

SOCIO-CULTURAL AND HEALTH-SEEKING BELIEFS IN MATERNAL HEALTH CARE UTILIZATION AMONG WOMEN IN RURAL NIGERIA

Magaji Dafi,¹ Iresha M Lackshman², Dilrukshi Abeysinghe² and Kaltum Ibrahim Jidda³

¹PhD Candidate, Faculty of Graduate Studies, University of Colombo, Sri Lanka

²Department of Sociology, University of Colombo, Sri Lanka

³University of Maiduguri Teaching Hospital, Borno State, Nigeria

ABSTRACT

One of the greatest maternal health challenges facing Nigeria, particularly in the northern states, is the influence of cultural and health-seeking beliefs arising from women in different ethnic groups of the country. The objective of the study is to explore socio-cultural and health-seeking beliefs related to maternal healthcare utilisation among women in rural areas of Bauchi state, Nigeria. The study uses qualitative exploratory research design guided by the Health belief model (HBM). The underlying concept of the HBM is that health behaviour is determined by personal beliefs or perception about a disease and the strategies available to decrease its occurrence. In-depth interviews are used to collect relevant data. All the participants were selected through convenience sampling. Fifteen in-depth interviews were conducted with five (5) pregnant/nursing women from each village in the three (3) randomly selected rural areas, making a total of fifteen (15) women. The data collected was transcribed and analyzed using verbatim quotation and thematic analyses. The findings reveal that sociocultural beliefs, health system-related beliefs, availability and accessibility of healthcare, structured by gender, social class, poverty and inequality influences the utilization of maternal healthcare services in rural areas of Bauchi State. The study recommends that policies and interventions aiming at addressing the issues of maternal literacy, cost of maternal health services must be formulated and well implemented. Health workers should be culturally competent when carrying out their duties. The male's role in reproductive health and other health issues should not be neglected. Health campaign and counselling need to be intensified to shape maternal health seeking beliefs of women in rural areas of Bauchi state and to make men more aware of these.

KEY WORDS: Sociocultural beliefs, health-seeking behaviour, maternal healthcare utilization, Nigeria

BACKGROUND

One of the greatest maternal health challenges facing Nigeria, particularly in the northern states, is the influence of cultural and health-seeking beliefs arising from women in different ethnic groups of the country. Specifically, Bauchi State is one of the states with high maternal deaths in the north eastern Nigeria. The state is dominated by Hausa and Fulani ethnic groups co-existing together as indigenous of the area. Nigeria is a patriarchal society and Bauchi state is not an exception. The patriarchy influences all aspects of social life and relationships particularly in seeking for health services by the women. Nigeria is a country of great cultural diversity consisting of over 300 different ethnic groups with an equal number of distinct languages and dialects. In Bauchi state, the source of maternal health and subsequent mortality extend beyond health care delivery, most

maternal morbidity and mortality cases can be attributed to sociocultural factors including cultural and religious influences and other social factors that affect individual preferences. There are demand factors that can be controlled at the community, household or individual levels which are susceptible to policy intervention (Azuh, Fayemi & Ajayi, 2015).

Women's access to and use of maternal health care service in rural areas is very poor and inadequate: where mass poverty, ignorance, disease, low status of women, unrestricted sexual behaviour resulting in high population growth rate. More so, harmful traditional beliefs and poor social amenities all combine to encourage reproductive ill health and developmental backwardness. Also, the rapid rate of population growth in Bauchi state especially in rural areas means that an increasing number of people are living without access and effective utilization of maternal health care services (BPHCDA, 2017). Thus, women are lagging behind in access and utilization of maternal health care services especially in Bauchi state, north-eastern part of Nigeria. It is estimated that about 80 percent of maternal deaths that occur today are due to preventable causes, which could be avoided if women had the timely access to and proper utilization of skilled maternal services (UN Millennium Project, 2015).

OBJECTIVES OF THE STUDY

The general objective of this study is to examine socio-cultural beliefs in maternal health care utilization among women in rural areas of Bauchi state. The specific objectives include:

- (a) To explore the socio-cultural factors that inhibits women from utilizing maternal health care services in rural areas of Bauchi state.
- (b) To examine the health-seeking beliefs influencing utilization of maternal health care services among women in rural areas of Bauchi state.

THEORETICAL FRAMEWORK

This study adopted Health Belief Model which was originally introduced by a group of psychologist in 1950s. It was developed as a systematic method to explain and predict preventive health behavior. It focused on the relationship of health behavior, practice and utilization of health services to help explain why people would or would not use available preventive health care services. The Health Belief Model (HBM) is a theoretical framework used to understand health behaviours and possible reasons for non-compliance with recommended health action (Stretcher & Rosenstock, 1997). The underlying concept of the original HBM is that health behaviour is determined by personal beliefs or perception about a disease and the strategies available to decrease it occurrence (Hochbaum, 1958). The model has four components: (i) Perceived seriousness, (ii). Perceived susceptibility (iii). Perceived benefits (iv). Perceived barriers. Each of these components, individually or in combination, can be used to explain health behaviour. Thus, the model has been expanded to include cues to action, motivation factors and self-efficacy.

In order for a new behavior to be adopted, a person needs to believe of new behavior outweigh the consequences of continuing the old behaviour (Centers for Disease Control and Prevention, 2004). This enables barriers to be overcome and the new behaviours adopted. In trying to increase utilization of maternal health care services by child-bearing women, it seems obvious that the threat of maternal mortality and morbidity would motivate adoption of utilization of maternal health care services. Certainly, maternal mortality and morbidity is a very serious complications for which only women are at risk as such the perception of threat is high. Even though all of these barriers of utilization of maternal health care services exert greater influence over the behaviour than does the threat of maternal mortality and morbidity itself (Elo, 1992; Robert et al. 2016; WHO, 2003) some of these barriers are culture beliefs, economic status and location of health centers.

A REVIEW OF RELATED LITERATURE ON SOCIO-CULTURAL FACTORS

Socio-cultural factors influencing the utilisation of maternal health care services in developing countries include ethnicity, religious beliefs practices, and culture. Ethnicity is one of the factors found by prior empirical studies as influencing utilisation of maternal health care services (Elo, 1992; Gobindasamy & Ramesh, 1997; Matsumura & Gubhaju, 2001; WHO, 2003). Different ethnic groups may exhibit different culture, values and belief systems, which invariably may affect behaviour and perception as well as the use of health care services.

ETHNICITY

Ekman, Axelson, Anh and Nguyen (2007) find ethnicity as a strong and robust factor influencing maternal health care use in Vietnam. From their results, they argued that belonging to the ethnic majority group determines the utilisation of service in a positive significant way. In addition, Abor et al., (2011) reveal that ethnicity and religious affiliation are variables influencing the application of maternal health care in Ghana. Furthermore, Babalola and Fatusi (2009) find similar evidence that ethnicity has a positive effect on maternal health care utilisation in Nigeria. Similarly, Ganle (2015) observes that ethnic differences in the utilisation of prenatal care were small. However, fewer births to women from majority ethnic groups such as Akan 21 percent took place at home compared with births to women from minority ethnic groups such as the Ewe 58.8 percent, Guan 42.7 percent, Gusi 53.4 percent, Mole-dagbani 74.7 percent and Gruma 58.8 percent. This means that there is ethnic disparities in the utilisation of maternal healthcare services in Ghana. Furthermore, Do, Tran, Phonvisay and Oh (2018) observed that there are worries in the disparities between major and minor ethnic group as well as worsening differences between the rich and the poor in using MHC services in Lao people's democratic republic from the year 2000-2012.

RELIGIOUS BELIEFS PRACTICES

Religious beliefs and practices are other factors identified in the literature as having negatively associated with the use of some maternal health services but show no significant difference for others. A study in Bangladesh by Kamal, (2009) finds that utilisation of skilled birth attendants (SBA) was relatively higher among non-Muslim women than among Muslims, but failed to find a

significant association for the use of ANC and institutional delivery. Similarly, a lower tendency for the use of SBA and PNC was found in women in northern Nigeria, who are mainly Muslim, compared to those in the southern part of the country who are mostly of the Christian faith. No significant difference was found in the use of ANC (Babalola & Fatusi, 2009; Nwankwo, 2013). Studies in Ethiopia and Ghana also reveal similar results (Ethiopian Society of Population Studies, 2008; Addai, 2000; Gyimah, Takyi & Addai, 2006).

A study in Ghana by Bour (2009) finds that women belonging to some religious groups; were more likely to refrain from the use of antenatal care and religion is an important determinant of maternal health care utilisation. Findings by Addai (2000), Navaneethan and Dharmalingam (2002) underscore that religion and related socio-cultural beliefs and orientations have significant influence on the antenatal health care seeking behavior of women. Religion may work through what Andersen and Newman (1973) refer to as the perception of need. In the circumstance that, religious beliefs may moderate women's perceptions of need and seriousness of morbidity conditions and therefore the desire to seek care remedies.

CULTURE

Leininger (1995) defines culture as the learned, shared and transmitted values, beliefs, norms and life-ways of a particular group that guides their thinking, decisions, and actions in patterned ways. Similarly, culture determine people's definition of mental, physical health and their interpretations determines how they deal with the illness (Gardener, Komitzki & Mutter 1998). Cultural attitudes such as religion and ethnicity determine the cultural belief of the people (Shire, 2002).

Gardener, Mutter and Koman (1998) reveal that in east Malaysia depression is believed to be caused by evil charms cast by jealous relatives and the affected person may seek assistance from a traditional Healer yet in North America, depression is believed to be biological and may be treated with antidepressants. Furthermore, Shire (2002) finds that if women's husband or mothers-in-law's belief that maternal health services are inappropriate or irrelevant has been shown to influence women's perceptions and utilisation of health care. Many traditional cultures of Africa require a period of seclusion for the mother and the newborn after delivery (for the first 40 days). During this time, access to formal health is limited. Strong beliefs in the spirit in the world and the fear that the baby or mother may be cursed can be very influential (UNICEF, 2004; WHO, 2003). Because of poor health information and strong beliefs in traditional medicine, mothers are denied attending health centers while patronizing traditional medicine.

The cultural perceptiveness on the use of maternal health services suggests that medical need is determined not only by the presence of physical diseases but also by the cultural perception of illness. In most African rural communities, maternal health services co-exist with indigenous health care services; therefore, women must choose between options. Individual women often influence the use of modern health services in such a context. Moreover, in many parts of Africa, women's

decision-making power is extremely limited, in matters of reproduction and sexuality. In this regard, husbands or other family members often make a decision about maternal care. The availability of women's, time is also important in developing countries. Women spend more time on their multiple responsibilities for the care of children, collecting water, cooking, clearing of farmlands and growing food and trade them at the expenses of their own health (Mekonnen, 2002; WHO, 2004, 2006).

Moreover, cultural factors affect the utilisation of MHC services in developing countries. For instance, Kea, Tulloch, Theobald and Kok (2018) report that cultural and traditional beliefs, trust in traditional birth attendants and lack of decision-making power of women all worsen the ugly and poor utilisation of MHC services. More so, cultural beliefs in accessing ANC, delivery and postnatal care services Robert et al., (2016) posit that: “ identified maternal cultural beliefs include: seeking advice from village elders, spousal fidelity, and disclosing pregnancy” (Robert et al. 2016, p.1). Cultural beliefs play an integral role in the decision-making process to seek MHC services. Significantly, the belief and practice of when to disclose pregnancy prohibit women from seeking antenatal care in the first trimester in Malawi. Similarly, Kane, Rial, Kok, Matere, Dielema and Broerse (2018) observed that women decision to use MHC services are shaped by variety of social fears, the encounter with health workers, other people, particularly other women in the facility premises are moment where women are afraid of experiencing dignity violations as reason for non-use of MHC services in Southern Sudan. Consequent upon, a study of mistreatment during childbirth in Nigeria, Bohren et al., (2017) find that women and providers report experiencing or witness physical abuse including slapping, physical restraint to delivery bed and detainment in the hospital and verbal abuse. The finding further reveals that sometimes women overcome tremendous barriers to a health facility, only to give birth on the floor, unattended by a provider because of being from the rural area, poor or uneducated.

According to Azuh et al., (2015) in their study on sociocultural factors of gender role in women health care utilisation in Nigeria, they interviewed 260 women, and the findings reveal that husband perception of pregnancy complication, age at marriage and family type is the mechanism towards the use of maternal health services. On the other hand, Shahahuddin et al. (2015) advance that higher women's autonomy positively influences the use of skilled maternal health among married and adolescent women in Bangladesh. Similarly, Afful-Mansah et al., (2014) obtained the same finding that also reveals women with the high degree of autonomy are likely to use maternal health care services than their counterpart who lack such autonomy.

Furthermore, Khan et al., (2013) in studying factors affecting utilisation of maternal and child health services in Pakistan indicate that sociocultural factors are the major reason for not visiting health facilities. In contrast, Subba (2013) reveals that the sociocultural group of a woman increases the chances of utilisation of maternal health services in India. Kifle, Azale, Gelaw and Melsaw (2017) reveal that maternal health-seeking behaviour of women was found as; antenatal 73.4 percent, attending institutional delivery 28.7 percent, postnatal care 22.6 percent. Whereas, knowledge of

pregnancy complications and religion of women were found to be significantly associated with antenatal health care delivery, postnatal and maternal health-seeking behaviour among women in rural Haramaya district eastern Ethiopia.

Additionally, Ogundairo and Jegede (2015) study sociocultural challenges in accessing antenatal care by pregnant Fulani women in Nigeria using a qualitative approach and discover that attitudes of health workers, communication barriers, the culture of pain suppression, patriarchy and culture of shyness are the major challenges in accessing antenatal care. Similarly, Ochako, Fotso, Ikamari and Khasakhala (2011) assert that ethnicity has a strong influence on the use of antenatal care in Kenya. More so, Sharma et al., (2013) consequent upon that, poor use of antenatal is associated with religion, language and cultural barriers in Uttarakhand. Similarly, Shamaki and Buang (2014) in a study of sociocultural practices in maternal health care in Nigeria, using a secondary data find that forced marriage, early marriage, female genital mutilation and traditional gender discrimination play a significant role in the use of maternal health care services.

MATERIALS AND METHOD

This research is an explanatory design that aims to explore socio-cultural and maternal health seeking practices among women in rural areas of Bauchi state, Nigeria. In-depth interviews is used to gather relevant data. Bauchi state comprised of 20 local government areas and is politically divided in to three senatorial districts, namely, (a) Bauchi North Senatorial District, (b) Bauchi Central Senatorial District and (c) Bauchi South Senatorial District. From each senatorial district one rural area is randomly selected for the study. The study focuses on women of reproductive ages (15-49) years. Accidental sampling is used to select the study participants for the in-depth interview with five (5) pregnant/nursing women from each village in the three (3) randomly selected rural areas, making a total fifteen (15) women. The data collected was transcribed and analyzed using verbatim quotation and thematic analyses.

EMPIRICAL RESULTS

Social factors influencing the utilisation of maternal health care services

Most of the women interviewed anonymously agreed that socioeconomic barriers play a very important role in access and utilisation of MHC services. Specifically, one of the women who was interviewed on August 28, 2017 at Kesa village had this to say:

“It is not that we do not know the importance of utilisation of ANC services. However, what will you do, if you do not have the money? It is for you and your husband to enter bush and collect herbs. Thank God, we have the min abundance here .God is just merciful. He knows that we do not have money and he blessed us with herbs and roots (IDI/37/ Kesa village).”

There was also the challenge of the negative attitude of health workers. Most of the interviewees accused the health workers working in rural areas of being harsh and unfriendly (Ajaegbu, 2013). Majority of the women argued that this unfriendly attitude was found to be a major challenge in the utilisation of MHC services. According to one of the interviewees:

“I do not go for antenatal or delivery, because the nurses are too harsh for my liking. They will be hitting you anyhow. They will be shouting at you. They will want to touch your private parts. This is totally against my cultural value (IDI/35/ Bashe village).”

Another woman remarked as follows:

“I do not like hospitals. The health workers are just too harsh. They see you as being inferior because you are a woman from a rural area. They used to insult and abuse us. They do not treat our husband with respect (IDI/36/Birshi village).”

Cultural factors influencing the utilisation of maternal healthcare

The culture of patriarchy and shyness in most rural African society where women are not expected to speak out even if it is against their will was identified as a major challenge in the study area. One of the women stated that:

“The husband has the final say. If he says I should not go, I cannot go. This means I have to make him see reason, plead with him to allow me to go. However, if he insists, I have no choice than to stay at home. Nevertheless, if he gives me permission to go to the hospital, even if I do not want to go, I must go if he insists (IDI/28/ Birshi village).”

Another form is shyness identified by the study were women not wanting to be touched by other male health personnel also came to the fore. For instance, one of the women bemoaned the situation thus:

“We guard our genitals jealously. Strangers are not supposed to see them. I do not like antenatal care because the health workers will want to examine my private parts. It is against our culture (IDI/30/Kesa village).”

This belief has been strongly supported by Islam and Christian religions, which indicate general disapproval for women to expose their genitals to men other than their husbands (Bui et al., 2018; Shamaki & Buang, 2014; WHO, 2006). Moreover, where rural health facilities workers are men or mixed discourages women from utilizing MHC services. Since most of the women in the study area were Muslims, two women reported their religion influenced their maternal health care seeking behavior. Muslim women did not want to be attended by male birth attendants because of their religion. As such:

“We Muslim women believe that only our husband can touch and see our nakedness. That is why we do not want to be attended by male midwives, that why we do not go to delivery at a health facility (IDI/28/Kesa village).”

And also

Our religion does not allow our naked body to be seen by any other person other than husbands. However, we are not sure whom we will be attended in the health facility. Even, we do not want to be uncovered so that our private parts do not be seen (IDI/29/Kesa village).

Another cultural influence is the culture of pain suppression. Ogundairo and Jegede (2016) asserted that women in rural areas are known to have the ability to suppress pain until it becomes very unbearable. They hold the culture of pain suppression in high esteem. They see it as an advantage they have over others. Most times, this makes them not to report for care or report late for treatment. One of the interviewees revealed that:

Most of our women give birth at home. We can suppress pain. It is part of our culture. It is a thing of pride. Sometimes, you do not even know a woman is delivering next door until she finally delivers. So if you can deliver on your own, there is no need for antenatal care (IDI/35/Bashe village). The study area is a patriarchal society where decision-making process is largely dominated by men in the society. This has a very significant effect on the utilisation of antenatal care services. Even after all the other factors have been taken care of, there is still need for the women to seek for their husband’s permission. One woman indicated at:

Another interviewee further stated that:

“During all my pregnancies, I did not attend hospital for antenatal, delivery or anything. Even for other sicknesses, I did not go to any hospital. This is because my husband is totally against it. I want to go like some of my fellow women do, but my husband’s aid no. Now that he is dead, I attend hospital if I am not feeling fine, pregnant or not pregnant (IDI /24/Kesa village).”

Health seeking beliefs of women in rural areas of Bauchi state

One of the aims of maternal health care service is to equip women with essential skills on how to detect and manage the pregnancy-related issues (Dansereau et al., 2018; Lincetto et al., 2006, who, 2004). The researcher argues that pregnant women awareness of pregnancy issues is fundamental if women are expected to seek maternal health care services.

It was found that most women in rural areas were not aware of pregnancy danger signs and had very little knowledge on how to understand complications when they arise. It was argued that better-educated women are aware of health problems, know more about the availability of health care services, and use this information more effectively to maintain or achieve good health status (Gao et al., 2017; Banke-Thomas et al., 2017). Although, there are awareness campaigns on use of MHC services in radio and television stations. These illiterate, rural, poor women could not be reached or

are constrain because they do not have television sets and radio couple with non-supply of power energy to most rural areas (Uneke et al., 2014). The majority of women in this group are first time mothers. Some of the women stated that:

“No, I don’t know what a pregnancy danger sign is. I have not started attending antenatal care clinic yet, maybe they will tell me if I go for antenatal care (IDI /22/Kesa village).

Maybe bleeding during pregnancy is dangerous but other issues I think are normal during pregnancy. I had vaginal discharge four months ago and I used a traditional medicine it stopped (IDI /25/Bashe village).

I’m not sure but I think they can’t cause any serious harm to my baby and me if I rest. I remember once or twice I had blurred vision when I was in the farm and lied down for a while then I felt ok (IDI /26/Birshi village).”

Some women belief that it was culturally inappropriate to reveal a woman’s pregnancy before a specific time. It was perceived that the ideal time to reveal the pregnancy was when the woman’s pregnancy was visible to all (usually around the fourth or fifth month of gestation). This cultural belief often prevented women from seeking care during the first trimester. This cultural belief is predicated on the idea that disclosing pregnancy too early to nonfamily members or distant relatives could put the woman in danger from witchcraft, which would cause a mother to miscarry. One woman says:

“Yes, it is true, women are not supposed to say they are pregnant if it’s not visible. They say if you talk about it then witches will kill your child. It’s a cultural thing; a pregnancy has to be announced when it is seen if it is not seen then it does not have to be announced. But it’s like people will do all sorts of things with your pregnancy, let it sit in (delay the birth of the child), some witchcraft that you should miscarry. So when a pregnancy is seen that will be almost 20 weeks. (IDI/30/Kesa village).”

FINDINGS

Maternal health care service is of paramount sociological concern because it is closely connected to social networks and interactions. Findings reveal that 90 percent of the women took herbs during pregnancy for pregnancy related health problems. These findings are consistent with the findings of studies elsewhere (Adamu, 2011; Aluko, 2013; John, 2016). Women opt for herbal medicine mostly because of their inability to afford the cost of maternal health services and also cultural beliefs in natural medicine. It was realized that majority of women in rural areas of Bauchi state utilisation of MHC services are inhibited by educational background, location of health facility, low income status, cost of health care (drugs, Lab tests, ultra-sound scan and delay at health facility), attitude of

health workers. The influence of cost of maternal health care on utilization of maternal health services have been confirmed in several studies (Adewuyi et al. 2018; Bhatta & Aryal, 2015; Mojumdar, 2015). Other factors such as the age of the mother, marital status and religious practices have no any influence on access and utilisation of MHC services in rural areas of Bauchi state.

Furthermore, the study reveals that maternal cultural beliefs are: seeking advice from elders, spousal loyalty and disclosing pregnancy. Patriarchy also influence women's health seeking beliefs. Majority of the women said that they needed to get the consent of their husband before they seek maternal health care and other services at the hospital. This is consistent with the findings of a study in the Northern part of Nigeria (Aluko, 2013; Robert, et al. 2016 Uneke, 2014) and rural north India (Sharriff and Singh, 2002; Mojumdar, 2015). This is a reflection of the patriarchal structure of the society influencing women's pertaining to maternal health care utilization.

Consequently, it was found that the most powerful ingredient that motivates women to utilize MHC services are perceived severity of illness and perceived benefits. This is to say most women do not visit health facility unless if there are complications and other pregnancy-related problem. They also prefer traditional birth attendants (TBA) than skilled birth attendants (SBA) during deliveries. Besides, some women have not ever delivered any of their child at a health facility. This has shown the health seeking behaviour of the women in rural areas of Bauchi state, Nigeria vividly.

CONCLUSION

In conclusion, based on the findings of the study, it can be seen that the major determining factor for access and utilisation of MHC services among women in rural areas of Bauchi state in particular and Nigeria at large is the perceived presence/severity of sickness. In this regard, women in rural areas must be convinced of their state of sickness before deciding to utilize MHC services. Employment status, level of income, level of education, the culture of pain suppression and shyness all contribute to access and utilisation of MHC services. Other elements moderating the access and utilisation of MHC services are location, cost of prescribed drugs, lab test, ultra-sound scan and delay at health facility continue to thwarts women from utilizing maternal health care services, and subsequently utilizes the services of traditional birth attendants (TBAs). The attitude of health workers matters a lot in encouraging women to utilize health facilities, especially those from rural areas. Therefore, health workers should be culturally sensitive when carrying out their duties. The impact of patriarchy on utilization of maternal health care is identified as significant factor that influences women's decision to use or not to use such services. The attitude of health workers goes a long in encouraging women, especially those from the low educational background, to access and utilize MHC services. Therefore, health workers should be culturally competent when carrying out their duties. The impact of patriarchy on the utilisation of MHC services cannot be over-emphasized. It influences the social interaction between the women and the health facilities. The male's role in reproductive health and other health issues should not be neglected. Health campaign and counselling need to be intensified to shape the maternal health seeking beliefs of women in rural areas of Bauchi state also to make

men more aware of these. Furthermore, policies and intervention aiming at addressing the issues of maternal literacy, cost maternal health services must be formulated and well implemented.

REFERENCE

- Abor, P.A., Nkrumah, G.A. & Sakyi, K. (2011). The Socioeconomic determinants of maternal health care utilisation in Ghana, *International Journal of Social Economics*, 38 (7), 628-648.
- Adamu, H. S. (2011). Utilisation of maternal health care services in Nigeria: An analysis of regional differences in the patterns and determinants of maternal health care use. *University of Liverpool*.
- Addai, I. (2000). Determinants of use of maternal-child health services in rural Ghana, *Journal of Biosocial Science*, 32 (1), 1-15.
- Adewuyi, E. O., Auta, A., Khanal, V., Bamidele, O. D., Akuoko, C. P., Adefemi, K., & Zhao, Y. (2018). 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. *PloS one*, 13(5), 0197324.
- Afful-Mansah, G., Amponsah, E. N. and Yiadom, L. B. (2014). Rural urban differences in the utilisation of maternal healthcare in Ghana. The case of antenatal and delivery services. *African Social Science Review*, 6(1), 238-247. <http://digitalscholarship.bjm/spa.tsu.edu.assr/vo16/issi/4>.
- Aluko, Y.A. (2013). Gendered impact of corruption in health services delivery in Nigeria. *The Nigerian Journal of Sociology and Anthropology*, 11 (1) pp.41-56.
- Anderson, R. & Newman, J. (1973). Social and Individual Determinants of Medical Care Utilisation in the United States. *Milbank Memorial Quarterly*, 51(2), 95-124.
- Azuh, D., Fayomi, O. & Ajayi, L. (2015). Sociocultural factors of gender role in women's healthcare utilisation in southwest Nigeria. *Open Journal of Social Sciences*, 3(1), 105 - 117.
- Babalola, S. & Fatusi, A. (2009). Determinants of use of maternal health services in Nigeria: Looking beyond individual and household factors. *BMC, Pregnancy and Childbirth*, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2754433/pdf/1471-2393-9-43.pdf>.
- Banke-Thomas, O. E., Banke-Thomas, A. O., & Ameh, C. A. (2017). Factors influencing utilisation of maternal health services by adolescent mothers in Low-and middle-income countries: a systematic review. *BMC Pregnancy and Childbirth*, 17(1), 65.
- Bauchi State Primary Healthcare Development Agency (BPHCDA) (2017). One-day Roundtable on maternal and child health in Zaranda Hotel Bauchi on 11th May, 2017.
- Bhatta, D. N. & Aryal, UR. (2015). Paternal Factor and Inequality Associated with Access to Maternal Health Care Services in Nepal: A community-based cross-sectional study. *Plos One*, 10(6), DOI: 10.1371/journal.pone.0130380.
- Bohren, M. A., Vogel, J. P., Tunçalp, Ö. Fawole, B., Titiloye, M. A., Olutayo, A. O., & Idris, H. A. (2017). Mistreatment of women during childbirth in Abuja, Nigeria: a qualitative study on perceptions and experiences of women and healthcare providers. *Reproductive Health*, 14(1), 9.

- Bour, D. (2009). Gender and the utilisation of healthcare services in Ashanti Region Ghana. *Health policy Science Direct*, 69(3), 375-388.
- Bui, H. T. T., Le, T. M., Van Pham, T., Doan, D. T. T., Nguyen, D. A., Nguyen, C. C., & Duong, D. M. (2018). The Association between gender inequalities and women's utilisation of maternal health services: A cross-sectional survey in eight south central coast provinces, Vietnam. *Journal of Public Health Management and Practice*, 24, S19-S27.
- Dansereau, E., Hernandez, B., & Mokdad, A. H. (2018). Antenatal care among poor and indigenous women in Central America and Mexico: a cross-country study of access, utilisation, and barriers. *PloS one*, 6(5), 133-144.
- Do, N., Tran, H.T.G., Phonvisay, A. & Oh, J. (2018). Trends of socioeconomic inequality in using maternal health care services in Lao people's democratic republic from year 2000 to 2012. *BMC Public Health*, 18:875 doi.org/10.1186/s12889-018-581-0.DOI: 10.177/0975425315591421.
- Ekman, B., Axelson, H., Anh Ha, D. & Nguyen, L. (2007). Use of maternal health care services and ethnicity: a cross-sectional analysis of Vietnam, available at: SSRN: <http://ssrn.com> abstract¹/4993713.
- Elo, I.T. (1992). Utilisation of maternal health care services in Peru: the role of women's education, *Health Transition Review*, 2(1), 49-69.
- Ganle, J.K. (2015). Ethnic disparities in utilisation of maternal health care services in Ghana: Evidence from 2007 maternal health survey. *Ethnicity and Health*. DOI: 10.1080/3557858.2015.1015499.
- Gao, et al. (2017). Progress and challenges in maternal health in Western China: countdown to 2015 national case study. *Lancet Global Health*, 5523-36 doi.org/10.1016/52214-109x (17) 30100-6.
- Gardener, H., Mutter, J. & Koman, C. (1998). Lives across culture, cross-cultural human Development. *Boston and London Allyn Bacon*.
- Gobindasamy, P. & Ramesh, B.M. (1997). Maternal education and the utilisation of maternal and child health services in India, *National Family Health Survey Subject Reports*, Number 5, International Institute for Population Sciences, Mumbai.
- Gyimah, S. O., Takyi, B. K. & Addai, I. (2006). Challenges to the reproductive health needs of African women: on religion and maternal health utilisation in Ghana. *Social Science & Medicine*, 62(12), 2930-2944. <http://www.socstats.soton.ac.uk/choices/wp20.PDF/>
- John, K. (2016). Ethnic Disparities in utilization of maternal health services in Ghana: evidence from the 2007 Ghana maternal health survey, *Ethnicity and Health*, 21(1), 85-90.
- Kamal, S. M. M. (2009). Factors affecting utilisation of skilled maternity care services among married adolescents in Bangladesh, *Asian Population Studies*, 5(2), 153 - 170.
- Kane, S., Rial, M., Kok, M., Matere, A., Dielema, M. & Broerse, J. E. (2018). Too afraid to go: fear of dignity violations as reasons for non-use of maternal health services in Southern Sudan. *Reproductive Health*, 15(51), 2-11.
- Kea, A. Z., Tulloch, O., Datiko, D. G., Theobald, S., & Kok, M. C. (2018). Exploring barriers to the use of formal maternal health services and priority areas for action in Sidama zone, southern

- Ethiopia. *BMC Pregnancy and Childbirth*, 18(1), 96.
- Khan, N., Khan, S., Khan, N. and Khan, S. (2013). Factors affecting utilisation of maternal and child health services: District sarat KPK Pakistan. *International journal of innovative research and development*. ISSN: 2278-0211 www.ijird.com
- Kifle, D., Azale, T., Gelaw, Y. A., & Melsew, Y. A. (2017). Maternal health care service seeking behaviors and associated factors among women in rural Haramaya District, Eastern Ethiopia: a triangulated community-based cross-sectional study. *Reproductive Health*, 14(1), 6.
- Leninger, M. (1995). *Transcultural nursing: concept theories, research, and practices* (2nd eds) New York Mc Graw-hill.
- Matsumura, M. & Gubhaju, B. (2001). Women's status, household structure and the utilisation of maternal health services in Nepal, *Asia Pacific Population Journal*, 16(1), 23-44.
- Mekonnen, Y. & Mekonnen, A. (2002). Utilisation of maternal health care services in Ethiopia, USA *ORC Macho. Ethiopian Journal of Health Development*, 17(1), 27-33.
- Mojumdar, S. K. (2015). Trends in Maternal care utilisation in urban India: A Temporal analysis, *Environmental and Urbanization Asia*, 6(2), 212-224.
- Navaneethan, K. & Dharmalingam, A. (2002). Utilisation of maternal health care services in Southern India, *Social Science & Medicine*, 55, 1849-69.
- Nwankwo, I.U., Okafor, N.I. & Olisa, A. (2013). Health sector reform agenda in an insecure Nigerian state: issues, problems and prospects. *The Nigerian Journal of Sociology and Anthropology*, vol. 11 (1), 57-74.
- Ochako, R., Fotso, J. C., Ikamari, L. & Khasakhala, A. (2001). Utilisation of maternal health services among young women in Kenya: insight from the Kenya demographic and health survey 2003. *BMC Pregnancy and Childbirth*, 11(1) [http:// www.biomedcentral.com/1471-2393/11/1](http://www.biomedcentral.com/1471-2393/11/1).
- Ogundairo, J. A. & Jegede, A. S. (2016). Socio-cultural challenges in accessing antenatal care by pregnant Fulani women in Ibarapa central local government Oyo state, Nigeria. *Annals of Public Health and Research*, 3(3), 10-34.
- Robert, et al. (2016). The role of cultural beliefs in accessing antenatal care in Malawi: a qualitative study. *Public Health Nursing*, 34(1), 42-49.
- Shahahuddin, A. S. M., Delvaux, T., Abouchadi, S., Sarker, M. & Brouwere, V. D. (2015). Utilisation of maternal health services among adolescent women in Bangladesh: A scoping review of literature. *Tropical Medicine and International Health*, 20(7), 822-828.
- Shamaki, M. A. & Buang, A. (2014). Socio-cultural practices in maternal health among women in less developed economy: An overview of Sokoto state Nigeria. *Malaysian Journal of Society and Space*, 10(6), 1-14.
- Sharma, A., Mathur, P. & Kothiyal, P. (2013). Utilisation of antenatal care services among pregnant women in the rural and urban areas of Uttarakhand. *Indo American Journal of Pharmaceutical Research*, [http:// www.jajpr.com/index.php/en/](http://www.jajpr.com/index.php/en/)
- Shire, N. (2002). Effects of race, ethnicity, gender, culture, literacy and social marketing on public Health, *Journal of Gender specific Medicine*, (2) 5, 48-54.

Subba, D. (2013). Maternal complication and utilisation of maternal health care services with special reference to west Bengal, India. *Open Journal of Obstetrics and Gynecology*, 3(3), 974-701.

United Nations (2015). Review of target for Sustainable development goals: The science Perspective. Paris: *international council for science (ICSU)*.

United Nations International Children's Emergency Fund (2004). OAU Charter on the Right and Welfare of the child Nigeria.

World Health Organization (2003). Antenatal Care in Developing Countries: Promises, Achievements and Missed Opportunities: An Analysis of Trends, Levels, and Differentials: 1990–2001. WHO & UNICEF, Geneva, New York.

World Health Organization (2004). Making pregnancy safer: the critical role of the skilled attendant; a joint statement by WHO, ICM and FIGO. *Geneva*.

World Health Organization (2006). Provision of effective antenatal care, World Health Organization.

http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/effective_antenatal_care.pdf