired, and some are dead without the government replacing professionals to fill the vacancy, from primary healthcare to tertiary institutions. You would see one doctor/nurse seeing over 200-300 patients a day. It makes the workload overbearing for the professionals. The government keeps training them but gives them no employment. To curb the health sector's

challenges, the government needs to start employing those they have prepared (Interview with Health Worker, Participant 2)

A health worker drew attention to an unequal distribution of health workers based on gender, which has consequences for both access to healthcare services and gender equality. He was of the that addressing this issue requires policies aimed at ensuring equitable deployment of health workers to remote areas and improving opportunities for women to receive medical training and actively contribute to the management of healthcare centres:

Conversely, the government does not send women nurses or female health workers to remote areas away from their husbands, so most health workers in remote areas are men. Female health workers are found in or around city centres. The remote community women are illiterates who cannot acquire the needed medical training that will enable them to manage the healthcare centres in their communities (Interview with Health Worker, Participant 1)

The findings showed staffing challenges in rural healthcare, shortage of human resources across tiers, the impact of the lack of human resources on maternal and child health, historical functionality and current difficulties, overburdened healthcare professionals due to the shortage of healthcare professionals, and gender disparities in the distribution of healthcare workers.

5.12.2: Staff Attitude

The theme refers to the behaviour and overall approach exhibited by health workers with the patients that utilise the healthcare facilities. A male participant addressed concerns about the lack of respect for women by healthcare staff, emphasising the emotional impact of such experiences and advocating for a more respectful and patient-centred approach in healthcare interactions:

The other issue is these health staff's lack of respect for our women. This is another painful experience; why would someone feel superior simply because they are a health worker? I don't want a situation where my wife would come back and tell me someone at the hospital disrespected her (Interview with Male Participant, M2)

Another male participant conveyed negative experiences of women in healthcare centres, emphasising issues such as inadequate facilities, poor reception, and lack of respect for older people. The participant also mentioned the need for improvements in healthcare practices to ensure a positive and respectful environment for all individuals seeking healthcare services, especially women. According to the participant:

> *Most testimonies from these women are discouraging to many women who had never experienced any healthcare treatment at the healthcare centres. They complain of inadequate facilities, poor reception at the healthcare centre, and lack of respect for older people or the elderly. These are very terrible practices that tend to hurt our women whenever they go to the health centres, especially those centres that are located in the cities (Interview with Male Participant, M4)*

Another male participant shared a significant complaint about perceived disrespect towards individuals with limited formal education at the health centre. The participant emphasised that the reluctance to return suggests a broader issue with healthcare practices that need attention and improvement, particularly in terms of cultural sensitivity and respectful treatment for all patients:

> *My wife complained bitterly about how she was treated at the health centre. She said most of the workers spoke to them without regard because they were illiterates with no formal education; they had not handled the way educated women were. My wife does not want to go back to the health centre because of this reason and other healthcare practices which our wives find uncomfortable whenever they visit the hospital (Interview with Male Participant, M1)*

Another male participant raised concerns about the behaviour of young medical personnel, highlighting perceived arrogance, a lack of respect, and a deviation from cultural expectations regarding interactions with older community members. He emphasised the importance of maintaining respectful conduct, especially in the context of healthcare interactions within the community:

> *Sometimes, the medical personnel are very young and do not know what they are doing. Health professionals are supposed to see the aged or at least those older than them and then salute them before passing by as a sign of respect and recognition. In the case of what is happening, these little children are*

feeling too big most of the time when they meet our women; they expect our women to salute them or even give them a way to pass before them simply because they are medical personnel. What a shame (Interview with Male Participant, M4)

A health worker emphasised the absence of corrupt practices in their clinic and the proper handling of free drugs. He indirectly acknowledged the possibility of such practices existing in other communities but reiterated their positive experience in their clinic:

I wouldn't know if this is practised in other communities because some of the staff are greedy and want to use any means to get money, but I would gladly tell you that I have stayed in this clinic for ten years, nothing of such. Whenever there are free supplies of drugs, we disburse these drugs accordingly. For example, immunisation, ANC, and any under-five services are free. Health committees oversee the disbursement of these free drugs, and representatives are sent to, if not all, of the clinics to monitor what the health workers are doing (Interview with Health Worker, Participant 2)

On the other hand, the health worker underscored the influence of past negative experiences with health personnel as a reason for some women's non-utilisation of maternal health services. To address this, sensitisation and awareness campaigns are being conducted to improve women's understanding of the services available and reduce any apprehensions caused by previous encounters:

Well, it could be because of what they (patients) experienced. We go for sensitisation and creating awareness about maternal health service use in the community. The few women I had an opportunity to chat with told me that some do not utilise MHSs because of the negative attitude of the health personnel they have come in contact with.

The findings showed a lack of respect for women by health staff, discouraging testimonies from women, discontent with treatment at health centres, young medical personnel, and lack of care, the response from health workers, and sensitisation efforts and impact for promoting maternal health services.

5.12.3: Distance of healthcare centres

This theme shows how far or near maternal healthcare is to the community members. A male participant highlighted the speaker's challenges in accessing a health facility due to distance and associated transportation costs. He raised broader considerations about the intersection of financial capacity and healthcare accessibility, highlighting potential disparities in access based on socioeconomic factors:

> *The health facility is far from my place. It would cost me eight hundred naira for transportation to and from the health centre. I believe it is accessible to the people around the facility and to those who are financially strong (Interview with Male Participant, M2)*

In addition, the participant underscored the complexity of reasons for not accessing healthcare services, with a specific emphasis on proximity as a major barrier., a response that suggests a need for strategies to improve the accessibility of healthcare services, especially concerning travel distances. According to the participant:

> The reasons are enormous; it is not like we hate the healthcare centres, but certain factors prevent us from accessing the services; firstly, proximity is a big issue; one has to travel a long distance to access these services.

Another male participant highlighted the distance of the healthcare centre to his residence alongside the cost of transportation:

> *It is pretty far from my place. It would cost me a thousand naira for transportation to and from the healthcare facility. Still, I believe it is accessible to those living close to the health centre or those with the means of transport no matter the distance (Interview with Male Participant, M3)*

The findings showed that despite the challenges posed by the distance, there is a recognition that those living close to the health centre or individuals with the financial means to cover transportation costs may find it more accessible.

5.12.4: State of Maternal Healthcare

This theme describes the condition or status of healthcare services provided to pregnant women, mothers, and newborns within a specific region or community. The theme encompasses various aspects, including the availability, accessibility, quality, and utilisation of maternal health services. A male participant interviewed affirmed the

existence of a healthcare facility in the community, indicated his knowledge about it, and highlighted its long-standing presence, "Yes, there is a healthcare facility in my community. I know quite much about it, and it has been in existence long before now" (M2). The participant highlighted establishing a healthcare centre in a neighbouring community during a democratic regime, with efforts to engage the community and publicise the project. The participant mentioned the inadequacy of facilities in the healthcare centre:

> *The mass mobilisation was done before establishing the healthcare centre in the neighbouring community, and it was done during the democratic regime. Every project bid was publicised in the media for the government to score political points. Few people enjoyed the services when it was newly established. Secondly, the facilities are not adequate (Interview with Male Participant, M2)*

A health worker interviewed acknowledged the small size of the healthcare facility in Kadage Village, emphasising its role in meeting the basic and daily medical needs of the local community, "This healthcare facility is a small one to meet the basic and daily medical needs of the Kadage Village people," (P1). Another male participant highlighted concerns about limited access to drugs and the inconsistent availability of health providers in the community. The participant underscored the importance of reliable healthcare services and raised questions about the reasons behind these challenges, advocating for potential improvements in healthcare delivery:

> *Most times, drugs to treat common diseases are hard to come by. Is there a reason why the health provider is not always around? How would I know? I know he is not always available, and I am not the only person who has observed it. (Interview with Male Participant, M2)*

Another male participant interviewed communicated a personal perspective on healthcare facilities, stating that they were not helpful to him because they did not utilise them: "In my case, these facilities are not helpful because I do not utilise them" (M3). The first health worker interviewed discussed the surplus of medical drugs, extended storage periods, efforts to revive a healthcare facility after twelve years, and the current underutilisation of the facility. He emphasised the importance of aligning healthcare services with the needs and preferences of the community to ensure effective and sustainable healthcare delivery:

Most times, the medical drugs supplied do not get exhausted within the stipulated time frame, so the drugs end up in the store for a year or more. After twelve years, it was revived and brought to life to benefit the community's people. The facility is there without people to utilise it (Interview with Health Workers, Participant 2)

In addition, the participant highlighted the abandonment of the healthcare facility due to a lack of community patronage, leading to the government's decision to discontinue allocating resources:

> The facility was once abandoned due to a lack of patronage by the community's people. The government felt it could not continue to spend money and waste its resources on such a community that does not need these services.

The findings showed mass mobilisation and initial utilisation of maternal healthcare, concerns about inadequate facilities in the healthcare centre, difficulties in accessing drugs for common diseases and inconsistent availability of the health providers, underutilisation of healthcare facilities, expiration of medical drugs, and abandonment and lack of patronage.

5.13: Women's Issues

Women's Issues typically refer to matters or concerns that specifically affect women individually or personally. Two sub-themes emerged under this theme (Figure 14).

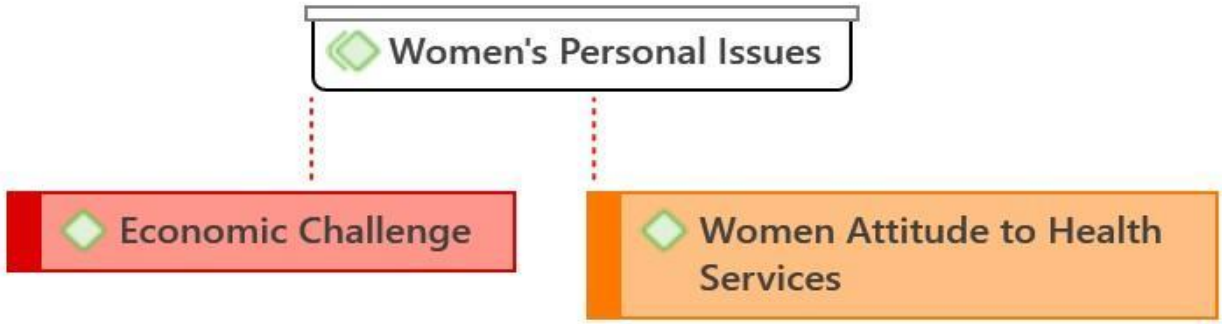

Figure 14: Thematic network showing women's issues in accessing healthcare

5.13.1: Economic Challenge

Economic Challenge refers to difficulties, obstacles, or hardships that individuals, communities, or societies face in managing their financial resources, sustaining livelihoods, and addressing economic needs. A male participant highlighted the

interconnected challenges of geographical distance and financial constraints that can impede healthcare access;

> *The health facility is far from my place. It would cost me eight hundred naira for transportation to and from the health centre. I believe it is accessible to the people around the facility and to those who are financially strong (Interview with Male Participant, M2)*

Similarly, a male participant highlighted the multifaceted nature of healthcare accessibility, incorporating geographical, economic, and individual factors. The perception of accessibility is not uniform and is influenced by the specific circumstances of individuals within the community:

> *It is quite far from my place. It would cost me a thousand naira for transportation to and from the healthcare facility. Still, I believe it is accessible to those living close to the health centre or those with the means of transport no matter the distance (Interview with Male Participant, M3)*

Another male participant spoke on the intersection of economic factors, healthcare costs, and decision-making within the farming community. The perceived financial challenges contribute to a preference for home delivery, emphasising the need for solutions that make healthcare services more accessible and affordable for individuals with limited financial means:

> *You know we are farmers and do not have any other source of income. Hospital services are costly; if your wife delivers in any healthcare facility, it will cost you not less than twenty thousand naira (#20000). This amount is a fortune for most of us. Some of us cannot raise that much within a year, so this is one of the reasons we prefer delivering at home (Interview with Male Participant, M4)*

Another male participant mentioned the dynamic nature of healthcare access decisions, influenced by personal resources, transportation availability, and economic considerations; he demonstrated a practical approach to ensuring their spouse can access healthcare services in a manner that is both feasible and economical:

> *Well, that depends on one's strength. When I had a motorcycle, I used to take her myself to the hospital, but today, the bike is not there. I only give her money*

to access the services of the healthcare centre. This is more economical than going there together with her in that situation (Interview with Male Participant, M1)

A health worker interviewed underscored the importance of understanding and adapting to the local context in healthcare delivery. He mentioned the adaptive measures taken by healthcare staff, along with community-wide communication, indicate a collaboration:

The few patients utilising these services always complain about the items they have been asked to bring for delivery, such as bleach, pads, and the like. Therefore, the staff only tells the patients to wash their old wrappers and come with them, and then they provide the pad for cleaning the child and the bleach to disinfect the surface after delivery. By so doing, they tell their fellow women to come to the clinic for ANC and delivery (Interview with Health Worker, Participant 2)

The findings showed that the geographical distance of the healthcare centres, financial constraints for transportation, preference for home deliveries, patients utilising healthcare services expressing concerns about the items requested for delivery, and economic considerations play a role in the choice for home deliveries.

5.13.2: Women's Attitude to Maternal Healthcare

The theme concerns women's general behaviours, beliefs, and perceptions of healthcare and medical services. A health worker interviewed spoke on the connection between the timing of healthcare seeking during childbirth and maternal deaths. He emphasised the need for addressing behavioural factors and potential barriers to ensure that mothers seek medical assistance promptly, ultimately improving maternal and child health outcomes:

What leads to these deaths sometimes is the negligence of the mothers. They stay at home during labour and only come to the clinic only when they cannot give birth by themselves due to complications (Interview with Health Worker, Participant 2)

The participant emphasised the importance of continuous ANC and the potential risks associated with assuming a static standard presentation. He underscored the need for

education, communication, and community health strategies to promote consistent antenatal care and improve maternal and child health outcomes:

> Sometimes, the presentation of the unborn child may not be usual, and the mothers may not be aware. When they come for ANC at some point and are told that the child is average, they never return to the clinic again, not knowing that the child's positioning may likely change and lead to delayed labour and uterine death before the patient is brought to the clinic.

Also, the participant highlighted an individual's proactive and community-oriented approach to improving healthcare access. By addressing financial barriers and encouraging clinic visits, the participant fostered a supportive environment for maternal healthcare within the community, "In my experience, I have used my money to provide the necessary items needed during labour to encourage these women to come to the clinic."

The findings showed the emphasis of the health worker that maternal deaths are sometimes linked to maternal negligence, as mothers tend to stay at home during labour and only seek clinical assistance when complications arise. Additionally, the health worker notes that some mothers may not be aware of abnormal presentations of the unborn child, leading to delayed labour and potential risks.

5.13.3: Women's use of maternal healthcare

This theme refers to the participants' views on how pregnant women access and receive essential healthcare services during pregnancy, childbirth, and postpartum in community healthcare centres. Two sub-themes emerged under this theme (Figure)

5.13.3.1: Emergent use

The theme refers to community members' utilisation of maternal medical services when they are in urgent and critical situations related to pregnancy and childbirth. A male participant spoke on a cautious and selective approach to healthcare services. He acknowledged the benefits of hospitals while expressing a preference for home remedies using a pragmatic approach to seeking professional medical assistance when needed:

> *We do not like going to healthcare centres for any medication or treatment. It is only utilised when it becomes necessary. When all options at home are exhausted, and there is no relief, we rush to the hospital. The hospital has been*

beneficial. Today, we don't have to go a far distance to access these essential healthcare services (Interview with Male Participant, M1)

A male participant spoke about the expertise of TBAs in managing childbirth complications with traditional methods. He also said the awareness of the limitations and a collaborative approach with modern healthcare is recognised when necessary; balancing traditional practices with timely referrals to hospitals contributes to comprehensive maternal healthcare:

If there are complications, the TBA takes care of that by the use of herbs, but if the complication is something that the TBA cannot manage, she advises we take the pregnant woman to the hospital services (Interview with Male Participants, M5)

Another male participant spoke about the community's reluctance to visit healthcare centres, indicating a need for targeted efforts in community engagement, trust-building, and health education:

We do not like going to healthcare centres for any medication or treatment. It is only utilised when it becomes necessary. When all options at home are exhausted, and there is no relief, we rush to the hospital. The hospital has been beneficial (Interview with Male Participant, M2)

Another male participant indicated a pattern where hospital visits are often prompted by severe complications during childbirth, leading to challenges in reaching the hospital in time:

We go to the hospital mostly when there is a complication that cannot be managed at home. Most of the time, women who are taken to the healthcare facility for delivery end up delivering on the way to the hospital (Interview with Male Participant, M4)

A male health worker highlighted a prevalent trend of limited utilisation of maternal healthcare services, with women predominantly staying at home during pregnancy, seeking professional assistance primarily in response to complications:

But in terms of utilising maternal healthcare services, it is not encouraging. Most of these women stay at home from conception to delivery. The few that come

around are due to complications during childbirth (Interview with Health Worker, Participant 2)

The findings showed women's reluctance to seek healthcare at maternal healthcare unless necessary, the role of Traditional Birth Attendants (TBAs) in managing complications using herbs, visitation to hospital primarily driven by complications that cannot be managed at home, and limited utilisation of maternal healthcare services.

5.13.3.2: Enlightenment

A male participant suggested a pragmatic and informed approach to healthcare, recognising both traditional and modern practices. The decision to choose herbal solutions or hospital delivery seems to be influenced by factors such as enlightenment, individual preferences, and perhaps the specific needs of each pregnancy:

Well, I cannot say there is nothing as such, but we do not rely entirely on herbal solutions to every pregnancy-related problem because there is enlightenment. This is why one of my children was delivered in the hospital (Interview with Male Participant, M1)

Another male participant highlighted the family structure, the number of children among the wives, and the community-wide practice of attending ANC while opting for non-hospital deliveries. The healthcare choices align with cultural and community norms, showcasing the influence of local practices on maternal healthcare decisions within the family and the broader community:

I have four wives. My first wife has eight children, the second has five, the third has four, and the last has five. None of them went to the hospital for delivery but went for ANC at one point or the other. However, some of the women in this community have included a few of my relations (Interview with Male Participant, M2)

Another male participant spoke on the combination of modern healthcare practices, such as regular antenatal care and adherence to professional advice, with an awareness of traditional dietary methods. The family dynamic includes a collaborative effort in household tasks, reflecting a holistic approach to maternal care that considers both the health and well-being of the pregnant wife:

My wife does go to the maternity for antenatal care. We follow the advice of health care professionals. However, we know both traditional and modern types of food are prepared to provide blood and nutrition to women. I relieve my wife from any hard work that requires much energy. She is only allowed to cook food for the family, which is less stressful, and sometimes her co-wives assist (Interview with Male Participant, M1)

I encourage my wives to go for antenatal care at the maternity unit because I know the advantages of utilising the modern healthcare system. We try to adhere to the instructions of the healthcare extension workers. However, we are familiar with both traditional and modern maternal services. We tend to abide by this advice. I ensure my wife doesn't get engaged in any hard work that may disturb her. She is only allowed to cook food for the family, which is less stressful, and sometimes her co-wives or her mother-in-law (Interview with Male Participant, M2)

The findings showed the expression of male participants about a nuanced approach to maternal healthcare, acknowledging both traditional and modern practices. While some have relied on herbal solutions in the past, there is a growing awareness and reliance on modern healthcare facilities. Participants highlighted instances where their wives went for antenatal care in maternity facilities, demonstrating a willingness to incorporate modern healthcare practices. The participants emphasise the importance of following healthcare professionals' advice, ensuring their wives' well-being during pregnancy, and balancing traditional and modern approaches to maternal services.

The findings showed participants' approach to maternal healthcare, growing awareness and reliance on modern healthcare facilities, integration of contemporary healthcare practices like wives seeking antenatal care and willingness to embrace modern maternal healthcare, the importance of healthcare professionals' advice, and balancing traditional and modern approaches.

5.14: Maternal **Healthcare** Adjustments

The theme refers to the suggested actions and strategies put forward by the participants to improve pregnant women's overall well-being and healthcare outcomes. Three sub-themes emerged under this theme (Figure 15).

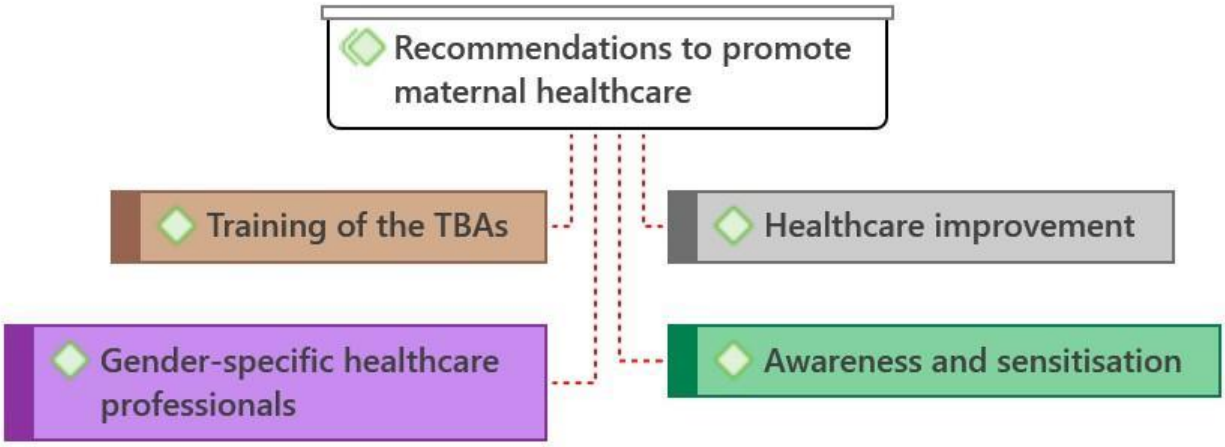

Figure 15: Thematic network showing recommendations to promote maternal healthcare

5.14.1: Awareness and sensitisation

The theme refers to educating the maternal healthcare stakeholders on specific issues, topics, or activities related to healthcare-seeking behaviour. A male participant advocated for an all-women healthcare team, including doctors, as a means to enhance healthcare utilisation, particularly for women's health, with the belief that such a change could address existing barriers and improve the overall experience and comfort of women seeking healthcare services:

> *I want to suggest to the government that when it comes to women's health, let the health professionals be all women, including doctors. If this is done, my problem and that of others who do not utilise the healthcare centre I mentioned earlier will start using these services (Interview with Male Participant, M2)*

A health worker's proposed strategy involves a targeted and culturally sensitive approach, focusing on community leaders and men, to educate the community about the importance, harmlessness, and effectiveness of healthcare services. This approach seems to recognise the role of influencers in the community and aims to create a foundation for positive healthcare practices:

> *I think the best way is to start educating the community leaders (the traditional chiefs) and then the community's men about the importance of healthcare services and how harmless and effective it is (Interview with Health Worker, Participant 1)*

In addition, the participant, in a call to action directed at the government, urging them to initiate awareness campaigns, promote healthcare utilisation, and address the specific challenges related to high infant and maternal mortality rates, especially in the context of prevailing illiteracy:

> I will advise the government to create awareness of the need and importance of health care utilisation because of the high infant and maternal mortality rate in the country where illiteracy thrives. There is a need for mass mobilisation by the government to use maternal health services to curb or reduce high death rates in both women and children.

The findings showed demand for gender-specific healthcare providers, community education and leadership involvement, and government-led awareness campaigns.

5.14.2: Training of the TBAs

The training involves providing education and skills to Traditional Birth Attendants (TBAs) who traditionally assist women in childbirth. A male participant appreciated the government providing training for the TBAs, "That would be great if the government can help train" (Interview with Male Participants, M2). Another male participant spoke about a positive attitude toward advancing the role of TBAs in the community through training and financial support. He underscored the potential for TBAs to contribute more broadly to community health, emphasising a holistic and community-driven approach to healthcare development**:**

> *It would be great if the TBAs were given advanced training to help them manage even diseases alien to the community. I also hope they will find some form of stipend to help their speedy development (Interview with Male Participant, M2)*

Also, a male participant advocated for a collaborative and community-centric approach to healthcare by incorporating trained TBAs into the formal healthcare system. He emphasised the importance of cultural competence, community empowerment, and the integration of traditional and modern healthcare practices to enhance maternal healthcare services in local communities:

> *Let the government of the day employ our TBAs, train them, and after the training, let the government bring these healthcare centres to our communities where those that would serve us would be people from our community who are*

part of our culture and know our way of living (Interview with Male Participant, M4)

The findings showed recommendations for advanced training for traditional birth attendants (TBAs), financial support for the TBAs, and employment and community-centric healthcare centres.

5.14.3: Gender-specific healthcare professionals

The theme involves advocacy for male health workers to attend to male patients and female health workers to attend to female patients only. A male participant desired gender-specific healthcare providers, emphasising the potential impact on patient comfort and satisfaction. He was of the view that understanding and acknowledging such preferences can contribute to more patient-centred and culturally sensitive healthcare practices:

> *Yes, of course, I feel if most or all the doctors and nurses that attend to our women would be women while those that attend to men at the healthcare centre would be men, that would make life look good for most of us (Interview with Male Participant, M1)*

Gender-specific preferences in healthcare settings to address cultural sensitivities and enhance patient comfort, particularly concerning potential issues related to jealousy or discomfort, were emphasised by a male participant:

> *I want to advise those healthcare centres. Let men attend to men, while women should attend to women. When this is adhered to, most of our jealous behaviours will be taken care of (Interview with Male Participant, M4)*

The findings indicated a preference among male participants for gender-specific healthcare providers. The participants believe that such gender-specific assignments for healthcare professionals would contribute to a more comfortable and harmonious healthcare environment for the community.

5.14.4: Healthcare improvement

The theme refers to systematic efforts and strategies to enhance the quality, efficiency, safety, accessibility, and overall performance of healthcare services, as suggested by the participants. The importance of recognising and preserving traditional herbal

medicine, advocating for a more inclusive healthcare approach that respects cultural practices alongside conventional methods was suggested by a male participant:

> *Another issue that needs the attention of the government is the issue of ignoring traditional herbal medicine. The government is fun of saying the conventional way of caregiving is terrible, while most of us grew up using that system of healthcare management (Interview with Male Participant, M4)*

A male participant highlighted the importance of equality, fairness, and respect in patient care, urging healthcare providers to adopt a disciplined approach that ensures every patient is treated with dignity and receives attention on a first-come, first-served basis:

> *Likewise, if the healthcare givers were disciplined enough to consider every patient equal at the healthcare centre and give attention on a first-come, first-served basis, that would help and accord them their respect (Interview with Male Participant, M2)*

The need to support healthcare services with the expectation of some specific issues to be addressed first was suggested by another male participant. The statement reflects a desire for improvements in the healthcare system to ensure better outcomes for the speaker's family members and, potentially, the community at large. According to the participant:

> *Yes, if all these things are corrected, I would give every support needed to make my wives and relations utilise the services (Interview with Male Participant, M4*)

A male participant recommended an all-female healthcare team for women's health, anticipating that such an approach would increase healthcare utilisation among individuals who currently avoid healthcare services; a statement that reflects a consideration for cultural sensitivity, comfort, and trust in healthcare interactions:

> *I want to suggest to the government that when it comes to women's health, let the health professionals be all women, including doctors. If this is done, my problem and that of others who do not utilise the healthcare centre I mentioned earlier will start using these services (Interview with Male Participant, M3)*

Similarly, a health worker advocated for providing a special allowance to female medical workers in remote health centres, emphasising the importance of recognising and addressing the challenges faced by women in the medical profession, particularly in less accessible locations:

> *There is also the need to give female medical workers who are posted out of city centres a special allowance to serve as an incentive to encourage women to work in remote health centres away from their homes (Interview with Health Worker, Participant 1)*

In addition, the participant highlighted the potential benefits of education for females in the community, emphasising the role of educated women in addressing healthcare needs and promoting community development, particularly within the healthcare sector:

> *The community members (females) should be encouraged to go to school to a certain level to be employed to serve at the healthcare facilities located in their communities (Interview with Health Worker, Participant 1)*

The findings showed suggestions for recognising traditional herbal medicine, equality and respect in healthcare centres, gender-specific healthcare professionals, incentives for female medical workers, and encouraging education for female community members.

5.15: Summary of Findings

This section summarises findings of the women's lived experiences and perspectives of the maternal healthcare stakeholders shared on utilising maternal healthcare.

5.15.1: Summary of findings of women's lived experiences

The communities exhibited a distinct and influential belief system that significantly shapes perceptions and behaviours related to healthcare. The findings showed:

- The women felt more at ease and preferred healthcare services from female health workers.
- Women's mobility and access to healthcare are heavily regulated by husband supremacy rooted in traditional norms.
- Women have the natural strength to deliver their babies without visiting any maternal health care for delivery.

- Community members relied heavily on traditional caregiving, which they considered a better alternative to modern healthcare services due to tradition and spiritual efficacy characteristics.
- Women preferred the service of TBAs because of factors beyond medical considerations, like herbs, same-gender status, and being economical.
- Women lack financial support from their husbands while they are too poor to afford medical services,
- Western healthcare was adjudged to conflict with traditional healthcare services because of spiritual beliefs, societal judgments, and a sense of cultural identity, which were considered not obtainable in Western healthcare services.

There were various elements and characteristics associated with healthcare centres and facilities. The findings showed:

- Insufficiency and accessibility challenges in maternal healthcare encompass women's unfavourable encounters and discontentment with the healthcare facility.
- Participants expressed concerns about the limited-service offerings and a shift toward serving a more privileged demographic.
- Many women discussed the use of the maternal healthcare centre, mostly during emergencies like complications.
- Maternal healthcare services in private hospitals and the cities were considered more effective than those in rural areas.

There were various elements and characteristics associated with healthcare centre workers. The findings showed:

- The attitude of the healthcare workers was not encouraging nor attractive to the women who utilised maternal healthcare services.
- There is a variety of adverse encounters regarding women's reception at healthcare centres, encompassing problems such as disrespect, insufficient patient attention, and systemic issues within the healthcare system.
- There are various difficulties with personnel qualifications, timely assistance during delivery, and apprehensions regarding the reliability of results and prescriptions of the healthcare personnel.

There were requests, modifications, and changes women expected to take place before readiness to utilise the maternal healthcare centres. The findings showed:

- Comprehensive training for TBAs and formal recognition of TBAs through inclusion in the state government's payroll should be provided.
- Request for provision of human and material resources in the healthcare centres.
- Request for education, awareness, and sensitisation of community members to address community belief systems that affected health-seeking behaviour.
- There is a need for interventions at various levels, including legal measures, gender-sensitive healthcare practices, and a commitment to fairness and professionalism within the healthcare system.

5.15.2: Summary of findings of perspectives of maternal healthcare stakeholders

The community exhibits a distinct and influential belief system that significantly shapes perceptions and behaviours related to healthcare. The findings showed:

- There was limited autonomy for women in accessing healthcare independently, as well as a limit to women's influence and involvement in decisions related to healthcare.
- Husbands felt more at ease and preferred their wives to receive healthcare services from female health workers due to their history of sexual abuse and the effect of their belief system on them.
- As community members, husbands relied heavily on traditional caregiving, which they considered a better alternative to modern healthcare services due to tradition and spiritual efficacy characteristics.

Traditional medical treatments, therapies, and practices were found to have various effectiveness and success in improving women’s health outcomes and the overall well-being of community members. The findings showed:

- There was a preference for the service in the community, providing care to women before, during, and after pregnancy.
- There was reliance on herbal remedies for medicinal purposes and the accompanying belief in the effectiveness of the natural substances.

There were issues related to Issues with the healthcare services within the healthcare system that hindered women's effectiveness in utilising maternal healthcare centres.

- There was a shortage of human resources across tiers, the impact of the lack of human resources on maternal and child health, overburdened healthcare professionals due to the need for healthcare professionals, and gender disparities in the distribution of healthcare workers.
- A mixed finding on the challenges posed by the distance, there is a recognition that those living close to the health centre or individuals with the financial means to cover transportation costs may find it more accessible.
- There were concerns about inadequate facilities in the healthcare centre, difficulties in accessing drugs for common diseases, inconsistent availability of health providers, underutilisation of healthcare facilities, expiration of medical drugs, abandonment, and lack of patronage.

Women's Issues typically refer to matters or concerns that specifically affect women individually or personally. The findings showed:

- The geographical distance of the healthcare centres, financial constraints for transportation, preference for home deliveries, patients utilising healthcare services expressing concerns about the items requested for delivery, and economic considerations play a role in the choice for home deliveries.
- Women were said to be negligent about maternal healthcare matters; mothers tend to stay at home during labour and only seek clinical assistance when complications arise.
- Husband’s willingness to embrace modern maternal healthcare, the importance of healthcare professionals' advice, and balancing traditional and contemporary approaches.

Maternal healthcare adjustment refers to the suggested actions and strategies put forward by the participants to improve pregnant women's overall well-being and healthcare outcomes. The findings showed:

- There was a demand for gender-specific healthcare providers, community education and leadership involvement, and government-led awareness campaigns.

- The findings showed recommendations for advanced training for traditional birth attendants (TBAs), financial support for the TBAs, and employment and community-centric healthcare centres.
- There was advocacy for male health workers to attend to male patients only and female health workers to attend to female patients only.
- There was a report of suggestions for recognising traditional herbal medicine, equality and respect in healthcare centres, incentives for female medical workers, and encouraging education for female community members.

5.16: Conclusion

The chapter was introduced by mentioning the groups of participants involved in the study. The application of Colaizzi's seven-step and Braun and Clarke's analytical techniques to the data collected for the analysis was also presented in the chapter. The participants' demographic was described, while the chapter's overview of the findings was presented. The themes that emerged were presented with their corresponding quotations.

CHAPTER SIX

DISCUSSION

6.0 Introduction

This study was conceived to explore the factors that cause the underutilisation of maternal health services among reproductive women in Bauchi State. The utilisation level of healthcare centres in rural areas has not been encouraging due to several factors this study discovered. The key findings from the survey showed the primary influence of communal belief on the health-seeking behaviour of the community members. The choice of qualitative research approach helped to go in-depth and unearth these factors from women's lived experiences and perspectives of maternal healthcare stakeholders. The experiences and views shared by the participants unfolded the reality of the phenomenon under study. This chapter discusses the findings of the study. The discussion covers each theme of the study.

6.1: Preference for Female Health Workers

The presence of male health workers during women's births has long been a significant issue in Northern Nigeria (Ariyo, Ozodiegwu, and Doctor, 2017; Sadiq, 2017a). The findings of this study showed that the women felt more at ease and preferred to receive healthcare services from female health workers. Similarly, the husbands felt more at ease and chose their wives to receive healthcare services from female health workers due to their history of sexual abuse and the effect of their belief system on them. This finding agrees with the past findings regarding the preference for female healthcare workers over their male counterparts. The male partners who were husbands to these women did not appreciate the mode of operation in the health centres, where male health workers are allowed to attend to female patients who are wives to their husbands. They considered it a violation of their privacy on the premise that the sensitive part of a woman should be solely seen by her husband or by female health workers who are of the same gender as the women receiving health care. They questioned the service of the male health workers regardless of their effort and the quality of service they rendered. The preference for female health workers overshadowed or overruled the expertise, effort, and quality of service of the male health workers. They rejected such services with an outright demand for female health workers to attend to female patients. Hence, they preferred female health workers to attend to their wives rather than males. This finding aligns with (Abubakar *et al.* (2017a), who opined that northern Nigerians, with a high concentration of Muslims,

have a high preference for female health workers attending to their wives during labour and childbirth.

Similarly, the findings of Okeshola and Sadiq (2013) from a study carried out in one of the northern states also support the results of this study, where most of the women interviewed in Southern Kaduna rejected maternal services based on the violation of their privacy when attended to by male health workers. Comparably, Sadiq (2017a) also found husbands' preference for the health care service of female midwives. The act of such rejection is not without some side effects. It opens the women to choose traditional healthcare, which is not considered scientifically proven to provide quality healthcare like Western maternal healthcare. Another scientifically proven alternative is that cultural beliefs hurt reproductive women primarily because they are the primary victims in case of any eventuality. This issue, where male health workers attend to female patients, was found to influence the decision of some pregnant women to resort to the patronage of the TBAs, who are primarily women. On this note, Sadiq (2017a) believes that women were comfortable utilising the service of the TBAs.

In this study, the gender dichotomy concern was raised by both women and men (husbands), unlike in other studies, where the issue was raised by women (Okeshola and Sadiq, 2013; Maina-Bukar, 2020). The findings of Sadiq (2017a) agree with this study regarding gender dichotomy. The husbands were comfortable and at rest when skilled health workers of the same gender examined their wives. To these husbands, abiding by cultural norms and personal jealousy seemed better than other health considerations and benefits. It could be explained that the husbands may have prevented their wives from attending the health care centres because of the limited number of female health workers, causing them to opt for traditional health care. Resorting to the patronage of traditional health care was a convenient alternative since gender dichotomy was the main issue. The TBAs are women, unlike in the formal health care in rural areas where skilled male health workers dominate. Therefore, the issue of TBAs examining their wives would not be an issue, an interaction that was culturally and religiously acceptable to the husbands. There was a high possibility of freedom of interaction between the TBAs and the female patients, a same-gender relationship. Sometimes, the TBAs were the patients' relatives, a factor considered a strong reason to escape the challenge associated with formal maternal health care.

One of this study's strengths is the triangulation in its data collection. The data collection included the husbands in the datasets, which helped explore their feelings and experiences regarding their wives and their health concerns. Including the husbands in the dataset helped understand why the health services were not used as much. The husbands' understanding of the importance of human health would have helped shift ground from cultural standards that seem to hurt human lives. There was an occasion where a husband shared an experience of how one of the wives in the community, who went to seek health care, was snatched by a male health worker. There was an experience that seemed discouraging and promoted the continuation of their cultural norms. However, this was only one case that was shared. This experience does not happen all the time. The fact that someone dies from eating does not prevent others from eating because there are measures that can be taken to avoid such an incident.

In this study, most participants had non-formal education, followed by those with no educational qualifications. The participants with non-formal education mainly studied Islamic education, primarily taught in Arabic and Hausa. Academic qualification is a significant factor in determining women's utilisation of healthcare services (Fawole *et al.*, 2012; Desai *et al.*, 2013; Umar, 2017). Also, the findings of this study align with the participants' religion, as almost all of them were Muslims. There were only three Christians out of the total 32 participants. The level of understanding of maternal education among the husbands spoke volumes and should cause a positive change of attitude. The participants' responses showed a lack of health education concerning the importance of maternal education and understanding of the anatomy of women's bodies regarding childbirth, among other issues. Education is powerful and can overcome stigma and societal common law. Education enhances human thinking to find the solution. It can help one think about coming out of an age-long tradition that is not helpful and can adversely affect human life. Both maternal and paternal education influence human decisions, including health decisions. The education status of male partners can influence their wives' utilisation of Western healthcare services, even if their wives are illiterate (Desai *et al.*, 2013). Husbands' educational development strongly motivates them to make health-promoting decisions that can save their families, wives, and children.

Furthermore, a skilled health worker who was one of the participants in this study shared her views regarding the shortage of female health workers that resulted in having more male health workers than female ones. She associated the reasons with the government's fault for not sending adequate female health workers to the rural areas. The WHO noted the shortage of health workers in a report produced in 2006. A concern worth noting is the difficulty regarding the readiness of female health workers, especially the married, to accept job roles in remote areas. Nature confers natural benefits to the male gender over the females regarding toughness and strength. The readiness of the husbands of these female health workers to allow them to travel far to rural areas was another concern. These are rural areas, indeed, where communication seems complicated.

A participant expressed limitations on the wives' freedom to exercise their rights. She shared that wives did not have the right to question their husband’s refusal to grant their permission over issues, even when they tried to explain why they needed to go to the healthcare centre for healthcare services. Giving such consent to their wives may be for a short time, but the dominance of male health workers continued. Even single female health workers considered their security above their job roles.

On the other hand, the existing cultural belief was associated with religious belief. Householders need to understand the power of knowledge, which can influence them to be aware of their wives' health issues. Usman and Maina-Bukar (2020) linked the preference for female health workers to a lack of knowledge and understanding of the importance of health. The outright demand for female health workers may not always work out because of the limited number of female health workers who can only attend to a few patients. Waiting to be attended to by female health workers may worsen the situation for pregnant women regarding their delivery. There could be an unnecessary increase in complications while the delivery process is halted, resulting in losing their babies and worsening their health conditions. Naturally, men tend to be moved by what they see. Seeing a naked woman may provoke such innate characteristics.

Skilled health workers are trained and expected to be professional. However, one of the male participants cited a case where a male health worker had snatched someone’s wife. The antecedent of such experiences of wife snatching strengthened the fear of the male partners in releasing their wives to be treated by male health

workers. Male health workers expect professionalism, but the presence of bad eggs among the good ones cannot be underestimated. In this study, there was a complaint by one of the participants about the attitude of the healthcare workers to their wives in the community. The participant shared how a male health worker snatched one of the women in the community. The participant was one of the women who went for healthcare visits. In corroborating the issue of male health workers attending to female patients, another participant opined that the temptation to marry another man's wife because of the opportunity of seeing her nakedness would have been averted if the health workers were the same female gender as the patient.

Including skilled health workers in the data collection sets helped provide detailed information on the issue of gender. The contribution of the health workers affirmed the issue raised by the husbands but also provided detailed information regarding the limited number of skilled female health workers. The health worker explained the reason for the shortage of female healthcare workers, unlike the number of male health workers, was that the government was not sending female health workers to rural areas because of their marriage status. Hence, training more health workers who hail from the rural areas where they reside may be necessary.

6.2: Husband Supremacy

The findings of this study showed that no provision was made for women's autonomy in cultural settings, an issue affecting women's maternal care. This finding agrees with Olayemi *et al.* (2009) and Baba-Ari, Eboreime, and Hossain (2018), who observed the influence of the husband's position on their wives utilising the maternal healthcare service. In similar settings, husbands are seen as a force with social and economic power that can facilitate their wives' access to maternal health services (Shija *et al.*, 2011; Aborigo *et al.,* 2018). The husbands' position implies women's attending maternal healthcare lies in the hands of husbands, who may allow or disallow their wives based on reasons best known to them. Their wives see these husbands as 'unquestionable' regarding any decision.

A study carried out in Bauchi State by Omer *et al.* (2014) found that husbands refused permission for their wives to attend maternal health care because of their status. A participant in one of the Focus Group Discussions organised by Omer *et al.* (2014) explained why husbands dominate at home. The participant said it is a threat to a husband's dominion to grant permission to his wife; such a man would be considered

a weak husband who cannot control his wife. The husbands were said to have an authoritative role in the family settings. The husbands are the significant decision-makers with the final say on every matter, including health.

In addition, it was found that husbands' decisions were considered significant and sacred, not to be challenged by their wives. Weldearegay's (2015) submission also finds expression in this finding. According to Weldearegay, the participants in his study agreed that their husbands made the family decisions most of the time. Therefore, any decision by their wives to deviate from their husband's instructions needed necessary approval before such wives could leave the vicinity of the home environment. It implies that wives usually stay home without a solid reason to go. The issue of the wives waiting at home confirms the low status of women in the community and the region (Bohren *et al.*, 2017). The study's findings revealed the nature of the husbands and how they handled their wives. The result shows the type of treatment husbands gave their wives despite the pain of motherhood in carrying pregnancy without adequate care from the husbands. It is worthwhile for husbands to appreciate their wives and should not deprive them of their fundamental human rights. The wives should be appropriately cared for by their husbands. They should be involved in the decision-making in the family. Participating in decision-making between the husbands and the wives does not limit the authority of the husband's headship. Participatory decision-making strengthens the love and bond between husbands and their wives.

The findings of this study also revealed women's lack of autonomy. The autonomy issue implies women's absolute dependence on their husbands for almost everything. Women had to seek permission before they could attend Western maternal care. Marriage union does not make women lose their human rights and freedom. Marriage aims to bring two adults together to strengthen one another. This issue of women's lack of autonomy was adjudged as one of the reasons the women did not utilise healthcare centres (Shaguy, 2019). In their study, Adewemimo *et al.* (2014) found that the women mentioned the need to seek their husband's permission to use maternal health centres where they would have the opportunity to be attended to by skilled health workers.

The issue of wives always seeking approval implies that women may not participate in health centres if their husbands decline permission. It is necessary to consider what

happens if such women need to be booked for a caesarean section as a life-saving measure to ease their delivery. It implies that women are at the mercy of their husbands. The study's findings showed the unnecessary pain some women experienced because of a lack of opportunity to attend maternal healthcare because their husbands' permission was not granted. Also, the findings showed that not all women who utilised traditional healthcare planned to do so. However, their husbands' lack of permission and support gave them no option but to use alternative healthcare to Western healthcare services. This study shows the limitations of women in making decisions of their own volition without their husbands' approval. It shows women were not being treated well by their husbands. It shows how some cultural and religious beliefs were not favourable to women. Husbands should make the home a conducive environment for their wives. Women are not enslaved and should not be treated as such. Health-seeking behaviour among women is beneficial to both husband and wife.

Wives are expected to be submissive to their husbands, but the submission issue must be treated cautiously, especially in life-and-death situations. This study was conducted in highly rural areas where information, communication, and technology are difficult to engage. A wife who decides to obtain permission on every matter before leaving home may experience unimaginable hardship, especially concerning maternal issues. This finding also was corroborated by Yusuf (2005) and Mercy, Wolf, and Abubakar (2008). They found that women from northern Nigeria were highly dependent on their husbands on every matter, including health. The statement's heavy part is the ending, '…*including their health'*.

Some other scholars recorded cases where participants expressed that they could not even attend antenatal service because the husbands refused. At the same time, some groups could not deliver their babies in the health centres because the head of the family did not grant such a request (Shamaki and Buang, A, 2014; Shamaki and Buang, 2015). Also, this is why Shaguy (2019) said that women's position is disadvantaged regarding being treated like a secondary citizen. Shaguy described the mode of family operation in northern Nigeria as being paternalistic, where men have a higher advantage than women. On the other hand, Adewemimo *et al.* (2014) believed that the issue goes beyond the husband and includes the low status of the women in these rural areas. It can be explained that since all the family responsibilities solely rest on the husbands, they may have a contrary view about patronising the

health centres. At the same time, they could easily prefer the TBAs, maybe because of the lower financial costs.

The study gathered responses from the women and husbands who shared similar views, confirming the husband's position in the cultural setting. This finding provides more information about husbands' roles in northern Nigeria. The result shows how the family heads' roles are cherished and celebrated. The finding reveals the level of understanding of health education by the husbands in the community. However, the extent of husbands' implementation of the cultural norms in handling their wives' matters seems far from reality. This finding may increase the existing poverty level in the region unless there is a change in the husbands' perceptions and attitudes regarding this matter. This finding may endanger the wives' lives, especially concerning pregnancy and child delivery issues. Husbands' refusal to grant permission to their wives to attend the health centre is not without some health implications. Dependence on traditional health care does not always work out. There are many health issues beyond the power of the TBAs.

6.3: Reliance on Traditional Caregiving

Reliance on traditional caregiving involving practices passed down through generations within the communities where the study was carried out. Traditional caregiving encompasses a range of activities, including health-related practices, support during life events, and assistance with daily living. The findings from the women's shared lived experiences and perspectives expressed by the husbands showed the communities' heavy reliance on traditional caregiving. Traditional medicine was considered more powerful and effective than the formal health care system and was found to be one of the reasons pregnant women patronised the TBAs. Traditional medication involves using herbs, concoctions, and holy water, among others, to ease the childbirth experience of pregnant women. This finding agrees with results from other sub-Saharan countries, where Sumankuuro (2018) found how pregnant women were being cleansed with unique and herbal concoctions. The health-seeking behaviour for traditional healthcare was because the pregnant women believed so much in the herbs to aid their birthing course for safe delivery. It can be explained that these conventional medications were almost free compared to drugs purchased after being recommended by physicians. In other words, the local medications are not as costly as drugs in the formal maternal health care centre.

The use of local herbs is embedded in the community culture. The finding agrees with (Morris *et al.*, 2014; Alabi *et al.*, 2015). Also, Shaguy (2019) notes that using herbal and local mixtures is a generational practice handed over to the present generation and has formed part of their culture. Shaguy further stresses that this practice is implemented through indoctrination. Hence, women who later become pregnant would prefer to use local herbs, either personally prepared or through the help of the TBAs. According to WHO estimation, the use of traditional medicine for meeting primary health care stands at 80% in Asia, Latin American, and African populations (Augustine, 2017). The findings of this study show the efficacy of traditional medicines and the high level of trust in local drugs. The researcher witnessed a scenario where a baby brought for traditional healthcare was given local medication. The baby was healed almost immediately when given locally-made medicines.

This study reveals that community members appreciated the affordability, availability, and accessibility of locally-made drugs more than Western medicines, which were considered expensive and sometimes unavailable. They also enjoyed the skills of the local medicine producers who worked to make the medication available. These findings show the place of traditional medicine, which has served as an alternative to Western medicine. Government and NGOs could partner with these local producers to standardise the traditional medicine that has proved productive to the community members over the years. The standardisation process implies that more tested and trusted treatments could be added to existing drugs if the traditional medicines successfully pass scientific tests. Other likely benefits of this process are that the prices of these medicines would be lower than the imported ones because industries producing medicines can be cited in the local areas because of the low cost of production.

6.4: Preference for TBAs Service

The findings from this study, both from the women's lived experiences and the perspectives of the maternal healthcare stakeholders, showed their reliance on traditional healthcare caregiving through the TBAs service, which they considered a better alternative to modern healthcare services due to traditional, cultural, and religious beliefs. The TBAs' services were found to be highly patronised by the community members. The pregnant women in the community did opt for the services of the TBAs for child delivery. The finding aligns with Ekeopara and Ugoha (2017),

who found high patronage of the TBAs because of their prominence in the community. The researchers found that between 60% to 85% of pregnant women patronised the service of the TBAs. In this study, the patronage of the TBAs was found to be due to their recognition as traditional health experts with spiritual power, specialised in maternal health with track records of convincing results. It was found that the patronage of the TBAs hinged on the capability of some to switch from natural to supernatural to handle birth issues that were considered too significant to be handled with physical knowledge alone. TBAs are often common in rural areas and highly respected because of their ability to provide maternal health care and perform some cultural rituals (Eshiet, Jackson, and Akwaowoh, 2016). The TBAs' ability to offer cultural rituals when needed was considered an edge over formal maternal health care. This study's findings regarding the TBAs show how they were valued and respected in the community. Many families placed their trust in the healthcare services offered by the TBAs. Hence, the government must train them to provide maternal healthcare services within their knowledge since they are a major community stakeholder.

Nigeria is a very religious society where people respect, honour, and easily believe in their religious leaders in almost every matter of life. Also, nearly all human issues are easily linked to spiritual realms with all forms of spiritual connotations. The issue of childbirth is not an exemption, whereby some people believe pregnancy to be spiritual with the need for spiritual touch from spiritual people. Williams (2018) found this as one of the reasons some pregnant women prefer patronising TBAs in rural areas, who have been trusted over the years. It suggests that pregnant women considered the aspect of spirituality a missing part in the formal maternal health setting. It was found that participants relied on the services of TBAs because of their availability and ability to attend to women after delivery if there were complications. The finding agrees with Adatara, Strumpher, and Ricks (2019), who noted that TBAs' services spanned through tripartite stages before, during, and after delivery. Based on this finding, the proximity of the TBAs to pregnant women could be a factor that strengthened their patronage because the women could call on them at any time. There may not be a need for transportation sometimes because of the proximity advantage. Hence, women could access the TBAs as fast as they needed.

The patronage of the TBAs' support was linked to their experience over the years. In northern Nigeria, TBAs are of the female gender only and are revered in the community because of their involvement in child delivery over the years (Serizawa *et al.*, 2014). This finding aligns with Okafor *et al.* (2016), who found the utilisation of TBAs convenient among pregnant women because of their skill to handle complications. On the other hand, Asu (2013) opposed the patronage of the TBAs for child delivery based on the TBAs' skill level. Asu notes a lack of training in health matters among the TBAs, as they solely depend on personal experience and experience from working with other birth attendants. He noted with dismay that the TBAs could not detect and handle complicated labour, which could throw them off balance when such a situation arose. He observed that TBAs were quick to consider such experiences a spiritual attack, a phenomenon that had resulted in the death of many pregnant women. Similarly, Umar (2017a) uncovered the alarming rate of unskilled health workers in northern Nigeria, popularly referred to as TBAs.

Similarly, Krah *et al.* (2018) noted that traditional healers in any form are rated a hundred times better than medical doctors. The trust in TBAs over the years seems insufficient as things change daily. Some of the things termed spiritual attacks may not necessarily be so. The spiritual dimension was why Fantaye *et al.* (2019) refer to traditional health as involving trial and error treatment, which is not reliable and dependable and may endanger the lives of the patients who come for help. Skilled healthcare workers, trained in the modern healthcare system, know the symptoms and diagnosis of the health issues considered to be spiritual attacks by the TBAs. Lack of awareness, exposure, health education, and the level of education of those patronising them could be possible factors for their patronage. We live in a technological-driven world where there appears to be health provision for all sorts of complications attached to childbirth, among others. The findings could be why some participants, though few, mentioned their patronage of modern and traditional health care. They seem to be aware of the benefits of the institutional health service and, at the same time, found it difficult to depart from the age-long practice of traditional health care delivery under the auspices of the TBAs.

This study differs from similar studies on the patronage of TBAs due to the triangulation of data collection techniques, which allows varying perceptions to be highlighted and acknowledged. In these similar studies, data were collected solely from women of

reproductive age (Eshiet, Jackson, and Akwaowoh, 2016; Ekeopara and Ugoha, 2017; Fantaye *et al.*, 2019), while this study's findings in respect of the support of the TBAs were found from the views shared by women, men, and TBAs. The opinions shared by both men and women were confirmed by the TBAs, which gave credence to the findings. The novelty of this finding lies in the appreciation of the traditional form of health care that has been in use since time immemorial. It shows how the community system developed its health care system before the advent of Western education. Furthermore, it is a signal to appreciate the traditional health workers. They have lent helping hands by using their experiences and money to significantly contribute to their community by providing help for pregnant women.

The TBAs usually have a manageable number of patients at a time, unlike formal health care, where a limited number of skilled health workers attend to many patients. The workload of the TBAs is not as much as that of trained health workers (Mwangakala, 2016). Pregnant women can enjoy more attention and friendliness because of the workloads of the TBAs. There is no doubt of the testimony of safe deliveries over the years. However, there are better ways of doing the same thing they have done over the years. Health centres exist to provide professional health services for people. The TBAs' mode of operation is not regulated like that of a formal system where health workers have been professionally trained. Several studies have revealed the challenges of patronising the activities of TBAs. These findings show the patronage of TBAs is a concern that should be checked for a life purpose despite their positive attributes. Government and NGOs could provide necessary training and tools for the TBAs. The TBAs in the communities must be registered without financial implications and trained to provide some assistance services to skilled healthcare workers.

6.5: Healthcare conflict with communal belief

Healthcare conflict with communal belief was found as situations where the practices, principles, or approaches of the healthcare system or healthcare providers were at variance with the collective beliefs within the communities used for the study. The difference arose due to differences in cultural, religious, and traditional perspectives on health and wellness between the communal belief and the healthcare system. The differences included belief in spirits and prayers to handle general and difficult situations in women's delivery.

The participants associated the issue surrounding illness and disease with the spiritual world, from which maternal care was not exempted. An aspect of religion that influenced pregnant women's underutilisation of modern maternal health was their perception of illness and disease connected with ancestral spirits. They believed in associating every disease with one spirit or the other. They thought that only specific spiritual people could help them with such problems. The importance of prayer was emphasised as a better and workable alternative to properly handling issues surrounding maternal complications, even if they were connected to the spiritual world. The tendency to connect maternal problems to the spiritual world, with prayer as a spiritual tool with an edge over formal maternal health services, encouraged pregnant women to opt for traditional health care. This finding aligns with Sharma *et al.* (2019), who believed that patients seek traditional health services because of issues with spiritual roots, necessitating prayers and rituals. Hence, such patients tend to patronise traditional health care over formal health care centres.

The findings from the study also showed the influence of religion on pregnant women's utilisation of maternal health services. There are Christians and Muslims in northern Nigeria, but the Muslim population dominates the region. The people of Bauchi State are predominantly Muslim. Therefore, tracing some customs to religious or cultural origins is sometimes difficult. Sinai *et al.* (2017a) took note of the intertwining closeness of religion and culture to the values and beliefs of the northern part of Nigeria. A study carried out by Solanke *et al.* (2015) confirmed the findings of this study. The study's findings showed that religion was a determinant factor for the underutilisation of maternal health services among pregnant Muslim women. The findings of Sharma *et al.* (2019) corroborated this finding that religion was a limiting factor in seeking maternal health care services. Other researchers considered religion a contributory factor (Coast *et al.*, 2014). The finding of this study also showed the influence of religion on patients' views about maternal health utilisation to the point that they associated almost everything with God's will, even phenomena that required their attention.

According to the Quran, they say, *nothing will befall us except what Allah has ordained for us. He is our master, and in Allah let the believers put their trust*.' (Āyat 9:51). The women believed they were perfectly healthy and did not need to utilise the institutional health centre. A participant from a study carried out by Ayamolowo, Odetola, and

Ayamolowo (2020) shared an experience of a revelation she had, how a spiritual being helped her during child delivery. The participant linked her experience to her belief in God for safe delivery with no need for any nurse to deliver her baby. There is a need for caution because experiences are specific and not to be used as a standard. Religious belief does not deny man's responsibility. This phenomenon is just one in millions and cannot be relied upon. Even the content of the holy writs does not permit the religious to exercise faith without works.

This finding reveals the type of development that took place in African settings before modern times. It reflects the research before discovering the traditional medicine available in the communities. It shows that African societies are not lazy but also have a way by which they take care of their people with local medication. The forefathers discovered different herbs that have been proven effective over the years. Africans have their form of measurement and timing for taking this medicine. However, the time of ignorance has passed. Traditional medicine has a lot of side effects, which are unknown to the users; even those who prescribed this medicine are unaware of the damages they have caused. Unlike in recent times, gradual steps are being taken to modernise traditional medicine to align with scientific standards. Nevertheless, it is not comparable with modern-day medicine, which has accurate measurements prescribed by trained and skilled professionals. Modern-day medication can be trusted because they have been tested following scientific processes.

6.6: Masculinity in Pregnancy

Home and self-delivery of pregnant women, a sign of strength among women, was another cultural practice responsible for underutilising formal maternal health services in Bauchi State. Home and self-delivery are why pregnant women desire to deliver their babies home without visiting a formal maternal health care centre. This practice was found to be common practice in the northern states of Nigeria (Pathfinder-International, 2013). The finding agrees with the position of Shamaki and Buang (2019), who described this phenomenon as pregnant women engaging in self-delivery at home and seeking assistance afterward for cleaning and placenta removal. The preference for home delivery was found in this study, as shared by the male participants. This finding agrees with Teklesilasie and Deressa (2020), who found many husbands preferred home delivery. The reason was based on the perception of child delivery as a normal process when women were expected to display their

endurance as long as they were not sick during the pregnancy. Women are believed to have sufficient natural strength to endure the pregnancy experience. In a study carried out by Ayamolowo and Odetola (2020), a participant specifically described any woman's decision to opt for formal maternal health care as an act of cowardice.

The findings of this study show women were appreciated for their natural strength and place as mothers. The value is embedded in the belief system in the community. The finding shows various delivery categories: institutional delivery, home delivery, and delivery in traditional healthcare centres. The findings show that women can naturally deliver their babies without human assistance. The result strengthens the power of preparation to prevent women from losing their babies. The findings share characteristics similar to the Western institutional delivery system, where pregnant women's preparation for safe delivery starts with attending an antenatal clinic and taking healthcare advice from skilled health workers. The Safe Delivery Act by pregnant women who practice home delivery also starts by taking necessary local medicines from the time they are aware of their pregnancy. Taking local medications strengthens them and prepares them for their babies' safe delivery.

The finding agrees with Ayamolowo, Odetola, and Ayamolowo (2020), who found that most women from the rural areas where their study was carried out prefer child delivery at non-institutional childbirth places. The non-institutional places covered places outside the formal health care system where there are skilled health workers—self-delivery locations happening mostly at home fall under this classification. The act of self-delivery at home demands pregnant women, at the onset of their labour, to silently display the virtue of bravery and endurance of labour pain witchcraft (Caulfield *et al.*, 2016). Studies have confirmed the normalisation of this custom, and it has come to stay, culturally acceptable and has become the pride of pregnant women; a reason most pregnant women in the northern area refuse to opt for maternal services provided by skilled health workers in the hospitals (Adewemimo *et al.*, 2014). This act has been widely reported to still be popular in rural and poor urban communities (Sialubanje *et al.*, 2015b). To emphasise this finding, Fapohunda and Orobaton (2013a) found that one out of five pregnant women preferred to deliver their babies at home. The results of this study show that women's act of home or self-delivery was enhanced with some traditional practices with local medicines.

Ayamolowo, Odetola, and Ayamolowo (2020) disclose the fear of surgery as a reason some pregnant women prefer home delivery. The surgery issue is a salient point as this perception may indicate fear of the outcome of undergoing a caesarean section. Some pregnant women in rural areas may perceive that delivery in the formal maternal centre is equal to a compulsory caesarean section, which is against their custom of self-delivery. Skilled health workers are positioned to help and care for pregnant women to have a smooth, safe delivery. Many pregnant women deliver their babies through natural birth with the help of skilled health workers. The use of formal maternal health helps to determine the appropriateness of the more accessible mode of safe delivery for pregnant women. Some women have been diagnosed where delivery through natural birth would be difficult, which may endanger either the mother's or child's life. Swift intervention by the health workers will help to save the lives of both mother and child. On this basis, WHO (2013) affirms that formal maternal health care provides the best health system and cost-effective access for pregnant women in rural areas.

Similarly, in a study carried out in Kaduna about the preferences of pregnant women for delivery, Okeshola and Sadiq (2013) found that most women preferred institutional delivery for their safety and their babies. Okonofua *et al.* (2018) found that most pregnant women (60%) in the local governments where they conducted their study received ante-natal treatment in the health care centre. Participants' level of education and exposure seems to be a factor in the departure from the so-called community tradition of home delivery. The primary concern was not the home delivery but the delivery mode without skilled health workers in attendance. The matter is how the pregnant women would handle the issue of complications and other unforeseen contingencies beyond their capacity or even the capacity of TBAs if they were eventually called for rescue. It is explainable that home delivery is a choice but not without measures, as it is being practised in developed countries. The possibility of giving birth at home is real but prudent, and delivery-enhanced measures need to have been appropriately implemented.

A factor that may cause a deviation from the women's choice of institutional delivery may be rapid labour, as found by some scholars who have reported some pregnant women who are on their way to the institutional centre (Kumbani *et al.*, 2013). The finding of this study shows that the women had already made up their minds to deliver

in the study centre due to their regular attendance of ante-natal care, which had positively shaped their minds. Pregnant women could be motivated to attend antenatal centres to benefit from the process maximally regularly. A partnership between healthcare managers and community heads would go a long way to encouraging pregnant women to attend healthcare services regularly. Attendance is likely to boost their maternal education.

This finding reveals a cultural appreciation of women's roles in their community. The pregnancy is not without pain, but the gain is higher than the pain. Prospective mothers may want to consider this option because of the cultural appreciation they enjoy. However, this finding may encourage home delivery among pregnant women, which could result in the underutilisation of maternal health care. Home delivery is not without some complications. Women's determination to follow this route would prevent them from taking necessary measures for child delivery since their minds have already been made up. The experiences accompanying home delivery are not palatable and may eventually lead to the loss of the baby and the mother. In advanced nations where medical personnel are readily available upon request, home delivery may be challenging in rural areas due to the scarcity of medical personnel. This finding may result in a subtle way of promoting the service of the TBAs. The TBAs live closer to these women. They are available most of the time. Their service may be sought in case there is any issue during childbirth, coupled with the fact that the health centre may be far from these women. This contribution of husbands, women, and TBAs gave credence to this finding as the three categories of the participants shared similar views. The views from each type confirmed the contribution of other participants.

Also, some women might feel more comfortable and relaxed giving birth in their home's familiar and private environment. This comfort can contribute to a positive birthing experience. Home births can give women autonomy and control over their birthing process, empowering them to make decisions aligned with their preferences and values. When attended by skilled midwives or healthcare professionals, home births may result in fewer medical interventions. Some women prefer a more natural approach to childbirth, and home births can align with this preference.

Additionally, home births may align more with cultural or spiritual practices for some women, incorporating cultural rituals or spiritual beliefs into the birthing experience.

For some women, the tranquil environment of their home may reduce stress and anxiety during labour, positively influencing the progression of work. Home births can also result in lower healthcare costs compared to hospital births, which is particularly relevant for women without access to comprehensive healthcare coverage.

On the other hand, home births entail a greater risk of complications compared to hospital births, primarily when the pregnancy has known risk factors. In case of unforeseen complications, delayed access to emergency medical interventions can pose severe risks to both the mother's and the baby's health. Access to emergency medical care, such as caesarean sections or specialised interventions, is limited in the home setting. Access can be critical when immediate medical attention is required to address complications during labour or delivery. Studies have indicated that home births could be associated with higher maternal and neonatal mortality rates, primarily in high-risk pregnancies. Absent immediate access to medical facilities and interventions can contribute to adverse outcomes.

Home births might not have the advanced monitoring equipment and medical interventions found in hospitals, potentially resulting in delayed detection and management of complications during labour and delivery. Pain management options available in hospitals, such as epidurals, may not be as accessible during home births, presenting a potential challenge for some women. Additionally, home births may lack immediate capacity for neonatal resuscitation in the event of neonatal distress, unlike hospital settings, which could impact the baby's health. The unpredictability of labour and the sudden onset of complications pose challenges in a home setting. The time required to transport a woman to a hospital can be critical in emergencies. Unexpected complications during home births may lead to psychological distress and trauma for some women. The absence of immediate access to medical support in such situations may intensify feelings of helplessness.

6.1.7: Women’s Spousal Support

The finding of this study showed that the spouses of the women in the community did not provide sufficient emotional, financial, and practical assistance support for them to utilise the maternal healthcare service. Spousal support is integral to a healthy relationship, contributing to both partners' well-being and mutual care. Socioeconomic status is a yardstick mostly used to measure people’s financial strength and stamina in a society, an issue affecting almost every area of human life, including health. This

study showed that the community members' socioeconomic status influenced their choice of patronising the health centre. In other words, socioeconomic status determined the use of maternal health centres. This study found that pregnant women in the community could not seek health care in the government-provided maternal health centre because of financial challenges. This finding agrees with studies that have established the influence of socioeconomic status on the utilisation of maternal healthcare services (Dehingia *et al.*, 2019; Agho *et al.*, 2018). In other words, the better the people's socioeconomic status, the higher the tendency to patronise maternal health services. This finding also aligns with the submission of Darin-Mattsson, Fors, and Kåreholt (2017), who posit that the more significant the socioeconomic disadvantage of a community, the higher the tendency of women to find it challenging to utilise healthcare services.

In this study, the participants acknowledged their poor financial capability, a factor they considered to be significantly underestimated. This finding is consistent with Abubakar *et al.* (2017a), who, from their study, found that most women did not have a dependable source of income to meet their needs. The participants' complaints regarding the cost of obtaining maternal health services are worthy of note. The complaints were one of the foremost reasons the participants resorted to the patronage of TBAs because their service is generally cheap compared to the formal health system. Other studies' findings affirm that health services' cost is a significant factor that hinders expected mothers from delivering their babies in the health centres (Yaya *et al.*, 2018b). This finding also aligns with Sodimu (2021), who found that people with low socioeconomic status tend to consider the patronage of maternal health services too expensive and, thereby, opt for a cheaper alternative, mostly traditional health care. Utilising traditional health services may be easily chosen considering other benefits and low service costs. Such benefits include the proximity of the TBAs to the community members, female-to-female interaction, and cheap healthcare costs.

The distance of the health centre was also a barrier for the participating women in this study, which appeared to affect their patronage. Usman and Maina-Bukar (2020) found transportation as a major issue hindering pregnant women from utilizing the maternal health service, especially if they experience labour at night. Such women may quickly resort to traditional healthcare service providers, who mostly live closer to

these women (Egharevba, Pharr, and Wyk, 2017). It implies that pregnant women's closeness to health centres is a significant factor that may aid their decision to have their babies in health centres. The distance between the health centres may appear relative, as available health centres in rural communities are mostly few. Finding more than one in a typical rural community may be difficult. Therefore, the health centre would be closer to some people and may appear far away from others. Women showed how they needed to pay for transport fares because of the distance of the healthcare centres from their residences. The influence of the poor financial status of the community members was acknowledged as a factor contributing to the women's difficulty paying transportation fares even when they desired to utilise the maternal health centres. The influence indicates the multiplier effect of financial incapability, which means that the lack of or inadequate finance influences several aspects of people's lives.

A generally high level of poverty in rural areas is assumed. From another perspective, some participants' responses hinted at their possible socioeconomic status. However, families were not all on the same level regarding socioeconomic status. The marriage system in the northern part of Nigeria appears to have a different structure from that of other parts of the country. Most wives depend on their husbands for a living to take care of themselves and their children. Human needs are numerous, and the resources to satisfy them are abundant. Having such limited resources to meet innumerable needs is not an easy experience. Having husbands with relatively good socioeconomic status in rural communities is not out of place. The nature of people's jobs and the quality of family connections could give them advantages over others. Some people have family members outside the rural areas who could always be ready to care for them, especially in health-related matters. These possibilities may not be overruled because there were participants whose complaints were not cost-related.

The possibility of having a different set of participants, namely, pregnant women, husbands, skilled workers, and the TBAs, gave credence to the study's findings. It helped to capture the understanding of the phenomenon from different angles. The trained health workers could present their observations about the subject matter and their actions to rescue the situation. A nurse shared how much she had used her money to buy some necessary materials to attract pregnant women to utilise the clinic because of the numerous benefits it could offer them. Hearing about the materials

could be attractive and should serve as an incentive to pull in many pregnant women. However, it may not be surprising that some pregnant women still struggle to pay transport fares to access such gifts. Another possible reason was the determination not to utilise the health centre at all. It isn't easy to talk people out of established traditions, especially those who have seen the traditional system working for them and their family members. The availability of many maternal health centres may not change their minds.

Also, the absence of support from a spouse can have severe consequences for women's health. Without encouragement or support from their spouse, women may be more likely to delay seeking healthcare or avoid addressing health concerns altogether. This delay can result in the progression of health issues and potentially lead to more severe conditions. Women often shoulder a significant share of caregiving responsibilities within families. The lack of spousal support can burden women, making it more challenging to manage their health while fulfilling other caregiving duties. The lack of support from a spouse can negatively affect the family's overall well-being. Such includes the emotional atmosphere of the household and the ability to function efficiently.

Moreover, the absence of spousal support can contribute to health disparities, particularly for women who may find it challenging to receive preventive care and timely medical interventions. Over time, the lack of spousal support can lead to long-term health consequences for women. Ignored health problems can result in the development of chronic conditions or complications.

6.8: Health Workers' Attitude

The attitude of workers in any organisation is pivotal to productivity. Perspectives of health care professionals can either enhance or deter practice within an organisation. Hence, the common saying is that someone's attitude can determine their altitude in life. The expression is also applicable to a would-be productive system. The findings of this study showed that the health workers' attitude was not encouraging and inviting to the women to patronise the healthcare centres. The women's experiences and perspectives of the maternal healthcare stakeholders showed that the healthcare workers were not receptive, respectful, and effective, as expected by the community members. The healthcare staff's behaviour, communication style, empathy, respect, and overall demeanour were below expectations. This finding aligns with a study in

northwest Nigeria by Idris, Sambo, and Ibrahim (2013b), who found skilled health workers' negative attitudes became obstacles to utilising maternal health services. The women suggested that noticing a positive change in the health workers' perspective would enable them to use the healthcare centres. This finding, concerning a study carried out by Sadiq Umar (2017a), showed that most women quit Antenatal care for home delivery because of the negative attitude of the health workers. It is challenging to persuade pregnant women to visit health centres, as health workers' attitudes harm them. Therefore, these women could not be easily attracted to utilise the health centres.

The participants mentioned some negative attitudes, including disrespect, lack of orderliness in attending to patients, and use of disrespectful language toward patients who are elderly, especially. This finding aligns with Ewa *et al.* (2012), who found the unfriendly attitude of health workers to be one of the factors that affected the participants interviewed not to patronise maternal health services. Similarly, Omer *et al.* (2014) corroborated this finding, having found that poor health workers' attitudes, such as maltreatment of patients, affected the utilisation of maternal healthcare services. The finding affirms myriads of factors that may sometimes be considered inconsequential. Still, there are factors patients could weigh up that could result in them attending elsewhere, leaving a place where they are not appreciated. Some of these patients, who have been encouraged to participate in maternal health care, would find it easy to justify their lack of readiness to patronise these maternal health care centres where patients are not accorded due respect.

Negative attitudes from healthcare staff can undermine trust and confidence in the healthcare system. Such attitudes can cause women to hesitate in seeking care, leading to delayed or inadequate maternal healthcare utilisation. Moreover, women may develop increased fear and anxiety about healthcare visits if they anticipate encountering disrespectful or dismissive behaviour from staff. This emotional distress can discourage women from seeking necessary maternal healthcare. Furthermore, women who experience negative attitudes during one healthcare encounter may be more likely to avoid follow-up care, resulting in missed opportunities for preventive care, early detection of complications, and appropriate medical interventions. The negative influence of staff's bad attitudes can contribute to adverse maternal health outcomes. When women feel disrespected or devalued, they may be less likely to

engage in behaviours that promote their health and the health of their infants. An adverse healthcare provider-patient relationship can have long-lasting effects. It may discourage women from seeking future care, and it can contribute to a broader sense of dissatisfaction with the healthcare system.

6.9: Shortage of health workers

The importance of an adequate number of workers cannot be over-emphasised in any functioning system. Inadequacy of staff numbers was a factor affecting the utilisation of maternal health services by women of reproductive age. The women were not encouraged by the limited number of female workers, which meant that the few available workers were almost all males. The explanation was based on the advantage of men that they could travel anywhere, unlike the females, who, if married, must stay with their husbands and children. The community's status in rural areas appeared to be discouraging for female health workers who might be unable to travel distances like their male counterparts. This finding agrees with Olusegun, Thomas, and Micheal (2019), who found that the inadequate number of qualified health workers, among other challenges, discourages maternal service utilisation. The inadequacy of staff had implications for the health centres' capacity to meet their patients' needs. Continuous observation or bad personal experiences of pregnant women may discourage their patronage of the centres. This type of experience quickly spreads, with patients sharing experiences, especially the unpalatable ones, with their friends and relatives, who may not see the need for the patronage of the maternal health centres when the need arises. The few available health workers could get easily overwhelmed if more patients than the number of skilled health workers can manage. This experience may impede their commitment, speed, quality, and productivity.

Insufficient health workers can lead to restricted access to maternal healthcare services, particularly in remote areas. Women may encounter difficulties in obtaining vital prenatal care, skilled assistance during delivery, and postpartum support. The shortage burdens existing health workers, resulting in heightened workloads and burnout, impacting the quality of care and stress among healthcare professionals. The inadequacy of health workers may cause delays in delivering antenatal care, affecting the timely identification and management of pregnancy-related complications. This delay can result in adverse outcomes for both mothers and infants. Shortages can also limit the availability of skilled birth attendants during labour and delivery,

potentially increasing reliance on unskilled or traditional birth attendants and compromising the safety of childbirth. In emergencies, the absence of health workers can have severe consequences, leading to delayed response times and inadequate availability of emergency obstetric care, contributing to higher maternal mortality rates. Additionally, the shortage may lead to reduced continuity of care, as women may interact with different providers at various stages of pregnancy and childbirth. Continuity of care, crucial for trust-building and ensuring a comprehensive approach to maternal health, is thus compromised.

6.10: Quality of healthcare services

The findings showed inadequacy and accessibility issues of maternal healthcare, women's negative experiences and dissatisfaction with the healthcare centre, initial positive shifts towards modern medicine and a subsequent return to traditional practices, and a call for improvement of maternal healthcare. Hence, the services provided at the maternal healthcare centres in the communities were not adjudged to be of sufficient quality for the community members to benefit. This finding aligns with WHO (2021), which reported disparities in access to high-quality healthcare, underscoring the significant gap between the affluent and the less privileged. These inequalities are closely associated with elevated maternal mortality rates observed in certain regions around the globe. Also, inequalities in respectful, high-quality healthcare outcomes were acknowledged by WHO (2023b) concerning women having access to maternity care. Attending antenatal care offers several advantages, including quality information on what actions to take, how to perform them, what practices to avoid, and the recommended channels for carrying them out. Yaya *et al.* (2019) emphasise that the quality of care, alongside service costs, is a crucial factor that can influence the decision-making of both reproductive women and their male partners in utilizing maternal healthcare services, irrespective of whether the costs are high or low.

The findings also showed the participants' dissatisfaction with community healthcare while they preferred public and private healthcare in the cities with better quality of service. This finding agrees with the results from Okedo-Alex *et al.* (2021), who compared users' satisfaction with the quality of service in private and public maternal healthcare centres. In their study, most of the respondents attending public maternal

health care centres were dissatisfied with the high cost of services in the centre, compared to the respondents attending private hospitals.

A better alternative healthcare system apart from the ones in the communities has the potential to diminish trust in the overall community healthcare infrastructure. Community members may develop scepticism toward seeking medical assistance, causing delays in obtaining necessary care and exacerbating existing health conditions. The disparity in health outcomes may widen between those who can afford superior alternatives and individuals with limited financial means. Vulnerable populations, particularly those with lower socioeconomic status, may encounter challenges in accessing even subpar alternative healthcare, further marginalizing certain community members and restricting their ability to access vital medical services. This situation may result in delayed or ineffective management of health conditions, potentially contributing to a surge in emergency cases that could strain healthcare facilities and emergency services.

6.11: Distance of healthcare centres

The finding from this study showed the proximity of the healthcare centre was an issue as the participants said they had to travel a long distance to access maternal healthcare services. Hence, distance limits women's utilisation of maternal healthcare. This finding agrees with Ganle *et al.* (2014), who found that long distances limit mothers' and their relatives' access to healthcare centres. The result also agrees with Ajayi, Ahinkorah, and Seidu (2022), who established that many women with low socioeconomic status in rural areas live far away from the healthcare centres, which demands they travel far to utilise the healthcare facilities. The challenge extends beyond the considerable distance to healthcare centres; there's also the issue of transportation, which is closely tied to financial constraints. Financial barriers impact the regularity of interactions with medical practitioners, making it challenging for pregnant women to access and utilize healthcare centres. (Tsawe and Susuman, 2014).

Shamaki, Yew, and Dahiru (2017) Identify a substantial correlation between distance and the utilisation of ante-natal care services in Sokoto State, northern Nigeria. Their research delved into the women's proximity to healthcare centres and its impact on ante and post-natal care utilisation. Participants in the study covered distances ranging

from 0 to 30 km (0-19 miles) to reach the nearest health centre. The implication is that longer distances impose added challenges on individuals, particularly pregnant women, who must travel to access healthcare. This can result in extended travel times, heightened transportation expenses, and physical strain, presenting difficulties for some individuals in prioritizing regular healthcare visits. The distance to healthcare centres may delay seeking care, particularly in emergencies or when complications arise during pregnancy. These delays can have adverse effects on maternal and infant health outcomes. Essential antenatal care is pivotal for preventive measures and the early detection of potential health issues. However, the distance to healthcare centres may impede women's access to timely preventive care, resulting in missed opportunities for health interventions. Longer distances may increase transportation costs, establishing financial barriers for individuals with limited resources. The associated financial burden may discourage some individuals, especially those with lower socioeconomic status, from utilizing healthcare facilities.

In situations where healthcare facilities are distant and transportation poses a challenge, there is a heightened risk of women resorting to home deliveries without skilled attendants. Such situations pose significant risks to maternal and neonatal health, as complications may not be addressed promptly. The distance to healthcare centres can further contribute to health inequities, particularly for individuals in remote or underserved areas who encounter more tremendous obstacles in accessing quality healthcare. This dynamic may exacerbate existing disparities in maternal health outcomes. Longer distances also place strain on emergency services, particularly in obstetric emergencies. The time required to transport individuals to healthcare facilities may impact the efficiency of emergency interventions, potentially compromising the outcomes of urgent medical situations. Addressing these challenges necessitates a comprehensive approach, including improvements in transportation infrastructure, community-based healthcare initiatives, and policies prioritising equitable access to maternal healthcare. Poor healthcare options can contribute to a diminished quality of life for individuals within the community. Such options may result from untreated or poorly managed health conditions, leading to chronic illness and disability.

6.12: Strengths of the study

One of the strengths of this study is the data triangulation. The data were collected from reproductive women, husbands, skilled birth attendants, and Traditional Birth Attendants in the datasets. The combination of the various sets of participants in the data collection produced a variety of responses to the experiences shared by the participants. The experiences shared by the participants served as a form of establishing the study's validity. The data triangulation helped to confirm the experiences shared by a group of participants with another participant. Including the husbands helped explore their feelings and experiences regarding the experiences shared by their wives and their health concerns. Including the husbands in the dataset helped to have a fuller picture of why the health services were not being used, as shared by the women. The study in Bauchi State helped get detailed information on the utilisation of maternal healthcare in the area of study since most studies carried out in the state have focused on other health-related matters apart from the utilisation of maternal healthcare in the study area.

6.13: Limitations of the study

One inherent weakness of this study is that the researcher did not collect the respondents' bio-data that covered their income or socioeconomic status and the proximity of participants' residences to the maternal healthcare centres. Even though they complained about the distance of the healthcare centres to their residence, the availability of their demographics concerning the distance of the healthcare centre to their home could be a practical and empirical way of ascertaining the impact distance had on their utilisation of the maternal healthcare centres. There is also the possibility of failure to utilise the maternal healthcare centre despite their proximity to the healthcare centres.

6.14: Chapter Summary

The factors associated with the underutilisation of healthcare centres were discussed in this chapter. These factors are categorised into community and individual factors. The elements are further classified into internal and external factors. The internal factors captured the community and personal factors, although they could sometimes be interwoven. The internal factors included factors limited to individuals and their community, while the external factors were the factors beyond the control of the community members. The internal factors were majorly communal belief, a mix of culture, religion, and tradition. The external factors were the number and gender status

of the skilled health workers in the health care, the quality of service being provided, the facilities available in the centre, and an increase in the level of utilisation of the health centres by the community members. The factors imply a realisation of community factors, individual member factors, and the government factor, which should produce a shift in healthcare utilisation from being underutilised to appropriately utilised.

Conclusion

7.1. Introduction

This chapter shows the summary and conclusions of the study derived from the study's findings. WHO's estimation of maternal health showed 536,000 annual death rates of pregnancy-related issues, with close to 10 million women with pregnancy-related complications (Adesina and Adegboye, 2020). There was a prevalent high maternal mortality rate in Bauchi State despite the provision of maternal healthcare facilities targeted to reduce the high maternal mortality rate. (Omer *et al.*, 2014; Abdullahi *et al.*, 2020). The realisation of utilising maternal healthcare services was followed by the research process in which data were gathered and analysed to produce the study's findings. The study's conclusions were built on the results, which led to the recommendations derived from the inferences. The various groups and individuals considered necessary for implementing the suggestions are also included in the recommendations. Skilled health professionals, Non-Governmental Organisations, and government all have roles to play in promoting the utilisation of Western maternal healthcare services among women of reproductive age.

The recommendations raised in this study are likely to promote an increase in the safe delivery rate among pregnant women because pregnancy involves the normal, life-enhancing process of procreation, which carries a high risk. The risk involved in pregnancy can be curtailed when people holding the responsibility for providing care for pregnant women display the expected responsible actions. The recommendations on the study's findings, utilisation of maternal healthcare services in Bauchi State, an under-researched area needing exploration, could reduce maternal mortality and increase positive child outcomes. The study's findings can draw Non-Governmental

Organisations' and governments' attention to the incidences and the realities that reproductive women experience in maternal healthcare centres in rural areas. The study's findings will serve as a basis for subsequent research. Consultants and researchers involved in research-based projects, seminars, or related investigations will benefit from this study because of its contribution to the body of knowledge.

7.2 Existing knowledge

The study was designed to identify the factors influencing women's decision to utilise maternal healthcare services in Bauchi State and to explore their lived experiences. The researcher engaged in a literature search to understand previous studies that various authors have carried out, in line with the study's aims, which are;

- To explore women's lived experiences about factors that influence the utilisation of maternal health services.
- To explore the perspectives of the maternal healthcare stakeholders on women's utilisation of maternal health services.

The review of the literature showed evidence of high maternal mortality as a significant challenge experienced by women of reproductive age in Nigeria, at a high rate in northern Nigeria among the six geo-political zones in Nigeria (Guerrier *et al.*, 2013; Sharma *et al.*, 2017; Gulumbe *et al.*, 2018; Meh *et al.*, 2019). The challenge of maternal mortality has primarily been associated with the low utilisation of modern healthcare centres in rural areas (Fagbamigbe and Idemudia, 2015; Fantaye *et al.*, 2019). An examination of different components showed some studies that have been carried out. Also, most of the studies were carried out in other states; very few were carried out in Bauchi State, while others focused on child's health and partners' health, but not maternal health (Andersson *et al.*, 2011; Omer *et al.*, 2014; Ansari *et al.*, 2016; Cockcroft *et al.*, 2018; Cockcroft *et al.*, 2019; Abdullahi *et al.*, 2020; Omer *et al.*, 2021). The few available studies on Bauchi State have specific areas of focus that differ from the present study.

For instance, the study by Cockcroft *et al.* (2019) was an experimental trial study in two communities in Bauchi State. The researchers adopted a quantitative analytical approach to analyse the data collected in the survey. The focus of the study was how home visits affected maternal outcomes. The present study focuses not on home visits but on factors influencing women's utilisation of Western maternal healthcare services.

The present study adopted a qualitative research approach as a methodological approach. In addition, Abdullahi *et al.* (2020) studied quantitative analysis of the state's geographical distribution of maternal mortality cases. The researchers used secondary data and records from existing hospitals, while the present study used primary data collected through interviews and FGD. The researchers focused on the causes of maternal mortality in the state but not on the factors influencing the utilisation of maternal healthcare services in the state, which is part of the objective of this study. The researchers were interested in the monthly distribution of maternal mortality rates covering 2018 and 2019. The few available studies affirmed the cases, causes, and distribution of maternal mortality in Bauchi State. However, they did not cover women's experiences and the factors influencing their utilisation of maternal healthcare services. Most studies adopted a quantitative approach, while a few adopted a mixed-method approach. Also, most studies focused on home visits, as they affect various maternal outcomes, while the few that cover some aspects of maternal use were conducted a few years ago. Therefore, this study was designed to address the identified gaps in the literature.

7.3 Contribution to the body of knowledge

Western maternal healthcare centres were established to provide healthcare services for women of reproductive age. Nevertheless, a wealth of evidence supports the low utilisation of healthcare facilities in rural areas in northern Nigeria. It has been established that the level at which pregnant women utilise healthcare centres is not encouraging (Dahiru and Oche, 2015). There was a need to extensively explore salient factors that accounted for the low level of patronage of the health centres in Bauchi State. The findings from this research provide some insights into the reasons behind this low usage level. The study centres on information on the state of utilisation of maternal health centres. The study has contributed to the body of knowledge in the following ways:

- This study extends knowledge about maternal healthcare usage in northern Nigeria. The study explored the views of different groups of people: wives, husbands, pregnant women, skilled health workers, and TBAs on utilising maternal health care. This study identified the factors that resulted in the underutilisation of maternal health care services from different categories of participants. The study captured the feelings of the husbands of these women

on why their wives could not utilise or did not regularly utilise the health care centres.

- Unlike in-depth interviews in phenomenological studies, the study included focus group discussion as a data collection method. The study established that FGD can serve as a good form of data collection in phenomenological studies, provided the researcher avoids contamination as participants share their experiences in a group discussion. FGD enabled each participant to share their experiences primarily, as others added valuable and related experiences during the interactions. FGD allowed participants to share divergent experiences on utilising maternal healthcare services. Sharing a participant's experiences was a trigger and a reminder for other participants to share some fading experiences. Experiences shared by some participants helped reinforce the sharing of some experiences by others.
- This study shows the multi-dimensional barriers affecting the study population's utilisation of maternal health care services. The study presents these factors that accounted for the low or non-utilisation of maternal health care centres. These included the personal factors of the reproductive women and their husbands, community factors, age-long cultural and religious beliefs, socioeconomic factors, health workers, and government-related factors.
- The study shows the exalted position that both husbands and wives occupied in the family and the community.
- The study shows a high preference for female health workers in providing healthcare services for reproductive women.

7.4 Summary of the Conclusions

The following conclusions were drawn from the study's findings on the women's experiences and factors influencing their utilisation of maternal health services.

- Within the community, it was believed that home and self-delivery of pregnant women was a worthwhile experience for every woman. It was an expected mode of child delivery for every potential mother in the community. Women's home birth experience of self-delivery indicated women's possession of natural strength to endure pregnancy and to deliver with the help of natural herbs void of support, a practice at variance with visiting Western maternal healthcare centres.

- Both male and female partners preferred female health workers to care for their wives during childbirth and health consultations. It is more convenient and safer to be under the care of female health workers than their male counterparts. Male partners preferred female health workers to attend to their wives to avoid defilement, sexual harassment, or wife snatching. Cultural and religious beliefs influenced the preference for female health workers and husbands' fears and past experiences. The level of education and good socioeconomic factors of male health workers could make women vulnerable when they attend to them.
- The position of the husbands in the family and community was highly appreciated but highly overrated. Women lacked autonomy and depended on their husbands to obtain permission to leave the house. Husbands were regarded as decision-makers with high family dominance, while family responsibilities rested on them. Hence, the community was considered patriarchal.
- The services of the TBAs were preferred over Western maternal health care services because of their gender, experience, proximity, affordable service charge, and possession of spiritual power to handle the spiritual aspect. TBAs had the same gender as the pregnant women, providing sufficient attention for the women. At the same time, the participants were convinced they had track records of successful child delivery and possessed the spiritual power to handle any eventuality.
- People utilised traditional health care more because of the belief that diseases were connected to spirits and illnesses to wrongdoings. Traditional healthcare providers can only manage spirits through prayers and chants. Traditional medicine is embedded in cultural beliefs and was adjudged more effective than the drugs prescribed in the formal health care system. Hence, the community depended more on traditional healthcare services than Western maternal healthcare services.
- The effect of communal belief was connected to the belief system of the community members about spirits, prayer, and spiritual treatment. It was believed that pregnancy-related issues with spiritual causes could not be treated in Western maternal healthcare centres. Hence, some pregnant women preferred the alternative traditional healthcare services to the Western type of maternal healthcare services.

- The women's and their husbands' socioeconomic status influenced their financial power and capability concerning transport fares, health service payment, and purchase of necessary materials for child delivery. Most women lacked the economic power to pay transport fares to the maternal healthcare centres, and paying for recommended drugs after the prescription was hard.
- Patients experienced disrespect and discrimination from the health workers. The attitudes were damaging to the patronage of the formal maternal health system.
- The limited number of skilled health workers attending to many patients was a factor that affected their efficiency and the quality of service and caused long waiting times for the patients.
- Women seeking healthcare and other stakeholders preferred traditional caregiving as an alternative to Western maternal healthcare. This preference reflects a need for healthcare services that align with cultural norms and traditional values.
- The preference for Traditional Birth Attendants (TBAs) services signifies a deeply rooted aspect of maternal healthcare choices within specific communities. This inclination often reflects cultural beliefs, trust in traditional practices, and accessibility factors.
- Lack of emotional, financial, and practical support from the spouses of women in the community poses a significant barrier to the utilisation of maternal healthcare services. This absence of support may contribute to delays in seeking care, underutilisation of essential services, and potentially adverse maternal health outcomes.
- The insufficiency of health workers leads to heightened workloads for a few health workers, resulting in burnout among healthcare workers and the quality of care delivered.
- Maternal healthcare was not utilised based on the quality of the healthcare provided. Many women returned to traditional healthcare practices after a taste of Western healthcare due to the poor quality of service experienced in Western maternal healthcare.

7.5 Effect of the study on my knowledge base

My work experience with the World Health Organisation (WHO) in Jigawa state, Nigeria, helped me have an overview of the health sector's problems that needed to be solved t. These experiences gave me an insight into one of the challenges in the healthcare sector, which later became my focus of study. During the research, I could apply my knowledge as an insider, that is, as an indigene of the state, although I am not from the study population. I understand the people, language, lifestyle, and peculiarities. The insider knowledge gave me an edge to interact with the participants freely. My experience as a mother also enhanced my interactions with the participants. However, I knew I should be reflexive throughout the research to ensure my cultural background and attachment did not influence my interaction with the participants. The essence was to avoid my judgment, biases, and personal characteristics from prompting the participants. I translated the interview questions from English to the people's dialect, the Hausa language. At the same time, I sought the assistance of a lecturer with a degree in Hausa to go through the translation from English to Hausa to check the content met the requirements.

The study aided my understanding of the impact of culture and religion on people's ways of life in the 21st century in seeking healthcare services. The study helped me understand the possibility of people considering Western healthcare services as optional and unimportant even when necessary. It aided my understanding more about factors contributing to maternal mortality in the northern part of the country. The study's time, cost, and psychological demand were worthy of note. This learning phase helped me study what I would not have naturally done. Research demands critical thinking to achieve stated objectives. Engaging in this research built my thinking capacity and critical thinking as major factors that enhance the achievement of goals. The conduct of this study widened my horizon about the need to explain the reasons behind my research decisions, such as methodology, research approach, and research design, among others.

7.6 Recommendations

This study was premised on the personal observation and research gap to find out the reasons for the underutilisation of maternal healthcare services and identify why women of reproductive age do not patronise maternal healthcare services in Bauchi State. Hence, the researcher makes recommendations based on the study's findings

and conclusions.

7.6.1 Preference for Female Health Workers

Governmental and non-governmental organisations should offer gender-sensitive training to male and female health workers, focusing on understanding and respecting diverse perspectives on childbirth and health consultations. This recommendation can enhance their ability to provide inclusive care. They should actively recruit and promote a diverse health workforce, including a significant representation of female health workers, to meet the preferences of both male and female partners and foster a more inclusive healthcare environment. They should Implement community engagement programmes to raise awareness about the importance of diverse healthcare teams and the benefits of having female health workers. Address any misconceptions or concerns within the community regarding gender roles in healthcare.

They should ensure that maternity services are designed to be inclusive and respect diverse preferences. Such services include creating spaces within healthcare facilities that accommodate the presence and participation of both male and female partners during childbirth and health consultations. They should launch sensitisation campaigns targeting the community and healthcare providers to promote understanding and acceptance of diverse healthcare teams, highlighting the positive outcomes associated with providing care that aligns with the preferences of male and female partners. They should establish feedback mechanisms within healthcare facilities to allow male and female partners to express their preferences and concerns. Use this feedback to continuously improve and tailor healthcare services to meet the community's needs.

7.6. Masculinity in Pregnancy

Governmental and non-governmental organisations should educate communities about home and self-delivery, including the potential risks and benefits. Collaboration between government and non-government entities and Traditional Birth Attendants (TBAs) can help bridge the gap between traditional practices and modern healthcare. Training TBAs on safe birthing practices and guiding them on when to refer cases to healthcare centres is imperative. Community leaders, elders, and influential figures can also advocate for a balanced approach to maternal healthcare. To improve accessibility, the government could introduce mobile healthcare services or outreach

programmes, bringing essential maternal healthcare services closer to the community. These services may include antenatal care, education on safe delivery practices, and postnatal care. To address community concerns, the government should prioritize improving the quality of maternal healthcare services in Western healthcare centres. This may involve facility improvements, cultural competence training for healthcare providers, and ensuring respectful maternity care. Introducing incentives or benefits for women who choose to deliver in healthcare facilities, such as reduced costs or transportation support, can further encourage facility-based births. These measures can help create a comprehensive and supportive maternal healthcare system.

7.6.3 Husband Supremacy

Non-Governmental organisations should engage community leaders, religious figures, and influencers to challenge harmful gender norms. Their endorsement can carry significant weight in shaping community attitudes and behaviours. They should advocate for and implement policies that promote gender equality in healthcare decision-making. Legal frameworks can play a crucial role in protecting women's rights and encouraging spousal collaboration in healthcare choices. They should establish empowerment programmes for women, including education and skill-building initiatives. Empowered women are more likely to assert their healthcare preferences and advocate for their well-being. They should create support groups or forums for men to discuss and understand the importance of their supportive role in maternal healthcare. Providing a platform for men to share experiences and challenges can foster a sense of community responsibility. Government and NGOs should launch media campaigns that challenge traditional gender norms and highlight positive examples of shared decision-making in healthcare. Utilize various media channels to reach a wide audience within the community. They should provide training for healthcare providers on recognising and addressing issues related to husband supremacy.

7.6.4 Traditional Caregiving

Community education programmes are essential to raising awareness about traditional and modern healthcare practices. NGOs should emphasise the benefits and limitations of each course and the importance of informed decision-making when seeking medical intervention. Collaboration between traditional healers and modern healthcare providers should also be fostered. Traditional healers should be trained to

recognise signs requiring referral to healthcare centres, promoting a complementary approach to healthcare. Healthcare providers should undergo cultural competence training to enhance their understanding of and respect for traditional practices. This training should enable them to work collaboratively with patients who choose to integrate conventional methods into their healthcare. Open dialogues should be facilitated within the community to discuss the advantages and potential risks associated with overreliance on traditional healthcare. Community members should also be engaged in decision-making processes to ensure cultural sensitivity in healthcare delivery. Finally, incentives or benefits should be implemented for individuals who utilise modern healthcare services, such as reduced costs, transportation support, or community-specific incentives, to encourage a shift towards seeking medical care in healthcare facilities.

7.6.5: Preference for TBAs Service

Healthcare managers, community leaders, and advocacy groups should train and retrain Traditional Birth Attendants who work with pregnant women frequently. This recommendation was borne out of the high patronage of the services of the TBAs over the years. It was evident that the study's findings showed that community members who utilised the services of TBAs did so because the services were considered cheap and efficient compared to those of modern maternal healthcare services.

Also, the TBAs were preferred to the skilled health workers as almost all of them were females. The male partners red the service of female health workers. Furthermore, the TBAs were respected for their spirituality and ability to handle pregnancy-related complications caused by spirits. The utilisation of the services of the TBAs, for various reasons gathered from this study, is a picture of their great influence in the communities. Pregnant women and their husbands had a high level of trust in them. Training and retraining of the TBAs will increase the safe delivery rate and the demand for additional trained healthcare service providers in rural areas.

TBAs should be trained to clean and disinfect delivery tools for hygienic practices. The TBAs are known for using unsterilised instruments during the delivery of pregnant women (Shimpuku *et al.*, 2021). In a study conducted in Borno State, sterilised tools were used among trained TBAs. (Bello, Ambe, Yahaya, and Omotara, 2008). The services of TBAs cannot be eliminated, especially in rural areas where skilled healthcare workers are in short supply, while the communities have a lot of TBAs

taking care of pregnant women. They contribute to the work of trained healthcare workers through the knowledge and experiences gathered over the years. They will be competent, skilled health workers. Mothers in rural northern Nigeria can build their trust in the services of trained healthcare workers and have more positive birth experiences. Implementing this practical change could help Nigeria reach its goal of making maternal healthcare accessible to everyone. Hence, the TBAs should have the tools to implement speedy and efficient services. The TBAs should be trained in an active evaluation and referral system to avoid complications and eventualities. They should be equipped with the necessary skills to detect potential dangers before, during, and after childbirth. This type of training can help them with the early detection of complications and how to quickly refer pregnant women to the health centre to avoid eventualities like losing mothers or their babies. They should be equipped with training to provide counselling services for pregnant women in alignment with Western healthcare services since they are closer to the community women. The TBAs have the experience to contribute to the work of skilled health workers.

Healthcare leaders should ensure all TBAs in the community are registered with the health centres for proper supervision and follow-up**.** Healthcare leaders should create a register of all TBAs in the community with free registration. Transport fares and other benefits that will enable the healthcare leaders to g*et the* attention of the TBAs should be provided. The registration could also be carried out from house to house by liaising with the community heads to capture the demographics of the TBAs. The registration would allow the healthcare managers to ascertain the number of TBAs in the communities, which will help to plan for the numbers that will be trained and retrained to have more skilled health attendants. An experienced health worker can be appointed to oversee a group of TBAs to ensure compliance and supervision of their activities.

7.6.6: Women's Spousal Support

Healthcare management should encourage fathers to attend healthcare visits, including antenatal check-ups and birthing classes, to foster a shared responsibility for maternal and infant health. Workplace policies should support paternal involvement in maternity-related activities. Such policies may include flexible work hours for attending medical appointments, parental leave policies, and family-friendly work environments. Incentives or recognition programmes should be introduced for

supportive partners. Public acknowledgment, certificates of participation, or other incentives can encourage active spousal involvement.

Fatherhood preparation programmes should be developed to address impending fatherhood's unique challenges and responsibilities. These programmes can provide practical skills and emotional support for expectant fathers. Policies should recognize the importance of spousal support during maternal healthcare. Health institutions, NGOs, and policymakers can partner to emphasize the positive impact of involved fathers.

7.6.7: Health Workers Attitude

From time to time, management and leaders of the maternal healthcare centres should organise training that promotes attitudinal changes and professionalism among healthcare workers. The training should be routinely delivered because periodic training cannot be overemphasised in any system. Experts should be invited to train healthcare workers. Healthcare management should partner with NGOs to achieve these recommendations. It is recommended that ongoing training programmes on interpersonal communication, cultural sensitivity, and patient-centred care be implemented for healthcare workers. The training should focus on empathy and understanding the patient's perspective. Additionally, integrating cultural competence training into healthcare education can enhance the understanding of diverse cultural backgrounds and beliefs among healthcare workers. Such integration can reduce cultural biases and improve communication with patients from different backgrounds.

Adopting and promoting patient-centred care models within healthcare facilities can also help. Such models emphasize collaboration between healthcare workers and patients, shared decision-making, and a focus on patients' needs and preferences. Establishing mechanisms for patients to provide feedback on their experiences with healthcare workers is also essential. This feedback can be used for continuous improvement and to identify areas for further training or support. Furthermore, healthcare institutions should actively support positive attitudes among healthcare workers by creating a culture that values respect, empathy, and patient satisfaction. They should also provide resources for ongoing professional development. Establishing recognition programs and incentives to acknowledge healthcare workers who consistently demonstrate positive attitudes and provide exceptional patient care

can motivate others to emulate positive behaviours.

Incorporating training on emotional intelligence into healthcare education and professional development can help healthcare workers better understand and manage their emotions while empathizing with patients. Regular supervision and evaluation of healthcare workers' interactions with patients, constructive feedback, and support for improvement where necessary can facilitate continuous growth.

7.6.9: Staff Shortage

To attract healthcare professionals to rural areas, the government should offer financial incentives such as signing bonuses, student loans, housing support, and tax incentives. They should establish community health worker programmes to train and deploy individuals from local communities to provide essential healthcare services. These workers can serve as a bridge between the community and formal healthcare facilities.

NGOs should collaborate with educational institutions to establish satellite campuses, training programmes, or partnerships to produce healthcare professionals committed to rural practice. Such collaboration can help create a pipeline of professionals who understand and are invested in rural healthcare.

They should implement flexible staffing models that consider the unique needs of rural healthcare facilities. Such implementation may involve part-time, rotational, or shared staffing arrangements to optimize the use of available healthcare professionals.

The government should invest in training and skill development programs to enhance the capabilities of existing rural healthcare staff. Such investment can include ongoing education, workshops, and certifications to ensure that staff members are well-equipped to handle various healthcare needs in the environment for healthcare professionals, including providing modern equipment, comfortable living arrangements, and supportive infrastructure.

7.7 Suggestions for future study

Based on the study's findings, the researcher raised the following suggestions for

future directions.

- Studies should be conducted into the patient demographics patronising Western maternal healthcare centres. The demographic should include family size, socioeconomic status, the distance of residence to the maternal healthcare centre, state of origin, religion, and educational qualification. The results could help determine the categories of patients that mostly patronise the western maternal healthcare centres in the communities in the state.
- Studies should be conducted to determine differences in the activities of trained and untrained TBAs to discover the impact of training on their services. The possible variables to consider are hygiene practices and perceptions about healthcare matters.
- This study used data triangulation to collect data from women, husbands, skilled health workers, and traditional health attendants. However, future studies could incorporate politicians, religious leaders, and community heads in the datasets to hear their views on the issue that deals with maternal health matters in the communities. The inclusion of the politicians implies they are in the best position to discuss the role of the government in promoting the utilisation of health care in the communities.
- Studies involving husbands' participation in maternal and child delivery in northern Nigeria should be encouraged. More studies should be conducted on the experiences of women who utilise the formal health care system and those who utilise the traditional health care system. The lived experiences of women who used the hybrid form, formal and traditional health care, could also be included. In contrast, similarities and differences in their experiences could be analysed. Such a study could provide detailed information the present study did not provide.

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Appendix 1

Participant Information Sheet for Focus Group Discussion

Study title

Exploration of women's lived experiences and perspectives of maternal stakeholders on the utilisation of maternal healthcare services in Bauchi State, Nigeria

Why have I been invited?

You are requested to take part in this research study on the impact of culture on maternal health service utilisation among women of reproductive age 15-49 years. Before you decide whether you wish to participate, you must understand why the study is being conducted and what it will involve. Please take some time to read the information provided and discuss it with others if you so wish. Please ask the researcher if anything is unclear or if you want more information.

What is the purpose of the study?

This study aims to explore the cultural factors that affect the utilisation of maternal health services among women of reproductive age 15-49 years in Bauchi state. The research objectives are to identify the cultural factors and evaluate and explore these factors to offer sustainable techniques that can improve maternal healthcare utilisation.

Why have I been chosen?

You have been chosen to participate in the study because you live in the target community where the research will be conducted and because of your experience with maternal health issues. Therefore, there is a possibility that some of you will be pregnant at the time of the data collection process. Because the study is to look at maternal health outcomes, you are more likely to recall pregnancy and other related complications. You will be, therefore, more exposed to maternal health issues. However, those who are more than 7 months pregnant will not be included in the study due to the discomfort associated with pregnancy at that stage (e.g., labour). A risk assessment has been conducted for those below 7 months pregnant to participate in the research.

Do I have to take part?

Taking part is entirely voluntary. You will be given 7 days (one week) to decide whether to participate or not. If you decide to take part, you will be asked to sign a consent form to confirm that you understand the project and are happy to participate. If you decide to take part and then change your mind, you are free to withdraw from the study or withdraw any data you have given within 30 days of participating.

What will my participation involve?

If you agree to participate in the study, you will be asked to participate in a focus group discussion of 60-90 minutes. You will be providing information about maternal health services that you are aware of and factors affecting the use of these services. During the focus group, notes will be taken, and the conversation will be recorded.

Will my information be kept confidential?

The summary of the research findings will be available publicly in academic journals, Conference papers for easy access. All the information collected for this study will be stored securely on a password-protected network drive provided by the university. Your details will be coded and anonymised during the analysis and reporting stage. Personal details will be stored in a separate folder in the researcher's network drive. This data is mainly for academic purposes, which could include publications in journal articles and conferences.

What are the possible benefits of taking part?

The study results can be used to improve the provision and utilisation of maternal health services, which will lead to improved maternal health in your area. You will receive a summary of the key findings of this study, which will enhance your decision-making process. Participating will also increase your awareness of available services.

What are the possible risks or disadvantages of taking part?

There are no perceived risks or disadvantages to your participation in this research study. However, if you experience any distress during the interview, you have the right not to answer particular questions. Should you feel distressed in any way, you will be referred to a support group organised for women with similar experiences.

What if something goes wrong?

If you have any concerns about any aspect of the way you have been approached or treated during this study, then please get in touch with The Honourable Commissioner for Health, Dr Halima Mukadd: the Ministry of Health Bauchi, P. M. B. 65. Telephone number: +243077542895, who will do her best to answer your query. Alternatively,

you can contact the project supervisory team. Dr Tracey Redwood (Tracey.Redwood@northampton.ac.uk), Dr Kay Calver (Kay.Calver@northampton.ac.uk), Dr Melinda Spencer (Melinda.Spencer@northamptom.ac.uk)

What will happen to the findings of the study?

The findings of this study will form the primary basis of my thesis. They will be used in the following ways: -

i. The results will be made available on the University of Northampton website

ii. The results will become part of the evidence base for policymakers in Nigeria who funded the study

iii. Other researchers could use the results

iv. The results will be published in healthcare journals and other appropriate publications

If you want to receive a summary of the findings, please indicate this on the consent form or contact the researcher.

Who has reviewed the study?

This study has been reviewed and approved by the Research Ethics Committee at the University of Northampton Waterside Campus, NN1 5PH, United Kingdom and Nigeria.

Contact for further information

If you have any queries about this study or your possible involvement, please contact me using the contact details below.

Hadiza Yakubu Azi. Email: Hadiza.Azi@northampton.ac.uk. Phone number: 07395242359, or you can contact my supervisory team: Dr Tracey Redwood. Email: Tracey.Redwood@northampton.ac.uk. Dr Kay Calver. Email: Kay.Calver@northampton.ac.uk. Dr Melinda Spencer. Email: Melinda.Spencer@northampton.ac.uk

Thank you for considering taking part in this study.

Participant Information Sheet for Individual Interview

Study title

Exploration of women's lived experiences and perspectives of maternal stakeholders on the utilisation of maternal healthcare services in Bauchi State, Nigeria

Why have I been invited?

You are requested to take part in this research study on the impact of culture on maternal health service utilisation among women of reproductive age 15-49 years. Before you decide whether you wish to participate, you must understand why the study is being conducted and what it will involve. Please take some time to read the information provided and discuss it with others if you wish. Please ask the researcher if anything is unclear or if you want more information.

What is the purpose of the study?

This study aims to explore women's lived experiences and perspectives of maternal healthcare stakeholders on women's utilisation of maternal healthcare services in Bauchi State, Nigeria, and evaluate and explore these factors to recommend sustainable strategies that can improve the utilisation of maternal healthcare.

Why have I been chosen?

You have been chosen to give your opinions because you belong to one of the groups of people listed below

i. You are the head of the family who, as the final authority, decides whether your wife or dependent should seek maternal healthcare

ii. You are a health care professional who renders maternal healthcare services.

Do I have to take part?

Taking part is entirely voluntary. You will be given 7 days (one week) to decide whether to participate or not. If you decide to take part, you will be asked to sign a consent form to confirm that you understand the project and are happy to participate. If you decide to take part and then change your mind, you are free to withdraw from the study or withdraw any data you have given within 30 days of participating.

What will my participation involve?

You will be asked to participate in an interview discussion that will last 30-60 minutes. You will provide information on your thoughts about maternal health service utilisation and the factors affecting these services.

Will my information be kept confidential?

The summary of the research findings will be publicly made available in academic journals and conference papers for easy access. All the information collected for this study will be stored securely on a password-protected network drive provided by the university. Your details will be coded and anonymised during the analysis and reporting stage. Your data will be stored in a separate folder in the researcher's network drive. This data is mainly for academic purposes, which could include publications in journal articles and conferences.

What are the possible benefits of taking part?

The benefits of taking part in this study are: -

The study's findings will lead to an increased understanding of the utilisation of maternal health services, which can contribute to improved maternal health in your region. You will receive a summary of this study's key findings, which will enhance your decision-making process. The knowledge acquired can be applied to real-life situations, and it will increase your awareness of available services.

What are the possible risks or disadvantages of taking part?

There are no perceived risks or disadvantages to your participation in this research study.

What if something goes wrong?

If you have any concerns about any aspect of how you have been approached or treated during this study, please contact The Honourable Commissioner for Health, Dr Halima Mukadd. Ministry of Health Bauchi, P. M. B. 65. Telephone number: +243077542895, who will do her best to answer your query. Alternatively, you can contact the project team at Tracey Redwood (Tracey.Redwood@northampton.ac.uk) Dr Kay Calver (Kay.Calver@northampton.ac.uk)

What will happen to the findings of the study?

The findings of this study will form the primary basis of my thesis. They will be used in the following ways: -

i. The results will be made available on the University of Northampton website

ii. The findings will become part of the evidence base for policymakers in Nigeria who funded the study.

iii. Other researchers could use the data as well

iv. The findings will be published in healthcare journals and other appropriate publications

If you want to receive a summary of the findings, please indicate this on the consent form or contact the researcher.

Who has reviewed the study?

This study has been reviewed and approved by the Research Ethics Committee at the University of Northampton Waterside Campus, NN1 5PH, United Kingdom and Nigeria.

Contact for further information

If you have any queries about this study or your possible involvement, please contact me using the contact details below.

Hadiza Yakubu Azi. Email: Hadiza.Azi@northampton.ac.uk. Phone number: 07417359685, or you can contact my supervisory team: Dr Tracey Redwood. Email: Tracey.Redwood@northampton.ac.uk. Dr Kay Calver. Email: Kay.Calver@northampton.ac.uk. Dr Melinda Spencer. Email: Melinda.Spencer@northampton.ac.uk

Thank you for considering taking part in this study

Appendix 2

An invitation letter to participate in the research titled: Exploration of women's lived experiences and perspectives of maternal stakeholders on the utilisation of maternal healthcare services in Bauchi State, Nigeria

Dear Sir/Madam,

Hadiza Yakubu Azi is a doctoral research student at the University of Northampton, the United Kingdom, with an interest in the health of women, specifically those in their childbearing age. The interview takes around 60-90 minutes for the focus group discussion and 30-60 minutes for the one-on-one interview. Your responses to the research questions will be kept confidential.

The study aims to explore women's lived experiences and perspectives of maternal healthcare stakeholders on women's utilisation of maternal healthcare services in Bauchi State, Nigeria. The researcher wants to capture your thoughts, views, and ideas about the research topic in a one-off focus group discussion and a one-on-one interview.

You are invited to take part in this research study as you have first-hand information about maternal health services. Before you decide whether to take part, it is important to understand what the research is about and what will be expected of you if you decide to participate.

A detailed participant information sheet about the research study is included with this letter; please take your time to go through it before you decide. If you have any questions about the study, please do contact the researcher's telephone number, +2347032830868, and I will be happy to discuss any of your questions.

Thank you

Yours sincerely,

Hadiza Yakubu Azi

Date: 02/12/19

Appendix 3
Consent Form for Focus Group Discussion

TITLE: Exploration of women's lived experiences and perspectives of maternal stakeholders on the utilisation of maternal healthcare services in Bauchi State, Nigeria

By signing this form, I agree that:

	Yes	No
I am voluntarily taking part in this study.		
I have read and understood the information provided to me, and I know what the research is about		
I understand that I am allowed to ask questions about this study and to discuss my potential participation with other people.		
I understand that there will be no payment or benefit of any kind for my participation.		
I understand that I can take part in the research if I am less than 7 months old. Pregnant		
I agree to sign a confidentiality form to ensure confidentiality and disclosure agreement		
I understand that I will be given 7 days to decide whether to participate or not. I am free to withdraw from the study without explaining my reason(s) and can withdraw any information I have given within 30 days of participation, after which I will not be able to withdraw my data.		
I understand that this data will be kept at the University of Northampton and its online systems and may be used for articles or reports as an output of this research thesis, but my confidentiality and anonymity will be maintained.		
I understand that confidentiality can be broken if I disclose that someone is at risk of harm to self or a risk to others, it will be reported to the appropriate authorities or the project supervisory team in order to reduce the risk of harm.		
The procedures regarding confidentiality and anonymity have been explained to me clearly.		
I have been allowed to have a summary of the findings via a method of my choice if I wish to receive them.		

Participant's Name…….
Participant's Signature…… Date:
Husband/Relative's Signature……Date…….
Researcher's Signature…… Date…….

CONSENT FORM FOR INDIVIDUAL INTERVIEW

TITLE: Exploration of women's lived experiences and perspectives of maternal stakeholders on the utilisation of maternal healthcare services in Bauchi State, Nigeria

By signing this form, I agree that:

	Yes	No
I am voluntarily taking part in this study.		
I have read and understood the information provided to me, and I know what the research is about.		
I understand that I am allowed to ask questions about this study and to discuss my potential participation with other people.		
I agree with the interview to be audio recorded.		
I understand that there will be no payment or benefit of any kind for my participation.		
I understand that I will be given 7 days to decide whether to participate or not I am free to withdraw from the study without explaining my reason(s) and can withdraw any information I have given within 30 days of participation after which I will not be able to withdraw my data.		
I understand that this data will be kept at the University of Northampton and its online systems and may be used for articles or reports as an output of this research thesis, but my confidentiality and anonymity will be maintained.		
I understand that confidentiality can be broken if I disclose that someone is at risk of harm to self or pausing a risk to others, it will be reported to the appropriate authorities or the project supervisory team in order to reduce the risk of harm		
The procedures regarding confidentiality and anonymity have been explained to me clearly.		
I have been allowed to have a summary of the findings via a method of my choice if I wish to receive them.		

Participant's Name…….
Participant's Signature…… Date:
Husband/Relative's Signature……Date…….
Researcher's Signature…… Date…….

Appendix 4
Interview Schedule

1 Are you familiar with the health centre in your locality?

2 If yes, how did you learn about the centre?

3 Is the centre easily accessible?

4 Have you had relatives, including wives (wife), that have utilised the maternal healthcare
centres?

5 If no, can you state your reasons?

6 If yes, how would you describe their experiences?

7 Do the services provided in these centres in any way conflict with your beliefs, values, and norms?

8 If yes, can you state the areas of conflict?

9 Are there adjustments that can be made to accommodate your beliefs, values, and norms?

10 If these changes are made, would you encourage your relatives and wives to utilise these
facilities?

11 How often are these services utilised?

12. Would you say the services are good/bad/helpful/unhelpful?

Appendix 5
Focus Group Discussion Questions

PROBE QUESTIONS

What do you think about the services where you live?

Are you aware of the availability of maternal healthcare services in your locality?

How did you learn about these services?

How familiar are you with these maternal healthcare services?

Would you say they are good, bad, helpful, or unhelpful?

FOLLOW-UP QUESTIONS

How often have you used these services?

Did you seek permission from a relative/husband?

What was the reception at the health centre?

Did you share your experiences with your friends?

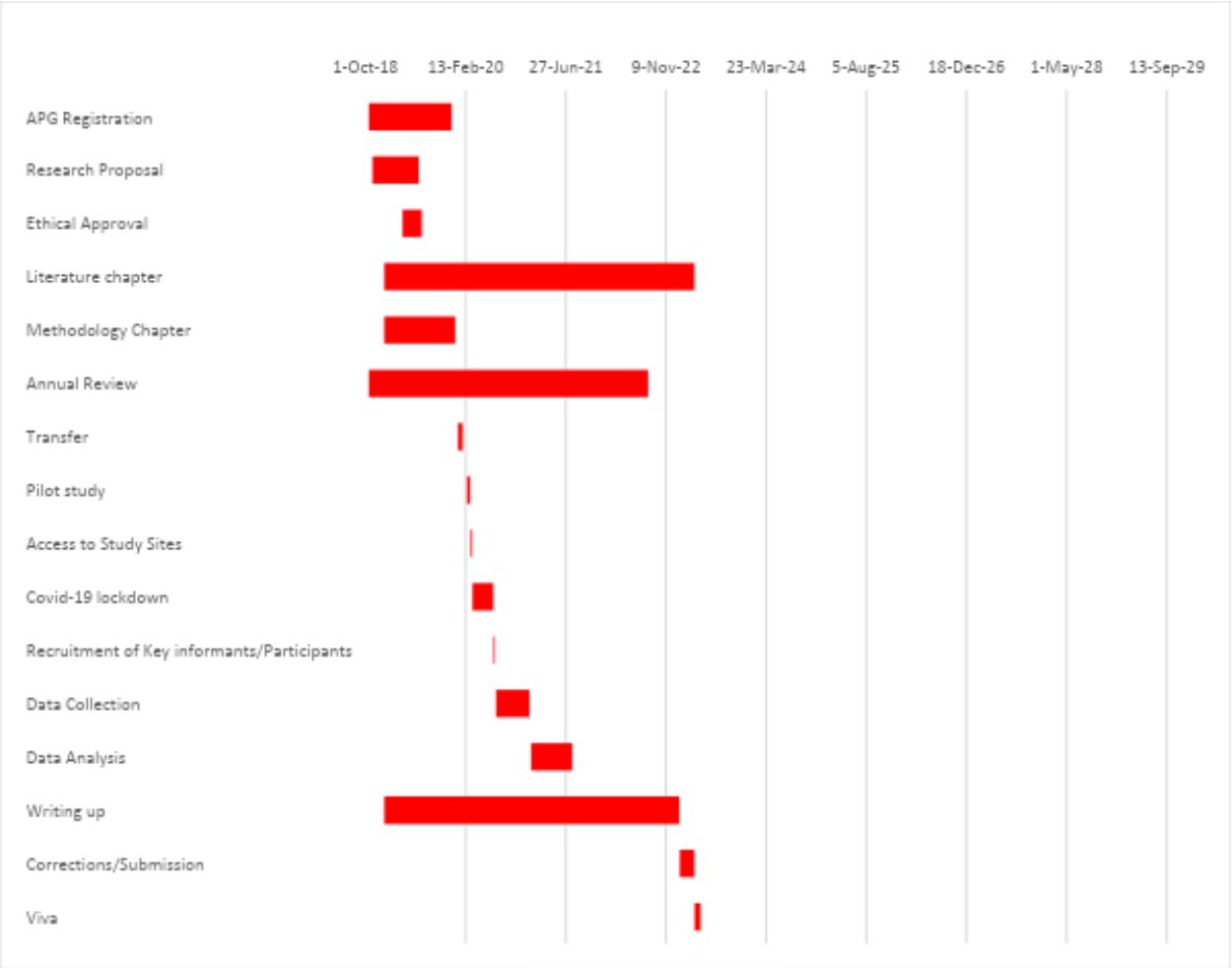
Did these services contrast with your beliefs and values?

If yes, what are the adjustments that need to be made in order to avoid this?

EXIT QUESTIONS

Is there anything else you would like to add?

Appendix6
Timeline



Appendix 7

Group Agreement for Maintaining Confidentiality

Title: Exploration of women's lived experiences and perspectives of maternal stakeholders on the utilisation of maternal healthcare services in Bauchi State, Nigeria

I, at this moment, agree/affirm that I will not, in any way, disclose public information discussed during the focus group discussion. Materials related to this study will not be mentioned to anyone.

Name: …….
Signature: …….
Date: …….
Researcher's Signature: ……

DATA EXTRACTION TABLE

S/N	AUTHORS AND YEAR	TITLE	LOCATION	STUDY DESIGN	RESEARCH POPULATION	FINDINGS	CRITIQUE
1	Abegunde *et al.*, 2020	Tracking maternal and child health intervention targets using Lot Quality Assurance Sampling in Bauchi State, Nigeria	Nigeria	Lot Quality Assurance Sampling (LQAS) technique.	760 households	In Bauchi State, improvements in the maternal and child health continuum were significant but modest.	Subjectivity due to self-reporting by the mothers. Recall bias, especially for children of older age. The shortness of time between the baseline and follow-up may affect the determination of the impact.
2	Abdullahi *et al.*, 2020	Geographical Analysis of Maternal Mortality in Bauchi Town.	Nigeria	Mixed-Method design	Hospital records from January 2018 to June 2019	20-24 years, women were the most vulnerable to experiencing maternal mortalities, which are generally Hausa by the clan, and a large portion of them are Muslim with practically no formal education.	Results and discussion focused mainly on the quantitative aspect, excluding the qualitative aspect.
3	Aborigo *et al.*, 2014	Obstetric Danger Signs and Factors Affecting Health Seeking Behaviour among the Kassena-Nankani of Northern Ghana: A Qualitative Study	Ghana	A cross-sectional design, Purposeful sampling technique, in-depth interviews, and FGD groups	Women who had just had babies, grandmothers, compound and household heads, community leaders, and formal and traditional health providers(n=72)	Misconception about the cause of pregnancy danger signs, cultural beliefs, absence of autonomy to seek medical help	Recall bias

4	Abubakar *et al.*, 2017	Determinants of Home Delivery among Women attending Antenatal Care in Bagwai Town, Kano, Nigeria	Nigeria	Cross-sectional administration of questionnaires	Pregnant women (n =139)	Prefer home delivery in order to evade male staff	In the small sample size, there was nothing to show ethical consideration; the use of questionnaires limited the questions that could be asked possible that could be given for opting for home delivery and the recruitment of only women participants.
5	Adamu *et al.*, 2018	Availability of Material Resources for Focused Antenatal Care in Health Facilities in Bauchi State	Nigeria	A cross-sectional descriptive design with a multi-stage sampling technique, semi-structured questionnaire, and observational checklist	384 pregnant women attending ante-natal clinic	insufficient material resources for Antenatal Care Services in the facilities examined	No report for pre-testing the questionnaire developed by the researcher
6	Adatara *et al.*, 2019	A qualitative study on rural women's experiences relating to the utilisation of birth care provided by skilled birth attendants in the rural areas of Bongo District in the Upper East Region of Ghana	Ghana	Semi-structured interviews, observations,	Adult women and mothers, Key informants(n=20)	disregard for cultural beliefs by skilled birth attendants, lack of trust in skilled birth attendants	Small sample size, respondents were chosen from a small population of women that utilise maternal services, inclusion criteria inadequate
7	Adedini *et al.*, 2014	Barriers to accessing health care in Nigeria: implications for child survival	Nigeria	A cross-sectional design using records	A sample of 18,028 women (aged 15-49)	Limited healthcare utilisation as a result of cultural and financial challenges	The use of secondary data, data sets prone to recall bias.

8	Adedokun *et al.*, 2019	Women who have not utilised health Services for Delivery in Nigeria: who are they, and where do they live? BMC Pregnancy and Childbirth (2019) 19:93	Nigeria	Multistage cluster sampling method, questionnaires	Women who had had children in the last five years	availability of traditional birth attendants	The use of secondary data, data sets prone to recall and self-report bias.
9	Adewemimo *et al.*, 2014	Utilisation of skilled birth attendance in Northern Nigeria: A cross-sectional survey	Nigeria	A cross-sectional survey with a structured questionnaire	400 women within 15-49 years age range (who had delivered a baby within two years prior to the study)	With the availability of skilled personnel, strengthening of the health system, and intervention to eliminate user fees for maternal health services, women are more likely to use maternal healthcare.	Data were gathered using open and closed-ended questions on the questionnaires.
10	Adewuyi *et al.*, 2019	Prevalence and factors associated with underutilization of antenatal care services in Nigeria: A comparative study of rural and urban residences based on the 2013 Nigeria demographic and health survey	Nigeria	Analysis of a cross-sectional and nationally represented health survey datasheet	Women who had had children in the last five years(n=19692)	Income and literacy levels, the proximity of health centre, religious background, spouse's literacy level, residential area, maternal age, mass media exposure, an insurgency in the North region	The use of secondary data, data sets prone to recall bias and self-report bias

11	Adeyemi *et al.*, 2020	Socio-Demographic Barriers to Utilization of Modern Maternal Healthcare Services (MHCS) among reproductive age women utilising the Services of Traditional Birth Attendants (TBAS) in Southwestern Nigeria	Nigeria	Cross-sectional design with multistage sampling technique with the use of a semi-structured questionnaire	(525) reproductive age women utilizing TBAs' services	Most of the respondents used TBA services.	The use of a random sampling technique in selecting the clients of the TBAs may exclude some clients with relevant information.
12	Agho *et al.,* 2018	Factors associated with inadequate receipt of components and use of antenatal care services in Nigeria: a population-based study	Nigeria	Analysis of a cross-sectional and nationally represented health survey datasheet	information on 20 405 singleton live-born infants of the mothers from the 2013 Nigeria Demographic and Health Survey	Common risk factors for underutilization and inadequate components of ANC in Nigeria included residence in rural areas, no maternal education, maternal unemployment, long distance to health facilities, and less maternal exposure to the media.	The use of secondary data, data sets prone to recall and self-report bias.
13	Ajayi *et al.,* 2020	Maternal health care services utilisation in the context of 'Abiye' (safe motherhood) programme in Ondo State, Nigeria	Nigeria	Cross-sectional design cluster random sampling.	434 women who gave birth between 2009 and 2013 409 women who had given birth between 2011 and 2015	The "Abiye" initiative has resulted in a significant increase in the utilization of maternal health services.	The use of secondary data, data sets prone to recall and self-report bias.

14	Ajayi *et al.,* 2022	I don't like to be seen by a male provider": health workers' strike, economic, and sociocultural reasons for home birth in settings with free maternal healthcare in Nigeria	Nigeria	A mixed, sequential, equal-status design	211 women who reported giving birth at home 6 focus group discussions 68 in-depth interviews	Economic, socio-cultural, and facility-related factors, among others, limited women's access to skilled birth attendants. Free healthcare does not guarantee that everyone will have access to healthcare	the review missed the perspectives of the ones who assumed key parts in navigation with respect to picking the spot of conveyance. The reasons health workers return the women home despite their convictions were not reported. ,
15	Alabi *et al.,* 2015	Why are babies born before arrival at health facilities in King Sabata Dalindyebo Local Municipality, Eastern Cape, South Africa? A qualitative study	South Africa	Purposeful sampling, One on one interviews, FGDs	Women who had delivered before getting to the health facility, nurses	Lack of transportation, unsafe trips to the hospital, inability to identify actual labour signs, cultural beliefs that promote home births	Results cannot be generalised; the interview location might have restricted the women's opinions
16	Anwar *et al.,* 2015	Trends and inequities in the use of maternal health care services in Bangladesh	Bangladesh	Quantitative research approaches the trend analysis	data from six Bangladesh Demographic and Health Surveys (BDHS), we	Both access and equity are improving in maternal health	The use of secondary data, data sets prone to recall and self-report bias. There is likely change in the definition of areas considered urban.
17	Ansari *et al.,* 2016	Insights Into Intimate Partner Violence in Pregnancy: Findings from a Cross-Sectional Study in Two States in Nigeria	Nigeria				

18	Ariyo *et al.*, 2017	The influence of the social and cultural environment on maternal mortality in Nigeria: Evidence from the 2013 demographic and health survey	Nigeria	Analysis of a cross-sectional and nationally represented health survey datasheet, questionnaires	Women(n=38948)	Region of residence, economic status, literacy level, religion, autonomy to make decision	The use of secondary data, data sets prone to recall and self-report bias.
19	Al-mujtaba, *et al.*, 2016	Evaluating Religious Influences on the Utilization of Maternal Health Services among Muslim and Christian Women in North-Central Nigeria	Nigeria	Qualitative research approach	7 FGDs with 2 Mentor Mothers, 2 for ANC clinic attendees, 2 among mother-to-mother (M2M) HIV support group, and 1 with young women,	Barriers to the uptake of maternal health services appear to be minimally influenced by religion. ANC/PMTCT	there was a disproportion in the number of Christian and Muslim women participants represented, ANC attendees, implying that they already had a preference for facility-based services over alternate or home-based care.
20	Arnold *et al.*, 2016	Getting There: Overcoming Barriers to Reproductive and Maternal Health Services Access in Northern Togo—A Qualitative Study Original Article	Togo	Key informant, semi-structured interviews, FGDs, purposive sampling	Formal and traditional healthcare providers, community leaders, women's leaders, and mothers(n=45)	Seeking spouse consent, gender barriers	Results cannot be generalised, with limited study time, recall bias, and small sample size.
21	Atekyereza and Mubiru, 2014	Influence of pregnancy perceptions on patterns of seeking antenatal care among women of reproductive age in Masaka District, Uganda	Uganda	Case study interviews and FGDs	Women of reproductive age(n=45)	Use of herbs instead of antenatal care, perceptions of pregnancy as a normal process needing no medical attention, observance of taboos	Recall bias, small sample size, and the result might not reflect the general views.

22	Atinge *et al.,* 2017	Factors Associated with Choice of Non-Facility Delivery among Women Attending Antenatal Care in Bali Local Government Area of Taraba State, North-Eastern Nigeria	Nigeria	Descriptive cross-sectional design with multi-stage sampling technique	320 women of childbearing age who attended ANC and had had a recent delivery.	It was found that non-facility delivery was too high, with ethnicity and antenatal place care as influencing factors.	Use of informed verbal consent instead of documented one
23	Azuh *et al.,* 2017	Factors influencing maternal mortality among rural communities in southwestern Nigeria	Nigeria	Multistage sampling, key informant survey approach, administration of questionnaires, FGDs	Spouses of the deceased women, birth attendants, community health workers, pregnant women, and community development associations(n=360)	Health services do not that incorporate cultural beliefs, preference for institutional delivery, or male dominance.	Small sample size, recall bias, results cannot be extrapolated.
24	Bohren *et al.,* 2017	Mistreatment of women during childbirth in Abuja, Nigeria: a qualitative study on perceptions and experiences of women and healthcare providers.	Nigeria	Qualitative research with in-depth interviews and Focus Group Discussions	Women who have given birth at any time in the previous year; healthcare providers; and facility administrators	Participants identified three main factors contributing to mistreatment: poor provider attitudes, women's behaviour, and health systems constraints.	Likelihood of recall bias from discussion with women who had given birth in the previous year. Possibility of underreporting with respect to discussion on mistreatment
25	Caulifield *et al.,* 2015	Factors influencing place of delivery for pastoralist women in Kenya: a qualitative Study	Kenya	In-depth interviews, FGDs	Women who had delivered in the last two years, husbands, traditional birth attendants, community health workers	Preference for home delivery, patronise TBAs, evade male health staff	Small sample size, translation error, and results obtained may not reflect the general view

26	Chi *et al.,* 2015	A qualitative study exploring the determinants of maternal health service uptake in post-conflict Burundi and Northern Uganda	Uganda	In depth-interviews, FGDs	Women of reproductive age, local health care providers, NGO staff	secrecy of pregnancy	Respondents are limited to the users of health care services, a small sample size.
27	Chimatiro *et al.*, 2018	Understanding barriers preventing pregnant women from starting an antenatal clinic in the first trimester of pregnancy in Ntcheu District	Malawi	Cross-sectional study, FDGs, in-depth interviews	Women of childbearing age, pregnant women, antenatal health service workers, key informants(n=138)	Mother-in-law permissions and the fear of witchcraft cause a delay in antenatal visits.	Respondents were selected from only the antenatal care clinic in a small sample size.
28	Chol *et al.*, 2019	Women's autonomy and utilisation of maternal healthcare services in 31 Sub- Saharan African countries: results from the demographic and health surveys, 2010–2016	Sub-Saharan African countries.	cross-sectional design with e probability sampling methods	31 countries (194 883 women)	weak, although statistically significant, associations between women's autonomy and use of both ≥4 ANC and SBAs.	DHS data are cross-sectional, so the direct relationship between women's autonomy and the utilisation of maternal healthcare services cannot be determined with certainty.
29	Cockcroft *et al.*, 2019	The impact of universal home visits with pregnant women and their spouses on maternal outcomes: a cluster randomised controlled trial in Bauchi	Nigeria	A cluster randomised controlled trial	women of childbearing age (14–49 years) in	Home visits reduced upstream maternal risks, improving maternal outcomes without increased use of health services.	Likelihood of imbalance of unmeasured cluster-level covariates between the groups.

30	Dahiru *et al.*, 2015	Determinants of antenatal care, institutional delivery and postnatal care services utilization in Nigeria	Nigeria	A cross-sectional descriptive design using records	38,945 eligible women and 17,359 men, all aged 15-49 years.	age of mother, place of residence, mother's and husband's level of education, working status of the woman, household wealth quintile, health insurance enrolment, religion, and woman's decision-making autonomy affected women's utilisation of institutional delivery	The use of secondary data recall bias. The result of causal inferences is better done with experimental study designs.
31	Dairo and Atanlogun, 2018	Utilization of antenatal and postnatal care services among adolescents and young mothers in rural communities in southwestern Nigeria	Nigeria	A community-based cross-sectional study with multistage sampling	251 young women.	Low utilization of full antenatal and postnatal services linked to personal health and economic factors.	Possibility of recall bias from self-reporting of antenatal visits by the young mothers. There is a likelihood of inaccurate reporting of post-natal visits due to the possibility of including a minor visit for a major visit.
32	Ebuehi and Akintujoye, 2022	Perception and utilization of traditional birth attendants by pregnant women attending primary health care clinics in a rural Local Government Area in Ogun State	Nigeria	A descriptive cross-sectional design using a structured questionnaire	250 pregnant women attending four primary health care clinics	Respondents' very positive attitude to TBA services in spite of their limited knowledge of TBA roles in maternal health care.	The respondents sampled have limited knowledge of the services of the TBAs.

33	Egharevba *et al.*, 2017	Factors Influencing the Choice of Child Delivery Location among Women Attending Antenatal Care Services and Immunization Clinics in Southeastern Nigeria	Nigeria	Cross-sectional survey	Women attending antenatal clinics, women who have delivered 18 months from a reference date, and women immunising their infants(n=217)	The frequency of home or facility delivery affected the use of healthcare centres.	Probability of self-report and recall bias, a small sample size
34	Egbewale and Odu, 2013	Perception and Utilization of Primary Health Care Services in a Semi-Urban Community in South-Western Nigeria	Nigeria	A descriptive cross-sectional	395 adults residing in the community for at least five years	There is low utilisation of primary health care despite a high awareness level.	
35	Fagbamigbe and Idemudia, 2015	Barriers to antenatal care use in Nigeria: evidence from non-users and implications for maternal health programming	Nigeria	Records of the 2012 national HIV/AIDS survey, a cross-sectional study of randomly sampled women and men of reproductive age	Women and men of reproductive age(n=2199)	Lack of autonomy to make decisions, religious barriers	The use of secondary data, recall bias
36	Fantaye *et al.*, 2019	A qualitative study of community elders' perceptions about the underutilization of formal maternal care and maternal death in rural Nigeria	Nigeria		158 community elders in 9 rural communities	Perceived reasons for the underutilization of formal maternal care included poor quality of care, physical inaccessibility, financial inaccessibility, and lack of community knowledge. Perceived	Small sample size,

37	Fapohunda and Orobaton, 2013	When Women Deliver with No One Present in Nigeria: Who, What, Where, and So What?	Nigeria	Quantitative records analysis	2008 Nigeria DHS data collected from 33,385 women aged 15–49 years and 15,486 men aged 15–59 years	Northern Nigeria has the highest number of cases of No One Present (NOP) in Nigeria. Women's age at birth, birth order, being Muslim, and region of residence were positively associated with NOP deliveries.	Recall bias
38	Ganle *et al.*, 2015	How intra-familial decision-making affects women's access to, and use of maternal healthcare services in Ghana: a qualitative study	Ghana	Cross-sectional study, FGDs, one on one interviews	Expectant and lactating mothers, key informant interviews (n=205)	Values and opinions of husbands, mothers-in-law, traditional birth attendants' patronage	Small sample size, prone to recall bias translation errors,
39	Jackson and Hailemariam, 2016	The Role of Health Extension Workers in Linking Pregnant Women with Health Facilities for Delivery in Rural and Pastoralist Areas of Ethiopia	Ethiopia	Purposive sampling technique, Interviews, and focus group discussions	45 Health Extension Workers (HEW) 14 women extension workers, 11 other health workers	Distance, lack of transportation, sociocultural factors, and disrespectful care barriers to utilising the healthcare service	Sim: both were carried out in rural areas. Not clear mentioning of research design and analytic technique.
40	Kaba *et al.*, 2016	Sociocultural determinants of home delivery in Ethiopia: a qualitative study	Ethiopia	Key informant interview, in-depth interviews, FGDs(n=182)	Women who had birthed at home or a health facility	Health facilities are not viewed as a natural place of birth	Recall bias
41	Karanja *et al.*, 2018	Factors influencing deliveries at health facilities in a rural Maasai community in Magadi sub-County, Kenya	Kenya	cross-sectional study, FGDs, Interviews	Women, health caregivers, community health volunteers, community chiefs, traditional birth attendants, and major decision influencers(n=257)	No autonomy of decision, male dominance, taboos concerning pregnancy	Small sample size, lack of ethical consideration, recall bias

42	Kea *et al.*, 2018	Exploring barriers to the use of formal maternal health services and priority areas for action in Sidama zone, southern Ethiopia	Ethiopia	In-depth interview, FGDs (n=58)	Women, men, traditional birth attendants, skilled health workers	Lack of autonomy to make decisions, cultural beliefs, confidence in traditional birth attendants, no cordial relationship between women and skilled health staff, perceptions of pregnancy as a normal process	Recall bias and the result might not reflect the general trend
43	Kohi *et al.*, 2018	When, where, and who? Accessing health facility delivery care from the perspective of women and men in Tanzania: a qualitative study	Tanzania	FGDs and semi-structured interviews	women attending postnatal clinic and men (n=35)	Autonomy in decision-making	Recruitment of participants from only a postnatal hospital makes room for bias in a small sample size.
44	Kumbani *et al.*, 2013	A qualitative study of women's perceptions of perinatal care from rural Southern Malawi.	Malawi	A descriptive qualitative study design with face-to-face, in-depth interviews	12 interview participants	The onset of labour at night, rainy season, rapid labour, socio-cultural factors, and health workers' attitudes were related to the women delivering at home. The participants were assisted in the delivery by traditional birth attendants, relatives, or neighbours.	Possibility of excluding some mothers with additional views who delivered at home within three months. Possibility of excluding some mothers who may not come to the health centre because of the rainy season. Follow-up of participants was not reported.

45	Laing *et al.*, 2017	Barriers to Antenatal Care in an Urban Community in the Gambia: An In-depth Qualitative Interview Study	Gambia	Semi-structured interviews	Pregnant women, male spouses, key informants, and healthcare staff(n=47)	Secrecy of pregnancy, the perception that pregnancy is normal, the use of herbs and traditional healers, the autonomy of decision	Small sample size, data were collected only via interviews, possible bias by some respondents
46	Mohamoud *et al.*, 2022	Knowledge Attitude and Practice towards Antenatal Care among Pregnant Women Attending Antenatal Care in SOS Hospital at Hiliwa District, Benadir Region, Somalia	Somalia	Descriptive cross-sectional design through interview method with a structured questionnaire	Sixty (60) pregnant women attending antenatal care	there was good knowledge and positive attitude towards ANC despite poor ante-natal care utilisation, the	Small sample size,
47	Morris *et al.*, 2014	Maternal Health Practices, Beliefs, and Traditions in Southeast Madagascar	Madagascar	Mixed method approach, in-depth interview, serial qualitative interviews	Pregnant women, mothers of children less than five years, and spouses(n=629)	Absence of knowledge, practices, unwholesome practices, deferment of clinics, lack of autonomy to make decisions	Data translation problems results not applicable to some areas

48	Morris *et al.*, 2014	Access barriers to maternal healthcare services in selected hard-to-reach areas of Zambia:	Zambia	A concurrent mixed methods approach: informant interviews, in-depth key interviews, and focus group discussions	190 women	respondents were happy with the facilities' opening and closing times in both districts. By comparison, however, women in Ngabwe spent significantly more time traveling to facilities than those in Kaputa, with bad roads and transport challenges cited as factors affecting service use.	Generalisation of results to other settings
49	Okafor *et al.,* 2014	Why are babies born before arrival at health facilities in King Sabata Dalindyebo Local Municipality, Eastern Cape, South Africa? A qualitative study	Nigeria	Semi-structured interviews	Women(n=25)	Traditional beliefs	Recall bias
50	Riang *et al.*, 2018	I should have started earlier, but I was not feeling ill! Perceptions of Kalenjin women on antenatal care and its implications on initial access and differentials in patterns of antenatal care utilisation in rural Uasin Gishu County Kenya.	Kenya	Researcher-administered questionnaires with closed and open questions, face-to-face interviews to enable body language observations	Pregnant and postnatal mothers traditional birth attendants (n=200)	Preference for TBAs, perception of pregnancy as normal, the use of herbs	recall bias, and results might not reflect a general trend

51	Serizawa *et al.*, 2014	Cultural perceptions and health behaviours related to safe motherhood among village women in Eastern Sudan: Ethnographic study	Sudan	Ethnography, snowball sampling technique, semi-structured interviews	Married women of reproductive age(n=6)	seek permission from husband or mother-in-law, the belief in the will of God in every circumstance, witchcraft	Utilised only interviews to collect data, small sample size,
52	Sialubanje *et al.*, 2015	Improving access to skilled facility-based delivery services: Women's beliefs on facilitators and barriers to the utilisation of maternity waiting homes in rural Zambia	Zambia	In-depth interviews, questionnaires	Women of reproductive age	Lack of autonomy to make decisions, cultural norms, gender inequality	Small sample size, the use of only interviews to collect data, recall bias, and results cannot be generalised
53	Some *et al.*, 2014	What prevents women from the sustainable use of maternal care in two medical districts of Burkina Faso? A qualitative study	Burkina Faso	In-depth interviews, FGDs, observations	Women attending health centres	Cultural barriers, lack of autonomy to seek help, the secrecy of pregnancy	Recall bias and results cannot be generalised
54	Sumankuuro *et al.,* 2017	The use of antenatal care in two rural districts of Upper West Region, Ghana.	Ghana	Mixed method approach, FGDs, in-depth interviews	Expectant mothers, skilled health workers, and community members(n=333)	cultural influences that lead to deferment of clinic birthing,	Recall bias
55	Tsawe *et al.*, 2014	Determinants of access to and use of maternal health care services in the Eastern Cape, South Africa: a quantitative and qualitative investigation	South Africa	Mixed-Methods Questionnaire and Interviews	267 female respondents health care professionals (2 nurses, 2 doctors, and 2 maternal health specialists)	A low number of women accessing the health care services. Staff shortages, financial problems, and lack of knowledge about maternal health care services and the	There was no clear-cut definition of the type of analytical technique used for the analysis of the qualitative data.

						importance of the services	
56	Wilunda *et al.*, 2016	Barriers to Institutional Childbirth in Rumbek North County, South Sudan	South Sudan	A cross-sectional qualitative study with focus group discussions (FGDs) and key informant interviews (KIIs). FGDs	169 women 45 men, and 18 key informant interviews	The barriers to the utilisation of institutional child delivery were Issues related to access and lack of resources, socio-cultural context and conflict, perceptions about pregnancy and childbirth, and perceptions about the quality of care	Possible loss of information from translation and transcription
57	Wudineh *et al.*, 2018	Postnatal care service utilisation and associated factors among women who gave birth in Debretabour town, North West Ethiopia: a community-based cross-sectional study	Ethiopia	Cross-sectional study, questionnaires	Women who had given birth within the previous year(n=588)	Apparent positive health condition	The probability of recall bias did not include other respondents from the community.

58	Yaya *et al.*, 2018	Why some women fail to give birth at health facilities: A comparative study between Ethiopia and Nigeria	Ethiopia and Nigeria	Cross-sectional data from demographic and health surveys. A three-stage stratified cluster design for Nigeria and a two-stage design for Ethiopia	Women and men, Nigeria(n=13053), Ethiopia(n=24033)	No female health provider, the autonomy of decision, no trust in facilities, health care not necessary	Data restrictions prevented proper analysis of results and prevented the determination of specific reasons for not using health care centres. The utilisation of predetermined questions limited the results obtained.
59	Yaya *et al.*, 2019	Maternal health care service utilisation in post-war Liberia: analysis of nationally representative cross-sectional household surveys	Liberia	Analysis of a cross-sectional and nationally represented health survey datasheet, questionnaires, stratified two-stage cluster design	Women who had had children(n=22621)	Religious beliefs	The use of secondary data, unable to determine causality, prone to recall bias
60	Zepre and Kaba, 2017	Birth preparedness and complication readiness among rural women of reproductive age in Aabeshige district, Gguraghe Zone SNNPR, Ethiopia	Ethiopia	A community-based cross-sectional study design	454 women were Opinion leaders, health extension workers, and selected women in the community were engaged in in-depth interviews and focus group discussions.	Lack of transportation and concern over the cost of services are key barriers. A major source of information was found to be health extension workers and one-to-five women networks.	Possibility of recall bias of the participants interviewed after 1-year delivery. The study focused on a district, generalisation to other settings may not be feasible.

Appendix 9:

Feedback on Recommendations from Examiners

The student should: -

1. Decide whether she should adopt a more pragmatic approach to her data collection, which would enable her to consider including her observational data, including the phenomenological female interviews, focus groups, qualitative male TBAs, and health practitioner interviews (which would entail a change in title and a revision of the methods); or focus solely on the phenomenological female interviews, which would not require the title to be changed.

The title has been modified to accommodate other healthcare stakeholders. The modification adapted the observational data, the phenomenological female interviews, focus groups, qualitative male, TBAs, and health practitioner interviews. The title is found on the title page. The new title is:

Exploration of women's lived experiences and perspectives of maternal stakeholders on the utilisation of maternal healthcare services in Bauchi State, Nigeria

The analytical method was modified as Colaizzi was used to analyse the women's lived experiences while Thematic Analysis was used to analyse the perspectives of other stakeholders (Pages 106-110; 124-217).

2. A more extensive reflective piece is required at the outset which focuses on the students own views of the values, benefits, and potential harms of both western and traditional healthcare approaches, her own potential bias in this area, and which then needs to result in changes to some of the strongly assumptive statements and language in parts of the thesis (eg that western healthcare and medicine is always beneficial and traditional approaches are usually ineffective and dangerous).

The details are found on page 8:

1.10: Researcher's reflective piece on Western and traditional healthcare (Page 8)

3. There needs to be a revision of the ordering and logical flow of the scoping and systematic reviews, especially where there is some repetition, and the reviews need to be updated with missing and recent relevant references, as discussed by the examiner.

The scoping review has been reviewed; the repetitions have been removed; the reviews have been updated with relevant references (pages 13-65)

4. The recommendations need to explicitly link to the data and findings so should be reviewed accordingly.

Each recommendation has been explicitly linked to the data and findings (Pages 255-261)

5. There needs to be more use of qualitative evidence to support the arguments being made, in the form of quotations, and these all need to be correctly labelled (i.e., that quotes from women should be labelled as such, and not mis-labelled as being from a man, and vice versa).

There was qualitative evidence to support the arguments being made, and all quotes were correctly labelled (Pages 145-226)

6. Statistics on maternity mortality need to be checked and amended to ensure accuracy and recency.

The Statistics on maternity mortality were checked and amended for accuracy and recency. The accuracy of the statistics can be confirmed from the references (For instance, Pg 1, paragraph 1)

7. As noted above, the overall balance of the thesis needs to be reviewed to ensure that the data have more weight, and to ensure that the women's voices are heard and not translated through the lens of their husbands, or of staff/TBAs, if the focus remains on women's experiences.

The researcher analysed the women's lived experiences separately from the other stakeholders' perspectives. The analysis of the women's experiences captured their lived experiences and ensured their voices were heard and not translated through the lens of other stakeholders (Pages 124-178)

8. All typographical/spelling errors, incomplete sentences, incorrect and missing references, need to be addressed throughout the thesis.

The thesis has been reviewed with a professional proofreader; all typographical/spelling errors, incomplete sentences, and incorrect and missing references have been addressed throughout the thesis.