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Exploring Women's Experiences, Maternal Practices and Problems in the Utilization of Maternal Health Services in Kwara State, Nigeria: A Qualitative Study

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Authors' contributions

This work was carried out in collaboration between both authors. The paper is an extract from PhD thesis of author AS, he was responsible for the collection of data, writing of the reports and this paper. Author AI is author AS supervisor, he supervised all the stages of the research and proof-reading of this paper. Both authors read and approved the final manuscript.

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ABSTRACT

Aim: To examine the women's experiences, maternal practices and problems faced in the utilization of maternal health services in Kwara State, Nigeria.
Methodology: An inductive and thematic analytical approach was adopted in analyzing the qualitative responses obtained from the respondents.
Results: The study found that women indulge in medical pluralism and that the optimal utilization of maternal health services was hindered by unfriendly attitudes of some healthcare providers and inadequacy of drugs in many of the clinics.
Conclusions: The study concluded that the utilization of maternal health services is influenced by the attitudes of healthcare providers and the availability of affordable drugs and that medical pluralism is a common healthcare practice of some of the respondents.

Keywords: Maternal health services; medical pluralism; health personnel; thematic approach.

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1. INTRODUCTION

Maternal health is the bedrock of every healthy and productive population [1,2]. Globally, significant progress has been made to ensure pregnant women are saved from deaths, temporary and life-threatening complications that are associated with pregnancy and childbirth. Given the joint efforts and programmes put in place, through Millennium Development Goals (MDGs), to checkmate huge global deaths that are arising from maternal complications, over 40% reduction in global maternal mortality was achieved in 2015 [3]. While a huge success rate has been achieved globally, maternal death remains unacceptably high in developing countries, especially in Sub-Saharan Africa, where thousands of women still suffer complications and avoidable deaths from pregnancy and childbirth [4].

Particularly, the menace is high and poses a great danger to women in Nigeria. The country, seconded by India, had the highest numbers of maternal deaths, and accounted for approximately 23% of all estimated global maternal deaths in 2017, with approximately 67 000 maternal deaths [5]. A survey conducted in 2018 also indicated that 512 maternal deaths per 100,000 live births and under-5 mortality were 132 deaths per 1,000 live births were recorded in Nigeria [6]. This is a great contrast to the third objective Sustainable Development Goals (SDGs) that aims at reducing maternal mortality to less than 70 per 100,000 live births and ensure universal access to reproductive health services by 2030 [7].

As revealed in Arthur [8]; Babalola [9]; Bayu, Fisseha, Mulat, Yitayih, and Wolday [10]; Oyedele [11]; the high maternal mortality rate in Nigeria, and other developing countries, is attributed to the low use of maternal health services (MHS), which in turn was influenced by demand and supply factors. Several other studies have documented numerous factors that militate against the utilization formal maternal healthcare services. In a study conducted by Chol, Cynthia, Berhane, Berhana, Joel and Robert [12], it was found that poor quality of care, lack of ultrasound machines, short clinic opening hours, and shortage of healthcare workers were the major barriers militating against the utilization of maternal health services. Other factors like health education and women's empowerment, driven by their role as combatants during the War of Independence, were also key determinants of utilization of and access to maternal health services. In a similar study conducted in Ethiopia by Kaba, Taye, Gizaw and Mitiku [13], it was found that perceived capacities of health facilities, friendliness of service providers, and sanctioned expectations by the community influenced their utilization of maternal health services.

Also in Akowuah, Agyei-Baffour and Asibey [14], travel time, long waiting time, transport cost, service cost, quality of service, and attitude of hospital staff were constraining factors against utilization of maternal health services, even after the introduction of free maternal health care. In Akhter [15], it was found that contrasting factors determined the level of utilization of maternal health services between women in low socioeconomic status and those in upper socioeconomic status. Women in low socioeconomic status detested institutional maternal health services because of fear and distrust of formal healthcare providers, while those in upper socio-economic groups show an overt sense of trust and dependence on modern maternal health care facilities.

The above review shows that different factors, depending on the locality, availability of medical equipment and staff determine the level of utilization of maternal health services. However, a review of the literature shows that there is a dearth of qualitative studies on maternal health dynamism in Nigeria. It is of great policy relevance to physically interface with women and get verbal expressions about their concerns, experiences, challenges and maternal health practices. Studies in this area, using narrative and thematic methods in studying women's healthcare behaviour are rare and necessary to complement the existing quantitative studies. The current study is therefore aimed at examining women's experiences, problems and maternal practices in the utilization of maternal health services in Kwara State, Nigeria.

2. MATERIALS AND METHODS

2.1 Study Setting and Selection of Respondents

This study adopted a qualitative case study design as a way of investigating utilization of maternal health services in Nigeria. The study was conducted in Kwara state, one of the thirty-six states in Nigeria, located in the North Central geopolitical zone of the country. The primary

ethnic groups in the state are Yoruba, with significant Nupe, Baruba, and Fulani minorities. The state is divided into three senatorial zones (Kwara Central, Kwara North and Kwara South), which are further divided into sixteen administrative units called Local Government Areas (LGAs).

The face to face interviews, used in the study, were conducted in 2019, using a multistage sampling method. In the first stage, two local governments were purposively selected from each of the three senatorial districts of the state, making a total of six local governments. The difference in language and rural-urban dichotomy are the criteria used in selecting the local governments. Ilorin East and Ilorin South are selected to represent urban areas from Kwara Central. Offa and Ekiti were selected from Kwara South; Offa represented urban areas while Ekiti represented rural areas. Baruteen and Edu local governments were chosen from Kwara North. The two local governments are rural areas, have good representations of the other two ethnic groups in the state. This approach ensures that approximately equal size of the sample was selected from rural and urban areas of the state. Accordingly, 10 persons were selected from each local government, making a total sample size 60 respondents.

2.2 Sampling Size, Sampling Procedures and Data Collection Procedures

Interview guide was used to collect information from the respondents. The guide contains prompt questions about experiences, problems and maternal practices of the respondents. Questions like “have you ever used formal maternal healthcare services?” If yes, questions like, “what were your experiences with the healthcare providers?, what were the challenges/problems faced why using the services?”. If no, “what are the reasons for not using formal health services?”, “what alternative services did you use during your last antenatal, delivery and postnatal services” The answers and the explanations provided to the questions were written in English Language by the research assistants, and later categorized and arranged based on their thematic pattern.

In other to select 10 respondents from each of the local governments, a combination of systematic, stratified and accidental sampling techniques were used. Systematic sampling technique was used to select political wards from each of the local governments, after being arranged in Alphabetical order. From the selected wards, number of the available houses were counted, and divided by 10. Thereafter, a respondent who was ready and willing to grant the interview was then accidently selected from each stratum of ten groups of households. The accidental sampling became most appropriate in selecting the respondents from each stratum of 10 groups of households because some women were not ready to grant interview despite the explanations, justifications and the presence of the community members.

2.3 Data Analysis

The study used face to face interview to elicit qualitative information from the respondents. Four research assistants were used in facilitating the administration and conduct of the interview, two of whom helped in writing the responses from the Yoruba and Baruba speaking respondents directly in English language, the other two participated in writing the responses from the Yoruba and Nupe speaking respondents and wrote directly in English language. The notes taken by the two research assistants, present in each interview, were compared and harmonized immediately after each interview. The competency in the English, Yoruba, Nupe, Baruba and English Languages by the research assistants, facilitated and enhanced smooth conduct and record of the interviews. The responses collected from the questionnaire were coded and categorized based on their thematic components. The experiences, problems and maternal practices of the respondents were analyzed using a thematic approach, direct quotation of responses and discussion of similar themes. The data were coded and analyzed descriptively, paying attention to issues and matters mentioned by most of the respondents, capturing any unique experience and strong quotes and facts. The steps and coding method adopted, as explained by Creswell [16]; Saldana [17]; and used in Akhter [15]; Chol, Cynthia, Berhane, Berhana, Joel and Robert [12]; Kaba, Taye, Gizaw and Mitiku [13]; are summarized in Table 1.

As shown in Table 1, responses categorized into two categories and coded 001 and 002 respectively. The first category reflects the theme of medical pluralism, while the second reflects that of access to care. The responses were further categorized into different sub-themes because it was found that there are dissimilarities

among the seemingly similar themes. This gave rise to the third column where the major themes were broken down.

3. PRESENTATION OF RESULTS

3.1 Socio-Demographic Characteristics of the Respondents

Table 2 shows the distribution of the respondents across some socioeconomic and demographic characteristics.

As shown in Table 2, 60 women of reproductive age participated in the study. The table shows how they are distributed along with different socioeconomic and demographic backgrounds. The table shows that the major ethnic groups and places of residence are evenly represented. It equally shows that most of the respondents are informally employed, a great number of them are unemployed, while remained others are formally employed. It equally shows that most of the respondents have both primary and secondary education qualifications, while the remaining others are distributed between higher qualifications and those without education. It is also shown that most of the respondents are between the ages of $30-45$, while the remaining others are between 18 and 29 years of age. This shows that the information got from the respondents is reliable since most of the respondents are experienced mothers.

Table 1. Multi-stage approach to thematic analysis

Coding	General Themes	Sub-themes
001	Medical Pluralism	001A.Combination of traditional and formal healthcare
		001B. Only traditional healthcare
		001C. Only formal health care
002	Access to care	002A. Availability
		002B. Accommodation
		002C. Affordability

Source: Author's design

Table 2. Socioeconomic characteristics of the respondents

	Characteristics	Frequency
Age Group	$18-24$	10
	$25-29$	18
	$30-45$	32
	Total	60
Education	None	10
	Primary	16
	Secondary	15
	NCE/ND	9
	Degree/HND and above	10
	Total	60
Occupation	None	20
	Formal	18
	Informal	22
	Total	60
Ethnicity	Baruba	20
	Nupe	20
	Yoruba	20
	Total	60
Residence	Rural	30
	Urban	30
	Total	60

Source: Author's design from fieldwork, 2019

3.2 Experiences, Problems and Maternal Practices of the Respondents

Using a thematic, narrative and inductive approach, the dominants themes among the responses to questions on experiences, problems and maternal practices of the respondents are thematized into two major categories: Medical pluralism and Access to care. The responses are presented and explained in sections 3.2.1 and 3.2.2.

3.2.1 Medical pluralism

Under medical pluralism, it was discovered that some of the respondents combine formal and traditional health care during their antenatal, delivery and postnatal services. Their justification for combining the methods is that the combination helps to achieve cheaper and safer results.

"I used both traditional and orthodox medical approaches for my maternal services because the two are complementary to each other. I went for traditional treatment because I could not conceive after four years of my marriage; I went to a traditional birth attendant who gave me some concoctions to use. After using herbal medicine for some time, I conceived. To take proper of myself and the pregnancy, I combined traditional and formal antenatal care. I finally delivered at a hospital. I have also heard of many women that combine the two treatments" (Ojomu North/004, 2019).

"I believe both traditional treatment and orthodox medicine are good for pregnant women. I do combine the two during my pregnancies. I know of a woman that was discovered to have a spiritual husband because of the nature of dreams she was having while pregnant. The traditional birth attendant took care of it and delivered it safely. Such cases can't be handled in the formal healthcare" (Tsonga 2/006, 2019).

"I use both traditional treatment and orthodox medicine during my pregnancies. I attend antenatal care informal healthcare and also visits traditional birth attendants. But I delivered my two children at home, with help of a traditional birth attendant. I learned that most doctors are male. During delivery, the doctors will see your private part and used their hands for evacuation after the delivery. Because of this, I feel unlike going to the hospital for delivery. I delivered my babies at home, but go to a clinic for antenatal and postnatal care" (Obbo-ile/003, 2019).

"I go to both traditional and formal healthcare during my pregnancies. The traditional treatment is customary, cultural and we feel freer than with the formal healthcare providers. The formal healthcare providers can also take care of any eventualities beyond the control of traditional birth attendants" (Magaji Are 2/006, 2019).

The above responses show that women combine the two methods of treatments because of different reasons like the presence of delay in conceiving, presence of male doctors, spiritual problems, customs and tradition, and complementarity of the methods. There are however some that beliefs in the superiority of the formal healthcare provider. The respondents below expressed their reservations for the utilization of traditional birth attendants:

"Formal health services are better than traditional ones. During my first pregnancy, I was sick and taken to a traditional birth attendant. I was given different types of concoctions but without any improvement. When later taken to the hospital, it was discovered that I had a low blood count, and was given more blood. Thereafter, I got better and later delivered safely. In my last two pregnancies, I only used formal healthcare services for my maternal care" (Balogun-Fulani 1/004, 2019).

"Formal healthcare is by far preferable. There they know the proper condition of the baby; they can tell you the gender and also take proper care of the mother. In the traditional treatment, incisions and concoctions are given without proper diagnosis of the problems" (Shawo southwest/006, 2019).

"I use only formal healthcare because I delivered there safely during my first and second pregnancies. Traditional birth attendance is commonly used by those with postnatal problems, or those with delays in conceiving and those that delivered their earlier pregnancy through caesarian operation and looking for a traditional solution towards self-delivery in the subsequent pregnancy" (Yashikira/006, 2019).

"I prefer formal healthcare because some of the traditional providers are fetish and diabolical. It is difficult to know the good ones among them. So, going there endangers the lives of both the mother and the unborn baby" (Koro/002, 2019).

Some of the respondents prefer formal healthcare because of lack and poor diagnosis of

the traditional method, competency of the skilled birth attendants, fetishness and diabolicalism of some of the traditional birth attendants and the belief that traditional birth attendance is meant for those with delay in conceiving, and those who had a caesarian operation in their earlier delivery and looking for ways out.

3.2.2 Access to care

Many other responses from the respondents are coded as access to care, they relate to experiences and problems encountered that reduce access to care during pregnancy. The responses are further sub-divided into availability and accommodability. The first aspect of access is the availability of maternal services. Some of the respondents complained about the lack of commitment by some of the healthcare providers and unavailability of the needed drugs and equipment at the hospitals:

"My experience during the delivery of the first child is unforgettable. During the antenatal, during my sixth month of pregnancy, we were told not to come for antenatal again because the doctors were going to write an examination, except those with critical cases were to come. So, I resulted in a private hospital for antenatal. During my delivery at the government hospital, the doctor left me in the labour room immediately after the delivery. The second day, it was discovered I was still bleeding and directed to go back to the labour room for investigation. It was discovered that some particles of the placenta were still left in my womb. The doctor had to re-evacuate it for the second time. I suspected that he was in haste because he had to go for his exam. It was God that saved me" (Gambari 1/002, 2019).

"I always deliver at a mission house, attended to by a retired nurse who now works with the church. I did not use the hospital during pregnancy and delivery of my three children because I learned the nurses nag, while most of the doctors are arrogant. They talk to you as though you are a child" (Shawo south west/005, 2019).

"The healthcare providers don't come every-day and on time. If you come early in the morning, you won't find any one of them there. You have to wait for a long time; they claim to come from town. On weekends, you won't find any doctor here except a few nurses" (Kpaura/004, 2019).

"Most of the hospitals do not have drugs. When you go there, you will be directed to go to the nearest pharmacy to buy the drugs yourself. For those of us in the villages, it may take a long time before you get the drugs. These are some of the problems we face here" (Osi 1/006, 2019).

The respondents complained about lack of punctuality, lack of commitment, abusive and poor attitudes of some healthcare providers, and lack of availability of drugs. The respondents complained that they face the aforementioned problems while using formal health care. The second and the last aspect of access to care is the level of accommodability of the medical personnel. Some of the responded that nurses and some health personnel are not friendly in their approaches.

"I use institutional healthcare services during my antenatal, delivery and postnatal periods. Most medical professionals are not friendly with their patients. If you try to express your opinion about what you think can help in militating some medical problems, ask for assistance or ask questions about what you are not clear at, you will be treated as though you have committed an offence. These and many more abusive attitudes of the nurses discourage me from going to clinics" (Essa-C /001, 2019).

"The attitudes of some of the nurses and doctors make one feels unlike telling them what is wrong with you. When you see the way they shout at you. Even if you go next time, you won't be free to tell them all you have in mind. I delivered my first and second children at home with the help of traditional birth attendants" (Tsaragi 2/004, 2019).

The above responses show that some of the healthcare providers are not friendly, and as such, discourage many people from using formal health services.

4. DISCUSSIONS OF RESULTS

As shown in section four of the study, qualitative responses from the respondents show that medical pluralism and access to maternal health services are the major dominant views of the respondents. Some of the respondents believe in the complementarity of formal healthcare services to the traditional method, while few others believe in the superiority of formal healthcare over the traditional method. The respondents also commented that the utilization

of maternal health care is affected by two components of access to health care: availability and accommodation. They complained about lack of punctuality and commitment, abusive and poor attitudes of some of the healthcare providers, in addition to the inadequacy of drugs in many of the public hospitals. The above challenges, experience and maternal practices found in this study are similar to the findings of Akhter [15]; Akowuah, Agyei-Baffour and Asibey [14]; and Kaba, Taye, Gizaw and Mitiku [13].

5. CONCLUSIONS AND RECOMMENDATIONS

The study found that some of the respondents engaged in medical pluralism, while many others are facing accessibility and accommadability problems; that discourage them from optimally accessing maternal healthcare services. The study concluded that the utilization of maternal health services is influenced by the attitudes of health personnel and the availability of affordable drugs and that medical pluralism is a common healthcare practice of many communities in the selected areas of study. It is therefore recommended that the following policies are put in place to alleviate demand and supply-side problems that are confronting women in their utilization of maternal health services.

i. Employment of enough healthcare providers to provide enough back-up and replacement for those that may not be at work because one factor or the other.
ii. Creation of awareness through mass media, religious gatherings and social functions about the need to utilize institutional maternal health services, and about the dangers associated with using traditional birth attendance.
iii. Provision of adequate compensation packages and appropriate incentives to health personnel to increase their commitment and motivation to work.
iv. Maintenance of adequate monitoring and supervision of health personnel to ensure the proper delivery of services.

ETHICAL APPROVAL AND CONSENT

During the course of conduct of the interview, sufficient information was verbally explained and written on the front page of questionnaire. Consent was sought from the participants; they were made to understand that they were free to withdraw from the interview at any time they feel like. They were equally told that their responses are confidential and anonymous, and will be used only for the purpose of the research. All necessary research ethics in the conduct of interviews were followed.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

REFERENCES

1. Girum T, Wasie A. Correlates of maternal mortality in developing countries: an ecological study in 82 countries. Maternal Health, Neonatol and Perinatol. 2017;19(3):1-6.
2. Suellen M, Belizán J. The true cost of maternal death: Individual tragedy impacts family, community and nations. Journal of Reproductive Health. 2015;56(12):1-4.
3. United Nations International Children's Emergency Fund UNICEF. Maternal mortality. Maternal. health. (Accessed Federal Republic of Nigeria (2009). Official Gazette. Report on the census 2006 final results. 96(2) B34. Abuja, Nigeria: Federal Government Printer; 2017.
4. Black R, Laxminarayan R, Temmerman M, Walker N. Reproductive, Maternal, Newborn, and Child Health. Disease Control Priorities; The International Bank for Reconstruction and Development, The World Bank: Washington, DC, USA; 2016. Available:https://openknowledge.worldbank.org/handle/10986/23833
5. World Health Organization. Trends in maternal mortality 2000 to 2017: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division; 2019.
Retrieved on 23rd November, 2019.
Available:https://www.unfpa.org/featured-publication/trends-maternal-mortality-2000-2017
6. National Population Commission (NPC) [Nigeria] and ICF Nigeria demographic and health survey 2018. abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF International; 2019.
7. World Health Organization. Towards a global action plan for healthy lives and well-being for all: uniting to accelerate progress towards the health-related sdgs, World Health Organization, Geneva, Switzerland; 2018.

8. Arthur E. Wealth and antenatal care use: Implications for maternal health care utilization in Ghana Health Economics Review. 2012;2(14):1–18.
9. Babalola SO, Factors associated with use of maternal health services in Haiti: A multilevel analysis. Pan American Journal Public Health. 2014;36(1):1–9.
10. Bayu H, Fisseha G, Mulat A, Yitayih G, Wolday M. Missed opportunities for institutional delivery and associated factors among urban resident pregnant women in South Tigray Zone, Ethiopia: A community-based follow-up study. Global Health Action. 2015;8(1):28-42.
11. Oyedele O, Determinants of Maternal Healthcare Utilization in Nigeria. African Research Review. 2017;11(2):283-294.
12. Chol C, Cynthia H, Berhane D, Berhana H, Joel N, Robert G. Stakeholders' perspectives on facilitators of and barriers to the utilization of and access to maternal health services in Eritrea: A qualitative study. BMC Pregnancy and Childbirth. 2018;18(35):1-12.
13. Kaba M, Taye G, Gizaw M, Mitiku I. Maternal health service utilization in urban slums of selected towns in Ethiopia: Qualitative study. Ethiop. J. Health Dev. 2018;31(2):97-102.
14. Akowuah JA, Agyei-Baffour P, Asibey B. A Qualitative Study on the Pathways to Evidence-Based Antenatal Care in Periurban Ghana. Obstetrics and Gynecology International. 2018;34(11):1-9.
15. Akhter S. Maternal health care seeking behaviour of women from lower and upper socio-economic groups of Dhaka, Bangladesh –fear or fashion? A thesis submitted in fulfillment of the requirement for the degree of Doctor of Philosophy School of the Environment at Flinders University Austral; 2015.
16. Creswell JW, Qualitative inquiry and research design: Choosing among five approaches (3rd ed.). Washington, DC: SAGE; 2013.
17. Saldana J. The coding manual for qualitative researchers. Los Angeles, CA: SAGE Publications; 2016.

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