Cultural Beliefs and Practices Influencing the Health Seeking Behaviour of Women During Pregnancy in Ota, Southwest Nigeria

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Dedication

This thesis is dedicated to my mother, Mrs Eniola Adeosun, who supported me in everything but didn't live to see the light at the end of the tunnel

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The Author

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Abstract

Maternal mortality is a global health challenge affecting women within the reproductive age group. The main causes of maternal death in low and middle-income countries are infections, obstructed labour, eclampsia, haemorrhage, and unsafe abortion. Sociological, economic, and demographic factors are the indirect factors contributing to poor maternal health outcomes. The review of the literature shows that the utilisation of antenatal care (ANC) and delivery in the presence of skilled birth attendants are evidenced-based approaches to improving pregnancy outcomes and reducing pregnancy-related complications.

The medical literature currently provides little information about beliefs and practices in relation to other factors within the human environment. Yet these factors are considered an essential part of ANC that cannot be ignored due to their impact on pregnancy outcomes. While healthcare stakeholders in different countries with high maternal healthcare indexes are developing new strategies targeted at reducing maternal deaths and improving pregnancy outcomes, this has not been effective in proffering a solution to all identified pregnancy-related issues.Thus, it is important to develop new approaches that will focus more on the needs of women seeking healthcare.

This research was carried out through an ethnographic approach, with the aim of exploring the beliefs and practices that may influence the health seeking behaviour of women in Nigeria in relation to their ANC needs. The study participants consisted of eight maternity service providers and twenty pregnant women in Ota, a community located in the south- western part of Nigeria. The pregnant women who were accessing a range of maternity service providers, were selected through a purposive sampling method whilst the maternity service providers were selected through the snowballing method. The data for the study were collected through semi-structured interviews and observations.The data were then analysed through thematic analysis. The findings of this study

provide insights into the indigenous beliefs and practices of the stakeholders involved in pregnancy, such as the use of safety pins, the preparation and consumption of a special soup made with snail or fish. In addition, due to previous pregnancy experience or fear of the unknown outcome of pregnancy, women seek care from local maternity service providers for protection from evil spirits. According to their individual beliefs, women will seek care from a range of maternity service providers to ensure they have a safe childbirth, where mother and child are alive and healthy.

This study contributes to the body of knowledge by offering, as its central theme, a theoretical rendering of what may be described as the supernatural power of caring. The participants in this study believe in the existence of a form of supernatural power. This power is being used for protection from any form of harm that could affect either the mother or the baby during pregnancy or on the day of childbirth. This unique perspective highlights the need to acknowledge indigenous practices alongside a biomedical model of care.

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List of Abbreviations

ADB	African Development Bank
ANC	Antenatal Care
BNI	British Nursing Index
FMH	Federal Ministry of Health
FRN	Federal Republic of Nigeria
HCPRDU	Health Care Practice Research and Development Unit
ICD	International Classification of Diseases
ICF	International Classification of Functioning, Disability and Health
IFGO	International Federation of Gynaecology and Obstetrics
LGA	Local Government Area
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK
MDG	Millennium Development Goal
NDHS	National Demographic and Health Survey
NFE	Non-Formal Education
OECD	Organisation for Economic Co-operation and Development
PHC	Primary Healthcare Centre
SDG	Sustainable Development Goal
SEM	Socio-Ecological Model
TBA	Traditional Birth Attendant
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Emergency Fund

USAID	United States Agency for International Development
WHO	World Health Organization

Glossary of Key Terms

Local maternity service provider: a local provider of maternity services in an area – may include spiritualists, herbalists, and TBAs (traditional birth attendants)

Culture: described as the way of life of people, comprising norms, values, beliefs, and practices

TBA: layperson who provides care for women during pregnancy and childbirth

Skilled birth attendant: a registered healthcare professional such as a nurse, midwife or doctor who has undergone the necessary training and is certified by a regulatory body to provide maternal and child healthcare services

Indigenous beliefs and practices: beliefs and practices particular to the inhabitants of a community

Traditional beliefs and practices: beliefs and practices passed down from previous generations – often perceived to be beneficial

Whilst acknowledging the difference connotations of the words indigenous and traditional, in this context it is used interchangeably.

Chapter 1: Introduction to the Study

1.0 Introduction

Maternal mortality is a major health concern for various countries around the world. More than 50% of maternal deaths occur in low- and middle-income countries. The fifth United Nation's MDGs (Millennium Development Goals) targeted reducing the rate of maternal deaths by 75% before the end of 2015 (WHO, 2020c). This target was not met. In 2016, a new SDG (Sustainable Development Goal) was set out to reduce the global maternal death rate to less than 70 per 100,000 live births by 2030 (UN, 2020).

The utilisation of maternal healthcare services for antepartum, intrapartum, and postpartum care is one of the major approaches that can be used to improve maternal health (Ariyo et al., 2017). However, in sub-Saharan Africa there is still low utilisation of the services of skilled healthcare personnel (Sumankuuro et al., 2018). This is because some pregnant women do not deliver in the presence of skilled healthcare personnel due to economic, political, and sociocultural factors (Firoz et al., 2016).

Despite global advancements in healthcare, some women within the reproductive age group patronise alternative maternity service providers because of the impact of some of the aforementioned factors. This has been attributed partly to the non-availability of other forms of maternity care services within their communities (James et al., 2018). It is also asserted that for people living in rural areas, who may not have reliable sources of income, alternative maternity care services are relatively more affordable (Amutah-Onukagha et al., 2017). In Nigeria, pregnant women use the services of TBAs (traditional birth attendants), herbalists and spiritualists; this is a widespread practice among women in rural communities (Adedokun & Uthman, 2019).

The low utilisation of the services of skilled healthcare personnel is classified, in part, as one of the factors that increase the risk of pregnancy-associated complications among women residing in remote or rural communities (Islam & Sultana, 2019; Sikder et al., 2014; Yahya & Pumpaibool, 2018). Although it is to be noted that pre-existing underlying health conditions, such as diabetics and chronic hypertension of the mother, can also increase complications in pregnancy, thereby affecting maternal health outcomes (Malcolm, 2012; Robledo et al., 2017).

Also contributing to the use of the services of unskilled healthcare workers by women within the reproductive age group during pregnancy are demographic factors, economic factors, structural factors, and cultural factors (Azuh et al., 2017, 2019; Nakua et al., 2015). The literature provides vast amounts of information about some of the underlying factors affecting the decision of where to seek care during pregnancy, such as levels of education, geographical location, and the role of mothers-in-law. However, none of the studies addresses the influence of cultural beliefs, practices and health seeking behaviour on individual women's choices regarding where to seek care during pregnancy. The result of a qualitative study conducted in six villages in Indonesia's West Java province shows that there are still women who seek care from unskilled healthcare personnel despite the availability of trained healthcare workers within their community. Their healthcare choices are based on the belief that it is only women that develop pregnancy-related complications who need to seek maternity care from qualified healthcare personnel (Titaley et al., 2010).

Although the cost of maternity services and a shortage of healthcare staff have been identified as part of the underlying factors contributing to the low utilisation of the service of skilled healthcare personnel (Titaley et al., 2010), this contrasts with a study conducted in rural Zambia. Here, Sialubanje et al. (2015) found that cultural norms surrounding pregnancy and childbirth were contributing factors in the decision by most women to opt for home delivery in the presence of unskilled healthcare personnel.

One of the other reasons forwarded for the non-utilisation of the services of skilled healthcare personnel for pregnancy- and childbirth-related issues is logistical; the distance between home and healthcare facility may be too far to travel (Adedokun & Uthman, 2019). Another study attributes the low utilisation of professional maternity healthcare services to socio-economic, demographic, and cultural norms (Moore et al., 2011). Perceived factors leading to the low utilisation of healthcare facilities during pregnancy and childbirth include levels of education, religion, and other associated cultural factors (Yahya & Pumpaibool, 2018). Despite the WHO stipulating that the provision of a contextual form of maternity care is the primary approach to improving maternal healthcare outcomes (WHO, 2018b), there continue to be high levels of pregnancy-related complications, low utilisation of the

services of skilled healthcare personnel, low attendance at ANC (antenatal care) in rural communities and high rates of maternal mortality in low- and middle-income countries.

Cultural beliefs and practices vary according to different contexts. Since cultural beliefs and practices have been identified in the literature as factors influencing women's choices regarding where to seek care during pregnancy and childbirth (Idang, 2015), it is important to explore these factors in particular contexts – in this case, an area in rural Nigeria.

1.1 Reasons for Undertaking this Study

There are several personal reasons for studying this topic. As a registered nurse–midwife trained in Nigeria, I have had the opportunity of working with non-governmental organisations in a voluntary capacity. The idea for this research emanates from my experience working as a trained first aider in Ogun State, Nigeria.

As a volunteer with the Nigerian Red Cross society, I witnessed several women who were bleeding after home births. Some of these women had never attended any form of ANC in a hospital until the onset of pregnancy-related complications, when they were admitted as emergency cases. Delays in initiating care and delays in reaching the point of care due to poor transport networks, coupled with delays within the healthcare setting, all contributed to the experiences of some of the women I assisted.

The death of my sister-in-law in such a scenario was a tragedy that cannot be easily forgotten, and one which also underpins my decision to undertake this research. Within 24 hours after delivery at a local healthcare facility in my community, she started to bleed profusely. Despite efforts to save her, my sister-in-law passed away due to complications that may have been averted. This was really devastating and led me to wonder when would all these deaths stop: what could I do to help the people in my community?

Anecdotally, I was aware that some pregnant women are compelled by the members of their family to seek care from an alternative maternity service provider, due to a belief in that form of care. People who urge such a choice on pregnant women in their families have been described in the literature as “significant others” who may impact on the choices women make regarding where to seek care during pregnancy (Fagbamigbe & Idemudia, 2015). It is therefore important to explore the beliefs and practices associated with women’s choices regarding where to seek care during pregnancy.

Research conducted in different countries shows that women prefer a form of maternity care that is in line with their beliefs (Choudhury et al., 2012; Culhane-Pera et al., 2015; Kaphle et al., 2013; Sharma et al., 2013). This is why it is important to understand what constitutes an individual belief when it comes to making choices about healthcare.

Furthermore, maternity service providers cannot improve pregnancy outcomes without the physical attendance of the pregnant woman who is at the centre of maternity care. Thus, it becomes imperative to explore the factors which may affect women's healthcare choices during pregnancy. Studies have documented a great disparity in the rate of attendance at antenatal clinics among women in Nigeria – the lowest rates of attendance are common among women with little, or no, formal education, women living in poverty and those living in remote parts of the country (Adewuyi et al., 2018; Fagbamigbe & Idemudia, 2017). Since cultural beliefs and practices have been classified as part of the factors contributing to low utilisation of the services of a skilled birth attendant during pregnancy (Benoit et al., 2010; Johnson, 2008; Kaphle et al., 2013; Sawyer et al., 2011; Titaley et al., 2009) this will be the focus of this study.

1.2 Statement of the Problem

The region of sub-Saharan Africa accounts for 62% of global maternal deaths (Mariga & Saleh, 2009). Nigeria has an estimated annual maternal death rate of 814 per 100,000 live births (CIA, 2017). Thus, the country is classified as one of the top ten countries with the highest maternal mortality rate (Cooke & Tahir, 2013). Previous research has identified the geographical location of women, their level of education, the lack of functioning health facilities, and lack of transport as the primary factors affecting the rate of ANC utilisation (Fagbamigbe & Idemudia, 2015). It has, however, been argued that the availability of a well-resourced and functioning healthcare facility does not always guarantee an increase in the rate of utilisation of such a service, since access to healthcare facilities may be impeded by road topography and distance to the facility (Efe, 2013). Thus, maternal mortality and morbidity continue to increase in Nigeria, with the attendant risks associated with a high fertility rate (Adebowale, 2017). This is further compounded by the impact of the health seeking behaviour of women on the rate of utilisation of ANC during pregnancy (Akeju et al., 2016).

Since the utilisation of contextual forms of ANC has been classified as an evidenced-based approach to preventing 99% of maternal deaths in low-resource nations (Akpomuvie, 2010; Fagbamigbe & Idemudia, 2017), it is important to carry out a study that will explore the experiences of women regarding beliefs and practices associated with pregnancy care.

1.3 Location of the Study

Most of the causes of women's deaths during the peripartum period are avoidable (Prata et al., 2009) as evidenced from the review of information from three developing nations (Sri Lanka, Malaysia, and Honduras), which shows that ANC and the presence of skilled birth attendants at every delivery are useful tools for improving birth outcomes in low-resource nations (Bale et al., 2003). However, most women in Nigeria either book late or do not register for ANC, as evidenced from a study conducted in southwest Nigeria in 2008, which shows that 82.6% of pregnant women register late for ANC (Adekanle & Isawumi, 2008). Meanwhile, more recent research in Nigeria shows that ANC will only be effective in the reduction of maternal mortality if there is appropriate intervention for the management of malaria, HIV, and pre-eclampsia/eclampsia in pregnancy – in conjunction with a focus on educating girls, eradicating poverty and implementing a community approach that will strengthen the healthcare system (Meh et al., 2019; Okereke et al., 2019; Olonade et al., 2019). However, the impact of such improvements may be adversely affected through the unavailability of healthcare personnel, shortage of staff, and lack of resources all contributing to low rates of attendance at antenatal clinics (Ozumba & Nwogu-Ikojo, 2008).

Previous research showed that early recognition of the signs and symptoms of pregnancy complications is crucial for saving a woman's life (Bauserman et al., 2015). Likewise, a study conducted among childbearing women in India showed that an improvement in perinatal services is crucial for safe childbirth and the reduction of the rate of maternal death (Pandit, 1992). However, it is a challenge to identify women who are at risk of developing any form of pregnancy-related complication if they do not visit a clinic. Thus, it appears that the availability of a healthcare clinic within a community does not translate to its utilisation. Since there remains a low rate of attendance at ANC due to the state of the healthcare system (Carroli et al., 2001; Fagbamigbe & Idemudia, 2015; Osungbade et al., 2011). It is, therefore, important that healthcare stakeholders and policy makers focus on the establishment of a form of ANC that will meet the needs of the women seeking care. Since there is a gap between what pregnant women want and the form of service available, it is important that existing forms of ANC consider the needs of the people

who are at the centre of maternity care. Therefore, this research will aid improvement in maternity care through the identification of the cultural factors and beliefs that affect healthcare choices during pregnancy in a particular community.

1.4 Aim of the Study

- To explore the cultural beliefs and practices that may influence the health seeking behaviour of women in Ota, southwest Nigeria, during pregnancy, especially in relation to ANC.

1.5 Objectives of the Study

- To identify the cultural beliefs and practices influencing the healthcare choices of women during pregnancy in Ota.
- To explore what is considered to be care in pregnancy among women within the reproductive age group in Ota.
- To identify who influences the choice of where to seek care during pregnancy.
- To explore the role of TBAs, spiritualists and herbalists in the community.
- To understand how cultural beliefs and practices affect women's decisions regarding ANC.
- To gain an understanding of what influences the health seeking behaviour of women during pregnancy.

1.6 Significance of the Research

This research is important because the reality of a woman seeking ANC in Nigeria is different from what is documented in the healthcare policy. An example of this is Section 33 of the 1999 Constitution of the FRN (Federal Republic of Nigeria), which stipulates that the government has the obligation to provide adequate healthcare and make it accessible to all its citizens as it has the ultimate responsibility to protect the life of all people. Likewise, the judicial and executive arm of the government also make laws to ensure all the citizens of the country have equal rights to health (Anyogu & Arinze-Umobi, 2013), but not all the citizens of Nigeria have access to the form of healthcare they desire.

Nigeria is also signed to Article 12 of the International Covenant on Economic, Social and Cultural Rights which stipulates that "special protection should be accorded to mothers before and after childbirth". Nigeria, being a signatory to international law, signifies willingness to abide by the covenant (Anyogu & Arinze-Umobi, 2013). However, the right to special protection is jeopardised through inequality in the distribution of maternal health care services within the different regions in the country (Ariyo et al., 2017); for example, there are several advocacy programmes for the provision of free maternal healthcare services for all women within the reproductive age group across the different states in Nigeria, yet the service is offered only partially by selected states within the country (Ogbuabor & Onwujekwe, 2018; Okonofua et al., 2011). The unavailability of healthcare clinics thus affects women's healthcare choices because they are left to make choices based on what is available within the community (Lanre-Abass, 2008). Therefore, geographical location can be classified as a factor which limits women's healthcare choices during pregnancy, thus contributing significantly to the low rate of utilisation of maternal healthcare services (Olonade et al., 2019).

Ajayi and Akpan (2017) conducted a study in south-western Nigeria, a region with a record of reduced attendance rates at ANC clinics, as shown in a cross-sectional survey conducted recently in the region. They found that the low rate of attendance at ANC within the study area remained despite the removal of the user fee by the government (Ajayi & Akpan, 2017). Likewise, other research shows that there is a need to identify the underlying factors affecting women's healthcare choices during pregnancy, since ANC from skilled

healthcare personnel is part of the approach to improving maternal health and reducing complications associated with pregnancy (Akeju et al., 2016a; Yaya et al.,2017). It is, therefore, important to conduct research with a focus on the underlying factors affecting the choices women make regarding seeking ANC during pregnancy.

Interventions targeted at improving maternal healthcare should not only focus on the supplier of healthcare; there is also a need to include information about the cultural beliefs of pregnant woman as consumers of healthcare. This is because the identification of the cultural factors affecting women's health seeking behaviour has been recognised globally as an approach to meeting the maternal healthcare needs of women in diverse settings (Coast et al., 2014). It is, therefore, important to identify the beliefs and practices influencing the health seeking behaviour of women in Ota, south-west Nigeria.

One of the evidenced-based approaches to improving the rate of utilisation of ANC services is to ensure that the available service meets the demand of the women attending the clinic. As beliefs and practices work synergistically with other factors within the external environment of the women to produce a pattern of health seeking behaviour, this research will contribute to knowledge by providing information about how cultural beliefs and practices in relation to other factors within the human environment impact on women's choices regarding where to seek ANC.

This research will also contribute to the existing literature by providing key insights required to understand maternity care in other parts of the world, especially countries with high maternal mortality and morbidity. Furthermore, the existing literature has not been able to provide information about all the communities within sub-Saharan Africa as highlighted in Chapter 4 of the thesis. The findings from this research will also be a valuable resource for charity organisations and healthcare workers that focus on improving maternal healthcare indexes of developing nations with high rates of maternal death, since they may not be aware of the traditional beliefs and practices applicable to pregnant women within different regions. Thus, this research will enable the implementation of measures to promote the appreciation of meaningful cultural beliefs and practices alongside evidence-based approaches.

My background knowledge as an indigene of Ota with previous working experience in the study area as a volunteer of the Nigerian Red Cross Society will aid my interpretation of the experiences shared by participants in this research. This is because I can comprehend the authentic meaning of participants' personal accounts during the analysis stage, without loss or alteration through the use of an interpreter, thereby increasing the credibility of the research study.

The result of the literature review shows that no research has been conducted on the beliefs, practices, health seeking behaviour, and antenatal choices of childbearing women in Ota. This research was, therefore, conducted through an ethnographic approach for the identification of non-biological and underlying factors affecting the choices of women when making decisions regarding where to seek care. Hence, this research will be contributing to the literature by identifying the factors affecting the individual as a member of the community.

1.7 Thesis Structure

The thesis consists of nine chapters, with each chapter focusing on an element of the study, as outlined below.

Chapter 1 provides an introduction to the study. This includes information about the reasons for undertaking this study, the statement of the problem, location of the study, the overall aim of the study, the significance of the study, and the structure of the thesis.

Chapter 2 gives a critical overview of Nigeria. This includes information about Nigeria as a country in Africa, the structure of the healthcare systems available, the providers of maternal healthcare services in the country and a general overview of maternal mortality as a growing health concern in Nigeria.

Chapter 3 focuses on delineating the various concepts related to this study. This includes descriptions of the concepts of health, health seeking behaviour and culture. This chapter also includes information about the theories of culture, health seeking behaviour and the SEM (Socio-Ecological Model) as applied to the research.

Chapter 4 reviews previous research studies on health seeking behaviour of childbearing women. Key findings from the literature research are discussed and a gap is identified.

Chapter 5 focuses on the methodology applied in the study. This includes information about the research paradigm and the various approaches to qualitative research. In addition, there is a detailed description of the ethnographic approach as applied in this study.

Chapter 6 looks more closely at the methods applied in this study. There is also a description of how study participants were selected for the study and the methods applied for collecting data for the research.

Chapter 7 presents the findings of the research. This includes the central theme and other themes that appeared after the analysis of the data collected from the study participants.

Chapter 8 provides a critical discussion about the findings of the research. It focuses on the results of the study using the SEM to explain how it adds value to the research. It also presents the limitations and recommendations for future studies.

Chapter 9 discusses the conclusion of the study. This includes implications of the findings of the study for different stakeholders involved in maternity care in Nigeria.

1.8 Summary

This chapter of the thesis introduces the study. This includes the reason for undertaking the study, the statement of the problem, location of the study and the objectives of the study. The chapter concludes with the description of the structure of the thesis. The next chapter will give an overview of Nigeria and the structure of the healthcare system in Nigeria.

Chapter 2: Nigeria and Maternal Mortality

2.0: Introduction

This chapter starts with a description of the FRN (Federal Republic of Nigeria) as a country geographically located within sub-Saharan Africa. There is also a section on the general overview of Nigeria as a nation followed with a brief description of the study area, which will be further developed in Chapter 6. Other sections in this chapter will focus on the forms of healthcare system available to the citizens of the country and maternal mortality.

Nigeria is one of the countries located in West Africa, with a total land area of approximately 925,000 square kilometres. The estimated population of 186,053,385 is the highest among all the 54 countries in Africa; FRN is ranked as one of the ten most highly populated countries globally (Phillips, 2004; Falola & Heaton, 2008; Imam & Akinyemi, 2016). The coastal trade between Africans and Europeans in the late fifteenth century led to the formation of Nigeria. The Republic of Nigeria was formed under the British Empire in 1914 by Lord Lugard; the country gained its independence from the United Kingdom on 1st October 1960 (CIA, 2017).

Nigeria has a total of 36 states and 774 local government areas; Abuja is the capital of the nation. Nigeria operates a federal political system (OECD, 2012). The official language in Nigeria is English and the country is a member of the Commonwealth, which comprises 54 states spread across Asia, America, Europe, the Pacific, and Africa.

2.1 An Overview of Nigeria as a Country

2.1.1 Economy

The Nigerian economy depends mostly on the day-to-day transactions of its citizens. In 2019, GDP increased from 1.9% in 2018 to 2.3%. This is because of improvements in the transportation sector, the oil and gas sector, and information technology.

Nigeria is the biggest exporter of oil and oil resources in Africa. Despite the reliance on oil, however, agriculture is also a mainstay of the nation but did not contribute to the increase in the GDP due to flooding and conflicts between the Fulani herdsmen and farmers. Agricultural produce includes cassava, rice, oil, sorghum, yam, cocoa, and peanuts, but the country still depends on produce from other countries for survival due to the population growth rate.

The rate of poverty in FRN is also very high; it is classified as one of the ten poorest countries in the world, with more than half of the population living in extreme poverty. This has been attributed to the high rate of corruption among the political leaders and other major stakeholders of the country (Phillips, 2004; Ventura, 2019; ADB, 2020). Presently, Nigeria is faced with numerous economic challenges due to unpaid international debts, heavy reliance on oil, poor infrastructure, and limited foreign exchange capacity (USAID, 2020).

2.1.2 Political System in Nigeria

Under the constitution of the FRN the president, currently Muhammadu Buhari, is the head of state and the chief executive of the country. Nigeria operates a three-tier system of government: federal, state, and local. The state and local governments are controlled by the federal government. The country consists of 36 states and the federal capital territory, which is in Abuja. Nigeria presently operates a democratic system of government with an election held every four years, yet the system fails to meet the needs of all its citizens because the country is not working, and its citizens are living in poverty.

The different arms of the government are the Federal Executive, the Legislature, and the Judiciary. There are different ministries under each executive arm of the government, one of which is the Federal Ministry of Health which implements healthcare policies for all the citizens of the country. The minister of health is Dr Osagie Ehanire (FRN, 2020).

2.1.3 Geographical Location

Nigeria is bordered by the Republic of Niger and the Republic of Chad to the north, and the Republic of Cameroon to the east, while to the west is the Republic of Benin and to the south is the Atlantic Ocean. The main rivers in the country are the River Niger and the River Benue, which meet at Lokoja and empty into the Niger Delta. Nigeria is a tropical region with wet and dry seasons. The geographical size is about twice the size of California (CIA, 2017).

Figure 2.1: Map of Nigeria showing the six geopolitical zones

2.1.4 People

Nigeria is home to more than 250 ethnic groups, with each having its own language and culture. The main ethnic groups are the Hausa and Fulani in the north, and the Yoruba, Igbo, and Edo in the south. The Hausa are the largest group; they occupy the northern part of the country and are predominantly Muslim. The Yoruba are settled in south-western Nigeria and the Igbo live in the south-east (Mustapha, 2005). Other ethnic groups spread across the country are the Tiv, Ibibio, Ijaw, Kanuri, Nupe, Gwarri, Fulani, Itshekiri, Edo, Urhobo and Ijaw (National Population Commission & ICF International, 2018). The total population is 186,053,385 and is projected to increase to 392 million by the end of 2050, thereby becoming the fourth most populous nation globally. Nigeria, regarded as the giant of Africa due to its population size (OECD, 2012), has a present populations growth rate of 2.44% and a birth rate of 37.3 per 1,000 (CIA, 2017).

2.1.5 Education

A report from the National Commission for Mass Literacy, Adult and Non-formal Education (NMEC) shows that about 35% of the adult population is uneducated. Literacy, according to the NMEC, is the percentage of people above the age of 15 who can read and write basic sentences required for daily communication among individuals (Thisday, 2019). The healthcare policy in Nigeria documents a higher rate of literacy among women than men in (FMH, 2016), with women in urban areas more literate than their rural counterparts (FMH, 2016).

2.1.6 Language

There are more than 500 languages spoken in Nigeria, with English being the official language used across all sectors in the country (Yusuf, 2012). All 36 states have an individual language, with each tribe spread across the country having their own unique dialect as a symbol of their respective culture. The other language spoken nationwide is pidgin English, which is a combination of standard English and a local dialect (Agheyisi, 2015).

2.1.7 Poverty

In Nigeria, about 112,519 million people are estimated to be living in poverty, thereby placing the poverty rate in the country at 60.9%. The northern state of Sokoto has the highest rate of poverty at about 86.4%. Despite the implementation of various policies for the alleviation of poverty, most people in Nigeria still live on less than $1.25 a day. The high rate of poverty has been attributed to the poor system of governance (Omoyibo, 2013). Thus, poverty can be described as one of the barriers that impede access to quality healthcare services among Nigerians (Fagbamigbe & Idemudia, 2015). Poverty also prevents pregnant women from seeking quality ANC services from skilled providers of maternity services. Poverty can, therefore, be categorised as a form of threat to pregnant women (Lanre-Abass, 2008).

2.1.8 Religion

Nigeria is a country with traditional and non-traditional forms of religion. People who practice traditional and non-traditional religions believe in a supreme being as the controller of the universe. The traditional form of religion espouses a belief in ancestors, spirits, and the afterlife, while non-traditional forms of religion are more common within the country with 50% of the population identified as Muslim and 40% as Christian (Adeyanju & Babalola, 2017).

The Christian groups in Nigeria include, but are not limited to, Baptists, Jehovah's Witnesses, Methodists, Catholics and numerous other ministries such as Four-Square Gospel Church, Redeem Christian Church of God, Christ Apostolic Church, Winners Chapel, Mountain of Fire, Christ Embassy, Deeper Life Bible Church, Celestial Church of Church, Cherubim and Seraphim Churches and other small ministries which may or may not be registered with any religious organisation within the country (Adeyanju & Babalola, 2017).

Although Christianity is more predominant in the south-west, the Igbo in south-eastern Nigeria also believe in God as the creator of the universe. This is evident in the names given to children by the Igbo to show the link with God; for example, the name Chukwuemeka means God has done so much; Chukwu nae me ihe nile means God knows

everything; Chukwu nke mara obi means God knows my heart; and Chukwu ma means God knows me (Okeke et al., 2017).

Islam is mostly practised among the Hausa in the northern part of the country. In the south-east, there are diverse groups that include Sunni, Shi'a, Sufi, and Ahmadi Muslims (Ostien, 2012). This is slightly different from what is common among Muslims in south-western Nigeria, where the several groups of Muslims include Nasr Allah al-Faith (NASFAT) and other related Pentecostal Islamic groups (Janson, 2020; Obadare, 2015). The practices of such groups vary from the way in which Islam is practised in the north (Janson, 2020).

The traditional form of religion is common among the Yoruba in the south-west Nigeria. This form of religion involves worshipping the Olodunmare, believed to be the creator of the universe. The various other gods commonly worshipped among the Yoruba are Sango (god of fire), Orunmila (custodian of the Ifa Oracle), Esu (the devil), Ogun (god of iron), Yemoja (mother of water), and Oya and Osun (river goddesses). An annual celebration of various gods is held in Ile-Ife, Osun State (Okeke et al., 2017)

Religion, whether traditional or non-traditional, plays a crucial role in Nigerian society. It influences people's ideas about the causes of disease and illness. The traditional practice involves ascribing the cause of an illness to witchcraft or to ancestors, as a form of revenge for not conducting established rituals for one's ancestors. Although Western education has changed perceptions about the causes of disease and illness, there are people in Nigeria who still associate the cause of disease as a form of affliction (Adewuyi et al., 2018; Aguwa, 2010; Solanke et al., 2015; Doctor, 2011). Due to this, some authors have also categorised religion as a factor associated with the low utilisation of antenatal healthcare services and delivery in the presence of a skilled birth attendant among women within the reproductive age group in Nigeria (Adewuyi et al., 2018; Solanke et al., 2015).

Religion is also described as part of the social determinants of maternal healthcare services in India, Nepal, and Zambia (Dey et al., 2018; Paudel et al., 2018; Sialubanje et al., 2014). This is because pregnancy as a psychological and physiological event have a strong connection with the spiritual beliefs and practices of the individual seeking care. Thus, a traditional system of care is widely practised in Nigeria, but it is more common in rural areas compared to urban areas (Solanke et al., 2015). It should be noted that a significant

percentage of urban dwellers also consider their traditional needs when seeking care, despite the widespread availability of functioning healthcare centres, pregnancy and childbirth are viewed as sacred events deeply rooted in the beliefs of women seeking care (Ohaja et al., 2019). Due to the unique nature of pregnancy and childbirth, the role of spirituality cannot be dissociated from women as seekers of maternity care. As such, it can be surmised that existing forms of maternity care do not meet the needs of women within the reproductive age group since mothers-to-be continues to deliver in indigenous healthcare facilities such as prayer houses and mission homes (Adanikin et al., 2014).

2.2 Brief Description of the Study Area

Ota is a community in Ogun State, in south-western Nigeria. Ogun State and two other states, Oyo, and Ondo were created from the old western region in 1976 (Oyeyemi et al., 2019). The total population in Ogun State is 3.75 million; this was projected to have increased to approximately 5.2 million in 2020 (Onyenwenyi & Mchunu, 2019). Ogun State consists of 20 local government areas with the study area, Ado-Odo/Ota, being the second largest local government area in the state, with a population of 527, 242 predominantly from the Awori community (Onyenwenyi & Mchunu, 2019). Ado-Odo/Ota is also referred to as Sango-Ota, which is also the capital of this local government area. Other communities within Ado-Odo/Ota are Ado-Odo, Agbara, Igbesa, Iju-Ota, Itele, Kooko Ebiye and Owode. The traditional sovereign of the kingdom of Ota is called the Olota of Ota (Adeosun, 1997) and the present ceremonial ruler is Prof Adeyemi Abdulkabir Obalanlege (Olota Palace, 2018).

2.3 The Healthcare System in Nigeria

In Nigeria, there are two systems of healthcare: the traditional (unorthodox) system of care and the modern (orthodox) system of care. Colonisation by the British empire brought about the orthodox system of care, which is now the officially accepted form of care by all the healthcare stakeholders in Nigeria. Prior to 1914, people relied on the traditional system of care that was developed with a total reliance on indigenous medical practices, and a large proportion of the population continue to access traditional forms of healthcare. The reliance on this form of healthcare has been linked to the strong beliefs held by Nigerians, and, as such, women within the reproductive age group utilise both traditional and modern systems of care for safe childbirth (Adefolaju, 2014). The primary providers of indigenous or traditional healthcare services are herbalists, TBAs and spiritualists, while the main providers of modern healthcare services are nurses, midwives, doctors, community healthcare workers, and other related skilled healthcare personnel.

Modern healthcare provision is more widely referenced in FRN healthcare policy than the services of traditional systems. This is because modern healthcare workers are trained and certified by a regulatory body while their counterparts acquire their skills from past generations and are never trained or certified by an accredited regulatory body (Adefolaju, 2014). Traditional healthcare workers acquire their skills from continuous practice and, or, through the information that is passed down to them from their mothers, grandmothers, and mothers-in-law (Jansen, 2006). Irrespective of the mode of education and training, the contribution of indigenous healthcare workers cannot be ignored in a country like Nigeria where culture is an important consideration when seeking care (Okafor et al., 2014).

The services provided by traditional healthcare workers are deeply embedded within the beliefs of the people they serve and are highly valued because modern forms of healthcare lack such characteristics (Ebuehi & Akintujoye, 2012). A clear preference for a traditional approach is evidenced with 60–80% of deliveries taking place in the presence of untrained health practitioners, outside a modern health facility (Imogie et al., 2012; Ebuehi & Akintujoye, 2012). Some authors assert that expectant mothers patronise traditional healthcare workers because theirs is the only service available in some parts of the country

(Ebuehi & Akintujoye, 2012). It is further argued that the traditional healthcare system remains the best option for some individuals because providers allow service users to practice what they belief without questioning their motives (Ebuehi & Akintujoye, 2012; Okafor et al., 2014). Despite any assumed or real benefit associated with the use of traditional services, research has documented high maternal health complications among childbearing women in rural areas as a disadvantage associated with such use. Although, there has been no substantial evidence when compared with their counterpart in the urban area (Ebuehi & Akintujoye, 2012).

The lack of skills and training required for the management of complications during pregnancy or childbirth is a factor documented in the literature as the primary issue associated with the use of traditional healthcare (Ofili & Okojie, 2005). Traditional practitioners are not registered as they do not fulfil the basic standards required for classification as part of the modern healthcare system, and as such, they are not members of professional regulatory bodies working with the federal or state government. Nonetheless, the contribution of traditional practitioners to maternity services cannot be side lined (Ebuehi & Akintujoye, 2012; Okafor et al., 2014). A challenge in regulating traditional practice stems from the inadequate information about the exact composition of the medicines and interventions used for such practice. A further issue arises from the lack of substantive evidence about its efficacy. This insufficient information about traditional healthcare methods and delivery places the system apart from modern systems and the regulations to which they adhere. (Adefolaju, 2014). Therefore, Nigerian healthcare policy focuses more on the modern system of healthcare because there is no documented policy about traditional healthcare practice.

2.3.1 Healthcare Policy in Nigeria

The state is guided by the 1999 Constitution of the Federal Republic of Nigeria, while the healthcare system is governed by the 2014 National Health Act. The aim of healthcare policy is to provide healthcare services for all Nigerians through the strategic implementation of its principles. These include making PHCs (Primary Healthcare Centre) the focus of the national healthcare system by ensuring the availability of healthcare

services to all, irrespective of the individual's geographical location. The act also includes strategies for the achievement of the UN's unmet MDGs (FMH, 2016).

2.3.2 Healthcare Financing in Nigeria

A recent review of public expenditure on the health sector and national health accounts indicates that each state in Nigeria allocates less than 5% of total expenditure on health. All three tiers of government allocate less than 6% of the total government expenditure on health: a figure that is less than 25% of the total amount spent on health within the entire country (Adebisi et al, 2020). The government finances healthcare through its yearly allocation to the federal, state, and local governments (Uzochukwu et al., 2015). It is tax-based because the amount of tax generated determines the amount spent on tertiary healthcare facilities, secondary healthcare, and PHCs (Odeyemi & Nixon, 2013). Other sources of income that determine the allocation on health are the amounts generated from oil exploration and agriculture (Mopani & Abimbola, 2015).

The amount the government spends on health is inadequate because it is not commensurate with the healthcare needs of the citizens of Nigeria – as was asserted in a 2001 macroeconomic report (Ejughemere, 2013). Healthcare needs in Nigeria have been shaped by an increase in the population, the emergence of new diseases, outbreaks of existing diseases, and the effect of globalisation (FMH, 2016). The low allocation of spending on healthcare affects the quality of healthcare services in government-owned facilities. Many individuals, therefore, rely on private healthcare for secondary and primary levels of care at excessive cost (Oyedeji & Abimbola, 2014). It is to be noted that the cost of private services does not guarantee a high-quality service due to the number of unlicensed practitioners within the healthcare sector (Olusanya et al., 2010).

Another source of health finance is the pooling system; this is a contributions-based system where healthcare services are financed through the contribution of its members (Uzochukwu et al., 2015). Out-of-pocket spending is another source of finance for healthcare in Nigeria and it is the main source of healthcare finance because it covers 75% of the total health expenditure (Onwujekwe et al., 2010).

2.3.3 Structure of the Healthcare System in Nigeria

The three levels of administration within the healthcare sector in Nigeria are the federal, state, and local government health departments. The Federal Ministry of Health manages the affairs of teaching hospitals and federal medical centres located across all the 36 states. Both the teaching hospitals and federal medical centres provide advanced forms of healthcare, which includes, but is not limited to, accepting referrals from secondary and primary healthcare facilities (FMH, 2016). Each state in Nigeria has one teaching hospital, two or more general hospitals (also referred to as state hospitals) and several PHCs. Private hospitals provide primary and secondary levels of healthcare services (FMH, 2016). Maternal and child healthcare services are provided by all the different forms of hospital listed above; however, proximity, financial status, personal preference, family member decisions, and the location of the patient determine the choice of service provider (Ewa et al., 2012).

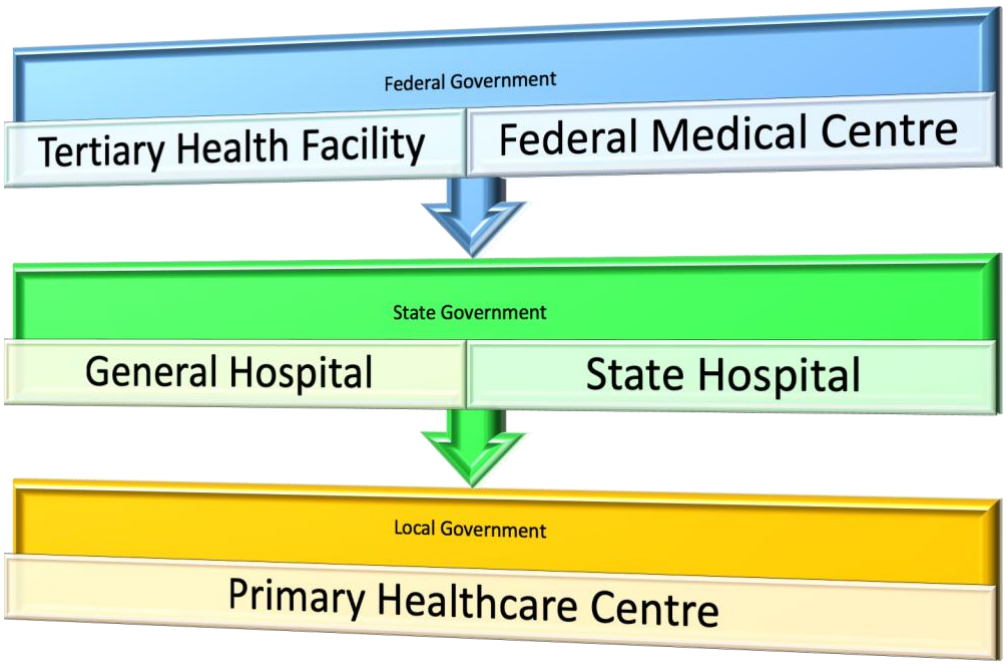


Figure 2.3: Structure of the healthcare system in Nigeria (Source: Akplagah, 2015)

The total number of healthcare facilities available across all the 36 states in Nigeria is 34,173. Of these, 88% are classified as PHCs within the community. Secondary healthcare is

provided by 12% of the total available facilities at the state level and only 1% provides advanced care at the tertiary level (FMH, 2016).

2.4 The Maternal Healthcare System in Nigeria

2.4.1 Maternal Healthcare Policy in Nigeria

In Nigeria, the federal government develops maternal healthcare policy, formulates standards for maternity care, trains healthcare workers, monitors the implementation of the strategies developed, and provides support at both the state and local levels. It also specifically focuses on the reduction of maternal deaths, the reduction of deaths of children, and increasing access to reproductive healthcare services. These policies support global initiatives such as the UN's MDGs and SDGs. Maternal healthcare policy also includes improving primary healthcare to ensure universal access to quality maternal and child healthcare services (FMH, 2016). However, the country has been unable to meet the MDG or SDG objectives.

As part of the strategy to improve maternal healthcare, policies are amended based on the needs of the people in the different regions of the country; for instance, a study was conducted in selected states in the northern Nigeria (Borno, Yobe, Adamawa, Taraba, Gombe, Bauchi, Nasarawa, Plateau, Jigawa and Kano) where high maternal mortality rates have been recorded (Galandanci et al., 2007). Other states within the country have also developed new strategies for the improvement of maternity services, but these are based on the available resources within each state.

Table 2.4: Previous maternal healthcare policy in Nigeria (Source: FMH: 2016)

Development of Primary Healthcare	1986
Safe Motherhood Initiative	1987
National Health Policy	1988
National Reproductive Health Policy and Strategy	2001
HIV/AIDS and PMTCT Policy and Strategy	2003
Revised National Health Policy	2004
National Child Health Policy	2005
MDGs Related to Maternal and Newborn Health	2005
Integrated Maternal Newborn and Child Health	2007

2.4.2 Maternal Healthcare Services in Nigeria

Accessing maternal healthcare services depends on the individual, their belief system, and the financial capability of the family (Okafor et al., 2014). This service is usually provided by private and public healthcare facilities at all levels (primary, secondary, and tertiary healthcare facilities). The private facilities are the hospitals or maternity centres owned by midwives or doctors. Although private treatment is usually an option for some families because of their status within the country, high-quality care is not always guaranteed (Olusanya et al., 2010). Other providers are faith-based centres, traditional healthcare providers, medicine hawkers, patent medicine vendors, and spiritual healers who use items such as holy water and olive oil for spiritual intervention in maternal health.

Figure 2.4: Maternal healthcare providers in Nigeria

2.5 Maternal Mortality: A Growing Concern in Nigeria

Maternal mortality is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (ICD-10; WHO, 2019).

The rate of maternal mortality does not reflect the true health of pregnant women because not all pregnancies lead to death (Gülmezoglu et al., 2004). Although pregnancy may predispose certain groups of women to illness, and it may increase the risk of pregnancy-associated problems in others, there are women who experience risk-free pregnancy and safe childbirth (Dietl et al., 2015). The definition of maternal mortality is further defined by the International Classification of Diseases (ICD-10) as "deaths caused by direct or indirect obstetric causes more than 42 days but less than one year after the end of pregnancy" (De Cosio et al., 2016; Lamadrid-Figueroa et al., 2016).

In 2000, the Millennium Summit was held at the UN headquarters to develop strategies on how to improve the socio-economic status of different countries around the world. One of the objectives agreed at the end of the summit was to reduce the global maternal mortality rate by 75% by the end of 2015 through improvement in all areas of maternal healthcare services (UNDP, 2018). However, not all countries were able to achieve the set target; some countries had a slight reduction while others had an increase in the rate of maternal mortality. This, therefore, led to the formation of SDGs, which set out a new agenda for the future (WHO, 2018).

2.5.1 Measurement of Maternal Mortality

Maternal mortality is often measured using the maternal mortality ratio, the maternal mortality rate, and the lifetime risk of maternal death. The most widely used is the maternal mortality ratio, which is calculated using the number of maternal deaths and the number of live births within a certain period as follows:

$$\text{Maternal Mortality Rate} = \frac{\text{Maternal deaths}}{\text{Number of live births}} \times 100{,}000$$

The required data for calculating maternal mortality in a country are usually generated from registrations of death, maternity service statistical records and surveillance (Mgawadere et al., 2017; WHO et al., 2015). The calculation of the global maternal mortality shows that there was a decrease in the world maternal mortality rate between 1990 and 2013, but this was not representative of all countries around the world, especially developing nations with high rates of maternal deaths (Lamadrid-Figueroa et al., 2016). The anomaly was attributed to a lack of accurate data on maternal mortality resulting from incomplete statistical information about the registration of births and deaths, which are the key variables for the estimation of the maternal mortality rate (Betran et al., 2005).

2.5.2 Causes of Maternal Mortality

Pregnancy and childbirth are biomedical processes that involve various physiological changes, from conception until delivery. The primary causes of maternal deaths are complications that include haemorrhage, eclampsia, unsafe abortion, infection pre-existing disease, age, mental well-being, and other underlying factors such as the level of education of the mother (Saraki, 2008; WHO, 2016). Medical records only show the medical diagnosis that resulted in death, with little or no information about the underlying factors affecting maternal health. Pregnancy as a biological and physiological process is influenced by many factors within the individual environment, which can affect the pregnancy either positively or negatively, but evidence has shown that there are many underlying factors affecting maternal healthcare (Owusu, 2008).

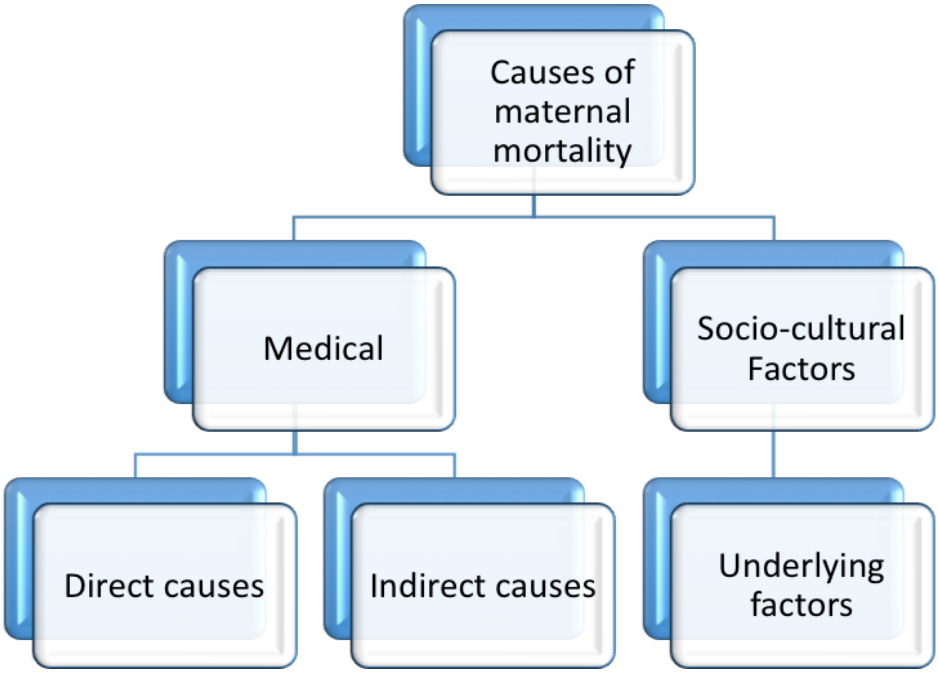


Figure 2.5a: Causes of maternal mortality (Source: Lanre-Abass, 2008; Storm et al., 2014)

2.5.3 Global Rate of Maternal Mortality

Maternal mortality accounts for approximately 6% of total deaths worldwide (Fawole et al., 2010). The top ten countries with the highest rates of maternal mortality are Sierra Leone, the Central African Republic, Chad, Nigeria, South Sudan, Somalia, Liberia, Burundi, Gambia, and Congo (CIA, 2017). This categorisation is based on the rate of maternal death, which varies among all the countries, ranging from 1,360 per 100,000 live births in Sierra Leone to 693 per 100,000 live births in Congo (CIA, 2017). Despite advancements in science and technology around the world, there is still a stark contrast in the rate of maternal mortality between developed and developing nations (Martha, et al., 2015); indeed, a recent report from the WHO (2018) shows that developing nations account for 99% of global maternal deaths.

Although maternal mortality is a major problem affecting low-resource nations, surprisingly it is also a challenge for some well-developed nation. The United States has been categorised as the country with the highest rate of maternal death in developed nations where, on average, 700 per 100,000 women die annually from pregnancy-related complications. The United States was not able to meet the national goal for maternal mortality and was still not on track to meeting the set aim of healthy people by 2020

(Maternal Health Task Force, 2015). Although the rate of maternal mortality is relatively low when compared to other developed nations, it is still high when improvement in maternity care is factored in. This problem has been attributed to the lack of a well-defined approach in managing complications of pregnancy, the presence of various underlying conditions, or the lack of maternal mortality review boards across all the states in the union (Agrawal, 2015; Lu, 2018). The global maternal mortality rate is expected to reduce to 70 per 100,000 or below by 2030 (McArthur et al., 2018).

2.5.4 Maternal Mortality in Nigeria

Nigeria accounts for 10% of global maternal deaths (Mariga & Saleh, 2009); the estimated annual maternal death rate is 814 per 100,000 live births (CIA, 2017). The country is classified as one of the top ten countries with the highest maternal mortality rates (Cooke & Tahir, 2013). For every single maternal death in Nigeria, between 20 to 30 other pregnant women develop a corresponding complication which may lead to death if not managed properly (Omo-Aghoja et al., 2013). The classification of Nigeria as a country with a high maternal mortality rate has been linked to a lack of accurate statistical data to provide reliable information about maternal healthcare indices (Okonofua et al., 2017). The government and other stakeholders within the country have been working on improving maternity care through the introduction of various evidenced-based interventions in all 36 states, but Nigeria still lacks measures to show an accurate record of vital registration. Nigeria thereby relies on international organisations to provide information about the nation's healthcare indices – records which are insufficient to show the trend of maternal mortality (Achem et al., 2014; Feyi-Waboso, 2016).

Research has shown that the availability of a maternal death review system like that of MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK) can help provide valid information about maternal deaths. Major healthcare stakeholders can use this to implement plans for the improvement of maternal health (MBRRACE-UK, 2016). However, recent research shows that the quality of reviews conducted locally is low when compared with the reviews conducted at the national level (Shah et al., 2016). Although, in Nigeria there is, impetus to review maternal deaths at both

the national and local levels, in practice there is no maternal death review board at the national level, while the few reviews conducted are usually facility-based (Achem & Agboghoroma, 2014), hence signifying incomplete information about maternal deaths in this area.

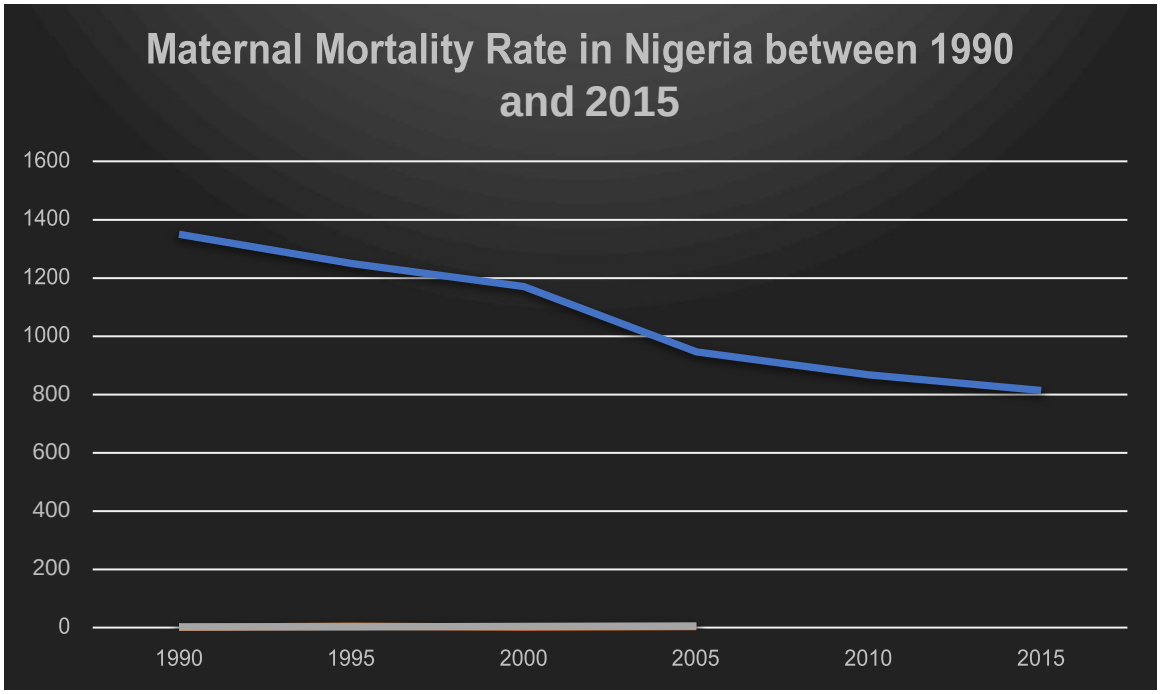


Figure 2.5b: Maternal mortality rate in Nigeria between 1990 and 2015 (Source: WHO et al., 2015)

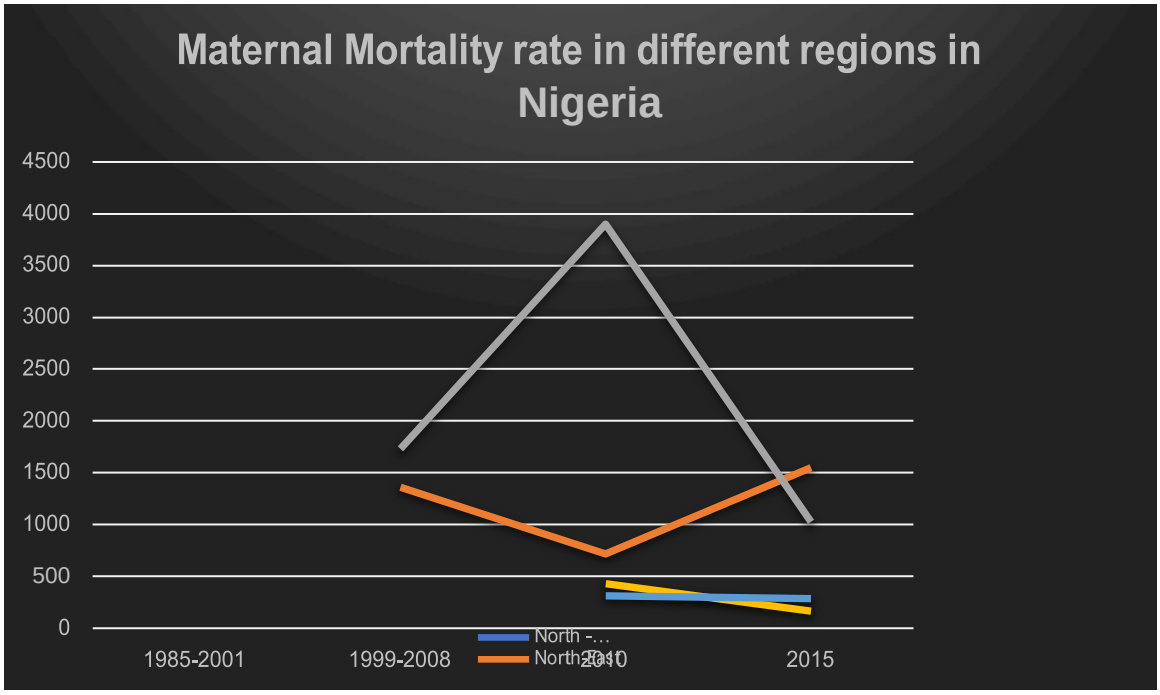


Figure 2.5c: Maternal mortality in different regions in Nigeria (Source: Ujah et al., 2005; Lalonde & IFGO, 2012)

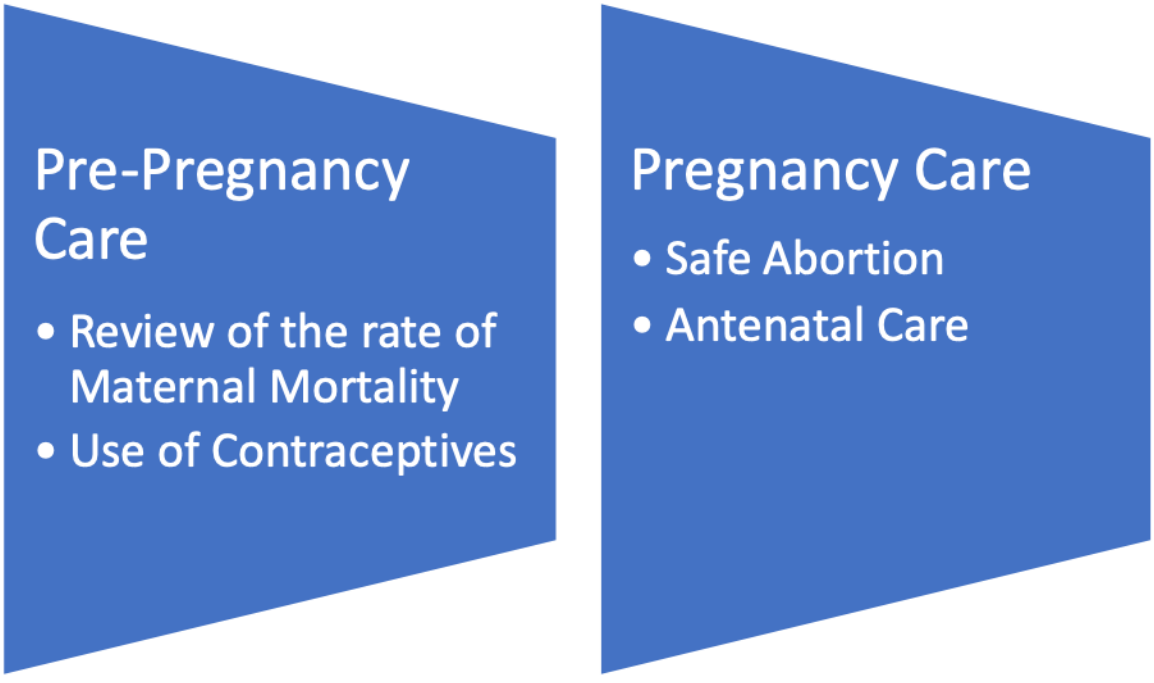


Figure 2.5d: Strategies for the reduction of maternal mortality (Adapted from Bale et al., 2003)

2.5.5 Review of the Rate of Maternal Mortality

A review of maternal deaths provides useful information for the reduction of maternal mortality and the improvement of maternal healthcare services. It further aids in the development of appropriate strategies for tackling the identified problem, thereby enabling the development of policies to suit the needs of the people (De Brouwere et al., 2013). This is evidenced in the MBRRACE-UK report which shows that the development of appropriate intervention for the management of women's mental health is crucial for the reduction of maternal mortality (MBRRACE-UK, 2017). However, despite the recommendation of the Nigerian Federal Ministry of Health for a periodic review into the causes of maternal deaths in all 36 states, it has only been conducted in a few states (Okonofua et al., 2017). Furthermore, the few reviews conducted in Nigeria were centred around data from hospitals, leaving out information at the community level which can show other factors contributing to maternal death (Hofman & Mohammed, 2014; Geller et al., 2018). One of the reviews identified the low rate of contraceptive use as part of the factors contributing to the high maternal mortality rate among women within the reproductive age group (Monjok et al., 2010).

2.6 Maternal Mortality Is Avoidable with ANC

Although inadequate contraception advice and a lack of safe abortion care are contributory factors in maternal mortality, this research will focus on antenatal care (ANC) due to its significance on maternal healthcare. ANC can be defined as the "care provided by skilled healthcare professionals to pregnant women and adolescent girls to ensure the best health conditions for both mother and baby during pregnancy" (WHO, 2016). It affects the pregnancy outcome by providing the opportunity to develop a care plan that will help improve maternal health and prevent death (Simkhada et al., 2008). The definition of ANC has also been amended to include a positive experience during pregnancy where labour and birth is risk free and motherhood is achieved with optimal satisfaction (Downe et al., 2016).

However, not all mothers have a good childbirth experience because some pregnant women are abused by healthcare workers through a non-respectful form of care either during their attendance at antenatal clinics or while in labour (Ishola et al., 2017). Although attendance at ANC will not predict all unforeseen circumstances that will require emergency treatment, it will provide women with necessary information about the various signs and symptoms they may experience in pregnancy – a critical factor in the early initiation of care when women experience complications in pregnancy. This includes providing information about where and when to seek help in an emergency (Lincetto et al., 2010). Other associated benefits of ANC are the prevention of pregnancy complications, the provision of emotional support through health education and counselling, the early identification of high-risk women, and birth preparedness (Kissule et al., 2013). However, the effectiveness of ANC in providing advice and information is based on the rate of utilisation of the service involved (Asundep et al., 2014).

2.6.1 ANC in Nigeria

ANC is an integral part of maternal healthcare services. In Nigeria, it includes a range of activities such as health education, physical examination, abdominal palpation, measurement of weight and height, urine testing for protein, tetanus vaccination, malaria prophylaxis, distribution of iron and folate supplements, and HIV testing and counselling (Aliyu & Dahiru, 2017). Typical ANC in a Nigerian hospital starts with a prayer session

conducted by a (usually senior) member of staff, or someone selected spontaneously from those attending the clinic. This is followed by a health education session and a medley of songs. The session is a meeting point for all the staff within the antenatal department. All members of the department – clinical and non-clinical staff – are involved in these sessions, which are set up to provide support for the women attending the clinic and to initiate positive relationships with attendees. The pastoral activities are followed by clinical consultation in a consulting room. The woman ends her visit to the clinic with a date for the next appointment (Aniebu & Aniebu, 2011).

Women are expected to register for ANC within the first three months of pregnancy. Early booking for ANC services with a skilled birth attendant provides baseline parameters about the health of the woman (Ndidi & Oseremen, 2010). However, most women in Nigeria register for ANC extremely late in pregnancy and they do not complete the required number of visits (Fagbamigbe & Idemudia, 2015). Likewise, millions of women within the reproductive age group in other developing nations also lack access to quality ANC from qualified healthcare professionals during pregnancy (Simkhada et al., 2008).

Research has shown that women who book for ANC early and attend the required number of visits are more likely to deliver in the presence of a skilled birth attendant (Gross et al., 2012). Similarly, it has been found that attendance at antenatal clinic will aid in the early initiation of treatment for any pre-existing condition that may affect the pregnancy (Wylie et al., 2010); for example, counselling about HIV in pregnancy will help prevent mother-to-child transmission, thus improving pregnancy outcomes and preventing mortality and morbidity. In addition, attendance at an antenatal clinic will also aid in the prophylactic treatment of malaria to improve pregnancy outcomes and prevent all associated complications (Aliyu & Dahiru, 2017). However, most women in Nigeria register for ANC extremely late in pregnancy, while a considerable number of women do not register or attend an antenatal clinic at all (Ndidi & Oseremen, 2010). This has been attributed to the cost of maternal healthcare services and inappropriate treatment from the skilled healthcare providers within the hospital setting (Sambo et al., 2013). However, other research highlighted that the inability of women to seek healthcare without the consent of

their husband or partner delayed booking for ANC – particularly where a woman may be reliant on her husband to pay for the service (Fagbamigbe & Idemudia, 2015).

Previous studies also argued that poverty and lack of education are the main factors that hinder women from seeking ANC – well-educated women who can independently afford the cost of ANC services may seek healthcare early (Akeju et al., 2016). It should be noted that there has been an increase in the overall cost associated with the utilisation of ANC (Fagbamigbe & Idemudia, 2015a). Although the government has stated that maternal healthcare services are to be free, in practice they are not; the resources supplied by the government are insufficient for all the patients' attending clinics, who then pay for some of the services received while attending antenatal clinic (Babalola & Fatusi, 2009; Uzochukwu et al., 2015). Presently, the rate of utilisation of ANC is just over 60% and the country is still not able to meet the required 90% attendance that is necessary to have a significant effect on pregnancy outcomes. This rate is low when compared with ANC utilisation in other African countries (Fagbamigbe & Idemudia, 2015).

2.7 Summary

Nigeria is a low-resource economy with opportunities for developing into an advanced nation due to the vast number of natural resources discovered in different states across the country. The healthcare system is not in a perfect state where all the citizens of the country have access to excellent quality services, but with economic stability and improved financial capability, people should be able to procure high-quality healthcare services that will meet their individual needs. Access to good healthcare is more common among the elites and those in urban areas within the country, whereas people in rural communities lack access and the financial capability to seek quality healthcare services close to where they live. Nigeria is, therefore, classified as one of the top countries with high maternal mortality. Numerous strategies have been introduced by the government, yet the country has a high maternal death rate due to complications resulting from the low utilisation of the services of skilled health attendants by women within the reproductive age group.

Chapter 3: Delineating the Concepts of Health, Health Seeking Behaviour and Culture

3.0 Introduction

This chapter outlines the meaning of health, health seeking behaviour and culture as concepts in relation to the research. The chapter also describes the theories related to health seeking and culture with a further section on the theoretical framework applied to this study.

A lack of awareness about the beliefs and practices influencing pregnancy and childbirth forms part of the factors contributing to the low utilisation of ANC (Magadani et al., 2015). In Africa, culture – being part of the main determinant of a woman's perception about pregnancy and childbirth – influences individual choices about where to seek maternal healthcare services (Okafor et al., 2014). It therefore becomes important to explore beliefs, practices and norms alongside the factors influencing the health seeking behaviour of pregnant women, to aid understanding the factors that guides their decision when seeking care.

3.1 Health and Health Seeking Behaviour

Health may be defined differently according to individual perceptions. An accurate definition for the purposes of this study is that health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (WHO, 1948, cited in Sartorius, 2006). Globally, people have different beliefs and practices regarding health. Before colonial masters introduced Western ideologies of health to Africa in the nineteenth century, Africans had broadly ubiquitous beliefs about health (Ataudo, 1985; Mokgobi, 2015). This system of healthcare remains a unique part of African society, especially among people who reside in rural areas where there is reduced access to quality healthcare services (Ataudo, 1985). As such, in a typical traditional African setting, health is not merely seen as the complete functioning of all the human vital organs, but it is viewed also as a unique harmony of the physical, mental, spiritual, and psychological state of individuals, with support from extended family relations and the community (Omonzejele, 2008). Health is thus viewed as a complex integrated structure that also includes reliance on God and in ancestors (Mokgobi, 2015).

This approach clearly differentiates the worldview of Africans from the orientation of Western stakeholders about health (Ataudo, 1985). The perception of Africans about health is deeply rooted in beliefs in the existence of divine or supernatural powers (Asare & Danquah, 2017). Such beliefs are described as biopsychosocial with emphasis on the spiritual causes of disease as passed down from generation to generation (Omonzejele, 2008). Beliefs about healthcare in Africa are, therefore, directly associated with African history and cultural practices (Mokgobi, 2015). Even though colonisation introduced a westernisation of Africans' beliefs about health, research has shown that it is important to consider indigenous health philosophies when promoting the health and well-being of people of African descent (Mokgobi, 2015).

Beliefs relating to health, it should be noted, vary across different tribes in Africa (Omonzejele, 2008). A tribe may be described as a "term that is used for indigenous groups that shared a culture, language or territory" (Van, 2014, p. 6). In Benin, Nigeria, health is seen as "the possession of a purified or clean mind in an active body capable of promoting peaceful living and in complete harmony with oneself, neighbours, and the community in

which we live", whereas ill-health is viewed as "a violation of certain taboos or offending some invisible force, i.e., gods or deities, capable of upsetting peace of the mind and the body. (Amadasun, 1987, cited in Idehen & Oshodun, 2007, p.114). These differing beliefs about health are therefore likely to affect a woman's decision to seek healthcare.

In Nigeria, some women perceive ANC as a curative rather than preventive measure. This perception, therefore, limits their level of utilisation of ANC and the time of initiation of ANC, as identified in research conducted among pregnant women in the Niger Delta area (Ebeigbe & Igberasse, 2010). Other research conducted in Nigeria highlights the association between healthcare behaviour and the time frame of booking ANC (Onoh et al., 2012). Women register for ANC early when they believe it is a preventive measure, while women who do not associate any benefit with ANC never register or book for ANC. The latter will only attend a maternity centre after developing complications that require emergency obstetric care (Onoh et al., 2012; Osubor et al., 2006). Although a study by Aliyu and Dahiru (2017) has shown that early booking or attendance at antenatal clinic does not guarantee a successful childbirth – women still die despite attending antenatal clinics. Research conducted in south-western Nigeria shows that ANC is effective provided women book early, complete the required number of recommended visits, and there is availability of resources for emergency obstetric care (Fagbamigbe & Idemudia, 2015).

WHO (1948) described health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Health is a fundamental human right, irrespective of the geographical location of the individual, the state of the economy, or religious belief and practices. However, in Akwa Ibom State in Nigeria, health is not viewed only in relation to wellness and sickness but also in association with God (Agbiji & Landman, 2014). The ancient Greek poet Pindar described health as the "harmonious functioning of the organs" showing the significance of the relationship between health, body, and the general function of the individual as a complete system, which accords with the Aristotelian view of humans as social beings striving to maintain a balance with the environment, through continuous interaction (Svalastog et al., 2017, p. 431).

Modernisation and advancements in technology have modified the meaning of health as not only the absence of diseases but as the ability to function completely in the

environment (Svalastog et al., 2017). Therefore, the identification of factors that affect health equilibrium should not only focus on identifying the pattern of disease, but it should also focus on factors that contribute to the complete functioning of the individual (Svalastog et al., 2017). Improved technology changes people's perception about health; since the advent of the internet, knowledge is more accessible and individuals, therefore, have access to a large amount of health information. Yet with the availability of vast amounts of health information, individuals still lack the skills to navigate through the new landscape (Svalastog et al., 2017). Since the environment is part of the main determinants of health, government policies should not only focus on the scientific factors affecting healthcare policies, but they should also address issues related to individuals' health seeking behaviour (Zahra et al., 2015).

3.2 Health Seeking Behaviour in Relation to ANC

Health seeking behaviour is described as “any activity undertaken by a person believing herself to be healthy for preventing disease or detecting it at an asymptomatic stage” (Kasl & Cobb, 1966, p. 246). As such, the nature of women’s health seeking behaviour during pregnancy is not uniform but based on various contextual factors within the individual environment (Oberoi et al., 2016). Thus, human health seeking behaviour can be described as an action mediated by motivation and perception about health (Short & Mollborn, 2015). When health seeking behaviour is described as an action, it simply refers to the journey of the woman in seeking antenatal healthcare during pregnancy. However, this action is based on the healthcare system and other sociocultural factors within the complex external environment. The multiple factors within the individual external environment are interrelated. They, therefore, interact to influence the health seeking behaviour of the pregnant woman as an individual within the community (Davies & Fazey, 2014).

Norms and values are some of the factors that determine how healthcare services are utilised by people within a community. Key determinants of health seeking behaviour, particularly among women within the reproductive age group in Africa, are education, finance, and geographical location (Aborigo et al., 2014; Atuyambe et al., 2009; Chandrasekhar et al., 2011; Kifle et al., 2017; Sialubanje et al., 2014). However, in some parts of Africa, illness during pregnancy is partly attributed to witchcraft or an attack from spiritual forces (De-Graft Aikins, 2005). This is evidenced from a study conducted among childbearing women in Ghana; its findings showed that spirituality played a crucial role in pregnancy-related decisions among the participants (Farnes et al., 2011).

In Nigeria, the primary determinants of health seeking behaviour are patriarchal structure, the quality of healthcare services (predicated on the state of the economy), and the availability of healthcare services (Adam & Aigbokhaode, 2018; Akeju et al., 2016a; Edu et al., 2017; Osubor et al., 2006). The analysis of the factors affecting healthcare choices justify the WHO definition of health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 1948). This is because the factors affecting healthcare within Nigeria as a region in Africa show that health is identified

as the possession of a purified or clean mind in an active body capable of promoting peaceful living and in complete harmony with oneself, neighbours, and the community (Amadasun, 1987 cited in Idehen & Oshodin, 2007).

Sickness, however, has been described as the outcome of violation of certain taboos or causing offence to invisible forces; in Nigeria, illness during pregnancy is perceived as a result of violating certain taboos, (Amadasun, 1987; citied in Idehen & Oshodin, 2007, p.114). This may, therefore, contribute to the low rates of ANC attendance during pregnancy because of shame, embarrassment, or fear (Fagbamigbe & Idemudia, 2015). This is evidenced in a qualitative study conducted among women in south-east Nigeria; the findings showed that complications during pregnancy were categorised as a form of spiritual attack from witches, or as an effect of a form of black magic called juju (Egbuniwe et al., 2016). Women's perceptions about the causes of health problems in pregnancy, therefore, affect their choices about where to seek healthcare services (Egbuniwe et al., 2016).

Consequently, the cultural beliefs of pregnant women also affect how they perceive healthcare with some viewing ANC as a curative measure rather than a preventive one and contributing, therefore, to the delay or non-utilisation of ANC (Ndidi & Oseremen, 2010). Other research conducted in Nigeria showed that women register for ANC early when they believe it is a preventive measure, while women who do not associate any benefit with ANC never register nor book an appointment until when they have problem (Mboho et al., 2013). A further study found that Nigerian women only attend maternity centres or seek help when any form of complication that requires emergency obstetric care arises (Onoh et al., 2012; Osubor et al., 2006). More recent research within the region has shown that early booking or attendance at an antenatal clinic does not guarantee safe childbirth, since women still die despite attending antenatal clinic during pregnancy (Aliyu & Dahiru, 2017), and ineffectual health seeking behaviour during pregnancy is linked to poor maternal health index (Latunji & Akinyemi, 2018). Therefore, it is crucial to identify the factors affecting the health seeking behaviour of women in Ota, the study area of this research, in order to address part of the challenges affecting maternity care within the area. As contextual factors shape the perception that people have regarding healthcare, understanding these factors is of greater importance when one considers that indigenous forms of healthcare

remain the preference and first point of contact of some people, especially women, in rural areas (Finlayson & Downe, 2013).

3.3 Classification of Health Seeking Behaviour

The classification of health seeking behaviour into several types is based on the reason for engaging in the action. This includes health directed behaviour, preventive health behaviour, illness health behaviour, and sick role behaviour.

3.3.1 Health Directed Behaviour

The pursuit of health directed behaviour is believed to be guided by conscious intention: people engage in behaviour with the intention that it improves their health. A simple inference would thus be that woman engage in behaviour with a result in mind (Aarts, 2007). However, the individual pursuit of a health goal also takes place unconsciously and, as such, people's behaviour is the outcome of the effect of environmental factors on their mental representation of a health goal (Fathnezhad-Kazemi & Hajian, 2019; Short & Mollborn, 2015)

3.3.2 Preventive Health Behaviour

Preventive health behaviour comprises actions undertaken by people with the aim of preventing disease or illness. Such action is believed to complement health promotion behaviour; it is an action which is believed to influence the rate of utilisation of healthcare services (Nam et al., 2019; Yom Din et al., 2014). Research has shown that a clear illustration of the meaning of preventive health behaviour along with the appropriate demographic and socio-economic factors is crucial for the identification of factors influencing the utilisation of healthcare service (Soskoine, 2015).

3.3.3 Sick Role Behaviour

Sick role behaviour was suggested by Talcott Parsons to include exempting unwell individuals from social duties (Varul, 2010). The individual is still expected to improve his/her state of health by seeking healthcare services and complying with the modalities of treatment (Sirri et al., 2013). The sick role is assigned to people by the healthcare professionals within the medical system. It starts with assessment and the initiation of treatment to promote or restore an individual's health back to its normal state of

functioning. Therefore, the decisions people make about their health are based on their cultural dynamics, since their experience lies within the same culture (Yew & Noor, 2014).

3.4 Maternal Health Seeking Behaviour

The health seeking behaviour of a woman during pregnancy depends on various socio-economic factors as well as her beliefs, level of autonomy and the decision-making power regarding her healthcare within the household (Ehiemere et al., 2017). The maternal health seeking behaviour of a woman during pregnancy is, therefore, described as including the rate of attendance at antenatal clinic (namely, the ability of a woman to complete the required number of visits as recommended by WHO) and the choice of the woman regarding the place of delivery (Osubor et al., 2006). However, another author classifies maternal health seeking behaviour as the method through which women take care of their health and that of their foetus *in utero* in order to prevent the onset of any form of complication in pregnancy, to ensure a safe childbirth, and to ensure an outcome where mother and child are alive and healthy (Adamu, 2011, cited in Ehimere et al., 2017; Kifle et al., 2017). This understanding of maternal health seeking behaviour is applicable in this study because the needs of a woman during pregnancy influence the decision of where to receive care during pregnancy; some women opt to receive care from indigenous traditional service providers due to their belief about the form of care.

Maternal health seeking behaviour can be influenced by religion, geographical location, cost of healthcare or the state of the healthcare system (Egbuniwe et al., 2016; Fagbamigbe & Idemudia, 2015). Factors influencing human behaviour are identified as being interrelated; one factor cannot be independent of another in the impact on a woman's health seeking behaviour (Akeju et al., 2016a; Shahabuddin et al., 2015). Therefore, the actions of attending antenatal clinics and seeking care from qualified healthcare personnel fall within the above description of maternal health seeking behaviour, and previous research has shown that the health of women in communities with poor utilisation of ANC can be improved by studying their maternal health seeking behaviour (Kifle et al., 2017).

3.5 Factors Affecting Maternal Health Seeking Behaviour

In identifying the key determinants of maternal health seeking behaviour, it is important to note that there are factors that cut across all the behaviours, although there are some that are specific to a behaviour, but majority of the factors influence each other (Kifle, 2004). As evidenced from a qualitative research study that focused on exploring the health behaviour of pregnant women with history of gestational diabetics, multiple interrelated factors such as level of understanding about the aetiology of the disease, beliefs, and societal norms influence a woman's health seeking behaviour during pregnancy (Parsons et al., 2019). Likewise, a study conducted in Bangladesh shows that the maternal health seeking behaviour of married adolescent girls is based on the interaction between various interrelated factors such as family members, traditional practices, belief in spirits, and sociocultural norms (Shahabuddin et al., 2017).

Another study, also conducted among Bangladeshi women, showed that women who made decisions regarding where to seek care in consultation with their husbands or partners were more likely to attend ANC and complete the required number of visits than women who make the decision alone without the support of a partner (Ghose et al., 2017). This is also evident in the findings of qualitative research conducted in South India, which showed that women made decisions about where to seek care after discussion with their husbands as the head of the family (Vincent et al., 2016). These women follow the decision of their husbands when it comes to making decisions about where to seek healthcare during pregnancy, as the institution of marriage confers greater influence on the husband (Sultana et al., 2017). That said, the decision of the husband is based on his level of education and the ability to provide financial support to cover all or parts of the cost of healthcare services (Joshi et al., 2014).

The patriarchal nature of society has also been considered as part of the factors affecting the utilisation of maternal healthcare services (Makama, 2013). This is the case in a study in south-west Nigeria which concluded that all the various interrelated factors within a woman's external environment impact on her decision regarding making choices about where to seek care during pregnancy (Akeju et al., 2016a). The study emphasised the need to consider the patriarchal nature of society when developing strategies to improve the rate

of utilisation of antenatal healthcare services during pregnancy. The study also showed that the contribution of the husband is important for a woman seeking care. Women who initiate care without obtaining permission from their husband are described as being as disrespectful (Akeju et al., 2016a).

The influence of the husband on the choice a woman makes about where to receive ANC has been linked to the categorisation of the male partner as the decision maker of the family (Mboane & Bhatta, 2015). Issues related to the impact of the decision-making power of the husband were also reported in a Nigerian study in which Osamor and Grady (2018) concluded that very few women make decisions regarding their health without the permission of their husband, with more than a third of the women who participated in the study reporting that decisions regarding where to seek care are made by their husbands. The decision-making power of the husband is, therefore, linked to gender inequality. The role of the husband limits the ability of the woman to make decisions regarding her health and the ability to access ANC (Tolhurst et al., 2009).

Research has also shown that age, race, and ethnicity compound the effect of gender inequality, particularly among rural woman (Mboane & Bhatta, 2015). The various identified factors influencing decision-making are thus classified as the factors contributing to low utilisation of maternal healthcare services (Shaikh & Hatcher, 2005). Therefore, women as individuals may not be able to make decisions regarding their own ANC without some level of education or independent finances. The numerous factors influencing women's decisions regarding the choice of where to seek ANC occur within various institutional structures such as family, community, or healthcare system (Shaikh & Hatcher, 2005).

3.5.1 The Family as the Determinant of Maternal Health Seeking Behaviour

The significant members of the family, that are highly respected by women, are mothers-in-law (Jansen, 2006). They are described as significant others due to their ability to influence women's decision regarding pregnancy and childbirth (Ganle et al., 2015; Magadani et al., 2015; Simkhada et al., 2010). A research study conducted among 50 participants in two different communities in Nepal showed that mothers-in-law have a

significant influence on decisions by daughters-in-law regarding healthcare seeking during pregnancy, due to their position as an important member of the family (Simkhada et al., 2010). It was also identified that their influence was both positive and negative; a group of participants reported that their mothers-in-law encouraged them to attend antenatal clinic and ensured that they complete the required number of visits (Simkhada et al., 2010). However, most of the respondents said their mothers-in-law negatively impacted their healthcare behaviour during pregnancy. This was attributed to the mothers-in-law's level of education – the majority had not received formal education. Mothers-in-law such as these viewed attending ANC as a waste of time and unbeneficial to their daughters-in-law as pregnancy was a natural process that did not require any form of intervention. Of the more educated mothers-in-law, those with a background or training in a healthcare-related profession supported their daughters-in-law in seeking care from qualified healthcare personnel (Simkhada et al., 2010).

The influence of the Nepalese mothers-in-law on women's ANC decisions was linked to indigenous traditional practices which stipulate that a woman must live with her husband's family after marriage and, as a consequence, be subject to the mother-in-law due to her position. In addition to living in the same household, the mother-in-law is traditionally given an elevated role and responsibility regarding pregnancy and childbirth due to her age and experience, (Simkhada et al., 2010). It is noted that the economic status of a woman can influence some of the decisions of her mother-in-law because a daughter-in-law with financial capability may justify seeking care from a qualified healthcare personal (Osamor & Grady, 2018). The influence of mothers-in-law on women's healthcare seeking behaviour during pregnancy can, therefore, be regarded as a social or class-based barrier common among families with low socio-economic status (Osamor & Grady, 2018).

3.5.2 The Community as the Determinant of Maternal Health Seeking Behaviour

The decision to utilise ANC during pregnancy does not solely depend on the individual; it is therefore important to consider the community factors that can interfere with women's choices regarding attendance at antenatal clinic and delivery in the presence

of a skilled birth attendant (Williamson, 2000). Previous research has highlighted the significance of an enabling external environment, such as level of education, on the choices women make regarding attendance at antenatal clinic. The findings of the research showed a positive relationship between maternal level of education and the utilisation of the service of a skilled birth attendant. In areas where members of the community were educated either up to secondary or university level, a high proportion of women attended antenatal clinic and delivered in the presence of a skilled birth attendant. Women living in areas where the members of the community were uneducated were likely to deliver at home in the absence of qualified healthcare personnel (Ononokpono & Odimegwu, 2014). These findings are based on another study where autonomy is linked to an increase in the decision-making power of the woman, and a corresponding increase in access to antenatal healthcare services (Williamson, 2000). However, some authors argue that autonomy without the financial capability to procure maternal health service can still impede access to antenatal healthcare services, as access involves making choices, controlling resources, and making decisions regarding where to seek ANC during pregnancy (Nigatu et al., 2014).

According to Okafor and Rizzuto (1994), the perception of the members of a community about pregnancy play a crucial role in women's decisions on where to seek ANC. When spiritual forces are believed to be the cause of a health problem in pregnancy, community members view the condition as an issue that does not need the intervention of trained medical personnel such as doctors or nurses. These women are, instead, advised to seek care from TBAs, spiritualists, herbalists, or healers. Similarly, Kruk et al. (2010) found that women's perceptions about the quality of healthcare systems may also be influenced by community-level social interaction. Their study, in rural Tanzania, showed that women's perceptions about the healthcare system were significantly associated with the likelihood of utilising the service of skilled healthcare personnel at PHCs or other available healthcare facilities, when measured at the community level but not at the individual level. This implies that women's health seeking behaviour during pregnancy may be influenced by community factors such as common local beliefs and norms (Kruk et al., 2010). This finding is also consistent with the information from the literature which states that the best approach to understanding the cause of a disease or illness in pregnancy is by collecting information

about the community and, more specifically, views in the community about the disease. Therefore, to understand the health seeking behaviour of women during pregnancy, it is crucial to view the woman as an individual within a larger system of community, and women's choices must be viewed within a given sociocultural context (Latunji & Akinyemi, 2018).

It has also been suggested that the best approach in understanding how women make decisions regarding their healthcare is not just by understanding the sources of the information that guides the behaviour, but also to understand the cognitive process involved in women's decisions on where to seek care during pregnancy (Jolly et al., 2019). Since health seeking is not homogenous in nature, according to Patil et al. (2016), it is important to consider the community factors affecting health seeking behaviour because healthcare services that do not meet the needs of the members of a community may neither improve health nor contribute to the improvement in the utilisation of antenatal healthcare services.

3.5.3 The Healthcare System as the Determinant of Maternal Health Seeking Behaviour

The healthcare system has been categorised as the primary determinant of the health seeking behaviour of pregnant women (Musoke et al., 2014; Shaikh & Hatcher, 2005). However, not all women utilise the service of skilled healthcare personnel during pregnancy. This has been partly attributed to various issues related to the health seeking behaviour of women during pregnancy. A positive healthcare seeking behaviour such as regular attendance at an antenatal clinic with a skilled birth attendant and completing the required number of visits is, therefore, believed to improve maternal health, prevent pregnancy complications, and reduce maternal mortality and morbidity (UN, 2017). Such an outcome may further increase the lifespan of a woman and prevent premature death through the implementation of multiple lifestyle changes (Belloc & Breslow, 1972, cited in Dreyer et al., 1997). A negative health seeking behaviour, such as non-utilisation of the service of a skilled birth attendant, often leads to poor or negative pregnancy outcome (Oberoi et al., 2016). It is therefore important to have a comprehensive understanding of

the behaviour, since a woman's health seeking behaviour determines her choice of healthcare services. Behaviour, it should be stressed, does not exist as a vacuum without impact from other factors such as culture (Mackain et al., 2004).

In many healthcare systems, particularly in countries such as Pakistan, Uganda and Nigeria, issues such as poverty, lack of functioning healthcare facilities, inadequate funding of healthcare centres and poor infrastructure have an enormous impact on the health indicators of the nations (Latunji & Akinyemi, 2018; Shaikh & Hatcher, 2005). In Nigeria, for example, women living in communities where the ratio of the population to a functioning maternity health centre is high are less likely to attend antenatal clinic, patronise qualified healthcare personnel or deliver in the presence of a skilled birth attendant (Latunji & Akinyemi, 2018). This was evidenced in a study that employed a multilevel approach in determining the factors affecting the utilisation of maternal healthcare services in Nigeria (Ononokpono & Odimegwu, 2014). However, other associated factors such as cost of healthcare services, inadequate knowledge about the danger signs in pregnancy and indigenous cultural practices and beliefs also affect the utilisation of maternal healthcare services. Thus, all the identified factors affect a woman's health seeking behaviour, especially among the poor, uneducated women in rural areas (Fagbamigbe & Idemudia, 2015). Even when there is a functioning maternity centre within the community, access can still be limited due to the influence of all the previously identified factors on women's behaviour (Musoke et al., 2014).

The inequality in the distribution of health facilities, with more facilities in urban areas than rural areas, has also been classified as a factor affecting the rate of utilisation of maternity service within the local community, namely, seeking care from a TBA, spiritualist, or herbalist. It has been argued that women seek care from alternative providers within the community because it is less costly than services in the hospital (Akeju et al., 2016). Such behaviour contributes to delay in seeking care from qualified healthcare personnel such as nurses or midwives, thus increasing the likelihood of high rates of maternal mortality and morbidity within the region (Ayotunde et al., 2015; Edu et al., 2017). This has been demonstrated in Nigeria where, despite the increase in the number of PHCs and maternity centres throughout all 36 states, women in some communities still lack access to quality

maternity services during pregnancy due to population size and geographical location. Therefore, a lack of adequate functioning healthcare centres that meet the need of community members may affect the healthcare seeking behaviour of women.

In conclusion, the key determinants of health and well-being are crucial factors for the development of the state of health of the citizens of any nation. They indirectly influence behaviour and, consequently, the choice of where women seek care during pregnancy (Fagbamigbe & Idemudia, 2015). Since inequities in health have been attributed to social, economic, and cultural influences (Ogu at al., 2016), it is not surprising that the UN's third SDG focuses on health and well-being, with a need to implement a multisectoral approach in improving access to healthcare services in regions with high maternal mortality and morbidity (UN, 2019) to ensure that the mother and child survive and are healthy (Ansong, 2015).

3.6 Culture

Individual belief does not just happen, but it is acquired as a member of an institution (Idang, 2015). Edward Tylor defines the term culture from an anthropological point of view as “that complex whole which includes knowledge, belief, art, morals, law, custom and any other capabilities and habits acquired by man as a member of society” (Manganaro, 2002, p. 9). Therefore, individuals are never taught but they tend to acquire their way of life due to socialisation (Idang, 2015). Socialisation occurs in two distinct stages: primary and secondary socialisation. Primary socialisation refers to factors such as language and gender identity, acquired as a member of the institution, while secondary socialisation comprises all the other elements acquired by an individual as they grow into their environment (Tones, 1979).

However, culture as a complex whole is not static but changes as the environment changes. In relation to the African context, culture is described as:

> the totality of the way of life evolved by a people in their attempt to meet the challenges in their environment, which gives order and meaning to their social, political, economic, aesthetic, and religious norms and modes of organisation thus distinguishing a people from their neighbour (Bello, 1991, cited in Idang, 2015 p. 98)

The culture of the people of Nigeria is based on the unique way of life of the various ethnic groups in the country (FRN, 2020). Cultural difference, says Aziza (2001, cited in Idang, 2015) is:

> the totality of the pattern of behaviour of a particular group of people. It includes everything that makes them distinct from any other group of people for instance, their greeting habits, dressing, social norms and taboos, food, songs and dance patterns, rites of passages from birth, through marriage to death, traditional occupations religions as well as philosophical beliefs (p. 31).

Thus, culture is not taught; a child observes and mimics the actions of older family members, as asserted by Fafunwa (1974), with the child growing into and within the cultural heritage of their people. A child in African cultures may watch naming ceremonies, religious services, marriage rituals and funeral obsequies. They may witness the coronation of a king or chief, an annual yam festival, annual dances and acrobatic displays of guilds and they may witness the participation of different age groups or relations in the activities. The child as a

member of the community cannot be separated from their environment or culture (Amos, 2013).

Culture can also be categorised as material and non-material: the non-material aspects are the traditions, norms, and values (Idang, 2015). The behaviour shown by pregnant woman as a member of the family institution is an example of a non-material aspect of culture. Although culture may be abstract in nature, it has a significant impact on people's lives because it guides human action and behaviour. Therefore, its impact on other aspects of human survival, such as pregnancy and childbirth, cannot be neglected in a society (Idang, 2015). A range of studies has identified delay in seeking care as a factor that affects pregnancy outcome. This delay is due to some societal norms which do not allow women to initiate care until the end of the first trimester or early second trimester (Fagbamigbe & Idemudia, 2015; Mourtada et al., 2019; Nguenda & Yene, 2016; Simkhada et al., 2008).

Culture as a construct is never stagnant but always changing, due to the nature of the society. Theorists such as Holloway, Alland and Montagu believed that humans, as members of a society, are always interacting with other things that exist within the society. Humans as objects interact with other objects within the society and are, in this regard, categorised as machines that are connected to other machines. A useful example of this is the reliance on technology for so many things. With advancements in technology, we can argue further that culture may not be the heritage of people. Culture changes as the world changes, due to human rethinking of culture as the result of globalisation. As such, culture develops as a consequence of the impact of environmental factors (Keesing, 1974).

Michel Foucault (1993, cited in Powell, 2015) however believes that "it may be that the problem about the self does not have to do with discovering what it is, but maybe it has to do with discovering that the self is nothing more than a correlate of technology built into our history" (p. 222). He explains the world differently and asserts the need to study the links between power, knowledge, and individual understanding of phenomena. He describes how the various constructs of power, knowledge and the individual are related to each other and how they vary based on contextual factors, without placing one over the other (Akeju et al., 2016). This means that the world is not based on objects alone, but that it is

also, an institution whose sustainability depends on discourse (Keesing, 1974); for example, a pregnant woman in a rural area is directly connected to the local maternal healthcare service providers available in her area just as any other pregnant woman in any other community is, to show similarity.

Sociologists believe that society is made of various elements which combine to determine the social structure of the society. According to Parsons (1951) values, beliefs, and norms are vital for the functioning of any society. Parsons further believed that individual behaviour is based on one's cultural heritage. Therefore, culture is regarded as being central to all aspects of human life in which society's economic and political systems are also significant for culture. Parson's functionalist view linked the individual, the society and culture with each element having an impact on the other (Segre, 2012). However, proponents of Karl Max argued that the structure of society is influenced by class and based on the ideas of its dominant class; those who control society can also shape the ideas of the members of that society (Jakopovich, 2014: Lazic, 2019). Marxists believe class, with its inherent social inequalities, is a conflict whereas feminists believe that gender is a social conflict (Lazic, 2019; Milner, 1999). Feminist theory views the patriarchal nature of society as a conflict because of economic and social power bestowed on men (Jakopovich, 2014; Lazic, 2019; Milner, 1999).

Therefore, culture is inseparable from society as described by Foucault and Mary Douglas, who both believed that interpretation of any phenomenon is based on the individual's level of knowledge and the characteristics of the phenomenon under study. The suggestion here is that a person's understanding about any phenomenon is based on how society has made that person think about the phenomenon. However, one's thought process and understanding of any phenomenon cannot be separated out. Furthermore, no two individuals within the same society will have the same interpretation about a phenomenon, as ideas can change based on culture and structure. People's ideas and perceptions are, therefore, believed to be based on culture, which is the primary determinant of behaviour (Keesing, 1974).

However, culture and societal structure were not viewed as being reciprocal, rather they were described as the driving force that shapes actions. Thus, signifying stories and

symbols as the main tool used for the interpretation of culture (Longhurst et al., 2016). Since culture is described as the symbol of what have been acquired from human to human, it is subject to change (Keesing, 1974). Therefore, the concept of culture will be narrowed down into specific traits to depict its actual meaning as acquired. These classifications will aid the disintegration of culture into different areas as an adaptive system, structural system, symbolic system, or cognitive system. This categorisation is based on the forces that shaped the theory (Keesing, 1974).

When culture is viewed as an adaptive system, humans as social beings within the ecosystem are seen as leading a certain way of life (Keesing, 1974). Our ancestors chose to work as farmers, to make their food from scratch and to marry many times because all these acts were required to meet their needs for survival at the time (Keesing, 1974).

Due to the adaptive nature of humans, it has been argued that culture is not transmitted genetically from parents to offspring, but it is acquired and shows the adaptations of humans to their ecological environment (Danchin et al., 2013). It can be seen that while genetical inheritance is transmitted from parents to offspring, culture is commonly transferred among members of the same or different generations (Danchin et al., 2013; Mouden et al., 2013). There are anthropologists who argue that relationships between culture and genes coexist; they refer to gene-culture co-evolution to explain that offspring, as members of the ecological setting, acquire both genes and culture as a way of life from their ancestors (Laland et al., 2010). According to this view, culturally acquired behaviours are transferred from one generation to the other, while genetic make-up (expressed in physical human characteristics) is acquired from ecological setting where, for example, the non-visible hair morphology of people in one part of the world is derived from the alleles which group them together as belonging to the same society. Anthropologists base their classifications on visible characteristics, such as hair colour, thus showing a correlation between genome and human science (Laland et al., 2010).

In contrast to the description of culture as an adaptive system, culture is also seen as a body of knowledge. This consists of a guide used in evaluating what is assumed to be right and how to decide on what is meant to be the standard, which is, according to Ward Goodenough (1971, cited in Patton, 1990):

> whatever it is one has to know or believe in order to operate in a manner acceptable to its members. Culture is not a material phenomenon: it does not consist of things, people, behaviour, or emotions. It is rather an organisation of these things, the form of things that people have in mind, their models for perceiving, relating and otherwise interpreting them (p. 77).

Culture as a cognitive system signifies that the system depends on the existing complex external environment (Keesing, 1974). Likewise, culture as a system of ideas is also a structural system that depicts various expressions of the mind; this includes language, art, and family, with the mind being the main element that guides the individual. Thus, the mind systematically defines the pattern of behaviour environment (Keesing, 1974). Since values and beliefs are the primary domain of culture, the individual culture is the result of the values and beliefs of this society – society being a social system that aids transmission of behaviours or knowledge.

Therefore, culture and society are inseparable as explained by Ezedike (2009 cited in Idang, 2015) who writes that within the African context, culture is described in such a way that it embraces the way of life of Africans. This can be applied to the Nigerian setting since different countries within Africa share some common values and traits. Although there are variations in terms of style of dress, language, and greetings, within the African setting culture can be described as “the sum of shared attitudinal inclinations and capabilities, art, moral codes, and practice that characterise Africans” (Ezedike, 2009, cited in Idang, 2015, p. 455). The Nigerian family as a unit can be used to explain the meaning of culture: parents as the guardians of children can make some decisions for them and, likewise, the husband is seen as the head of the family with the right to make certain decisions on behalf of the members of his family, with or without prior consultation. This has been described by various feminists as patriarchy. Since culture is an heterogenous concept (Longhurst et al., 2016), the notion of a wife depending on her husband for sustenance varies from culture to culture (Idang, 2015; Throsby, 2001); it is therefore important to understand the cultural view of each group of people in order to ascertain the reasons for the choices some people make regarding where to seek care during pregnancy.

Culture can also be broadly defined as material or non-material. The material aspect of culture can be thought of as functional; it has a significant role in the development of the

economy of any nation (Idang, 2015). As such, the integration of cultural tradition as an object into the economic framework of any society is important for human survival (Throsby, 2001). Culture is also a product of the traditions common among people within the same environment. Tradition as an embodiment of non-material culture consists of the practices that are passed down from one generation to the other.

Many negative indigenous practices have been associated with tradition (Jimoh, 2018). This is due to the implication of traditional practice on the health and well-being of individuals (Ojua et al., 2013). This is evidenced in studies which show that despite the availability of a local PHC, some women still receive care during pregnancy from alternative service providers who lack formal or accredited training (Mugo et al., 2015). The potential risks that may arise from the non-utilisation of skilled healthcare personnel during pregnancy range from the development of pregnancy-related complications such as sepsis, miscarriage and still birth to maternal death (Mugo et al., 2015; Ugboaja et al., 2018). Despite the risks associated with the utilisation of alternative maternity service providers, pregnant women still use traditional care because it is affordable, accessible and in line with their cultural beliefs (Chi & Urdal, 2018; Ugboaja et al., 2018). Thus, the role of the alternative service provider cannot be underestimated because they are the primary providers of maternity services. The literature shows that they are also the first point of contact for women in rural communities (Ebuehi & Akintujoye, 2012).

There has been a high rate of negative health complications because of some indigenous practices common among people in sub-Saharan Africa (Sumankuuro et al., 2018), thereby affecting the rate of maternal and child death within a specific region (Jimoh, 2018). Examples of some common traditional practices with negative health implications in Africa include, but are not limited to, female genital mutilation, forced marriage, early marriage, and preference for sons (Glover et al., 2018). The risk associated with traditional practices does not only affect the health and well-being of the individual but also affects the individual in totality, due to resultant limitations on an individual's interaction with, and contribution to, their community (Ojua et al., 2013).

Despite the risks associated with utilising traditional practices, there are also numerous health benefits associated with this form of care. Research in Tanzania described

reliance on traditional forms of care as an essential component of the health and well-being of the people in rural areas – signifying that members of rural communities rely more on traditional than hospital-based care, which is partly linked to the low or non-availability of qualified healthcare personnel in the community (Msuya & Kideghesho, 2009). Others, too, have argued that women patronise alternative forms of maternity service due to the non-availability of a functioning healthcare facility (Sumankuuro et al., 2018). Factors such as the geographical location of a facility, its distance from users' homes, costs, personal beliefs and preferences of the people and the beliefs of the members of the community about indigenous traditional practices also affect women's choices in the utilisation of maternity service (Akter et al., 2018).

Due to myriad interpretations of the meaning of culture, this research will only focus on culture in relation to the way of life as it pertains to the overall aim of the study (Idang, 2015; Manganaro, 2002). This is important in this research because pregnant women, as individuals within an environment, also possess the ability to transmit culture.

Every culture has some form of practice that symbolises their values and beliefs. These are usually transferred from one generation to the next (Smith et al., 2008) and are believed to have a profound effect on women by shaping beliefs about healthcare and, in turn, determining health seeking behaviour during pregnancy (Ebuehi & Akintujoye, 2012). Every culture, therefore, serves as a blueprint that determines the values and beliefs of people. This also includes those related to making choices about pregnancy and childbirth (Magadani et al., 2015). Thus, pregnancy is governed by various norms and values within the society, with these factors influencing the health seeking behaviour of women during pregnancy (Gabrysch & Campbell; 2009, Glei et al., 2003). This, according to the founder of the culture care theory, Madeleine Leininger (2002), is also classified as culture because it guides individual ways of thinking or doing things; therefore, a pregnant woman as an individual within a community cannot be complete without her culture.

Leininger (2002) asserts that the care provided to a patient is not complete without consideration of the culture of the individual; for example, a pregnant woman, being a member of a family as an institution, is expected to comply with the beliefs and practices associated with the family. This affects where and when to seek ANC because it involves

some basic practices (Okafor et al., 2014). These practices are passed from one generation to the next (from mother-in-law to daughter-in-law) and they also change over time (Wither et al., 2018). Although some women are not in support of the various cultural practices associated with pregnancy, they nevertheless engage in them due to pressure from family members, particularly mothers-in-law (Lundberg & Thu, 2011). The lower socio-economic status of women also affects their ability to make decisions about their health, which has been described as a form of sex-based discrimination with effects that increase the likelihood of death in some parts of the world (Adhikari, 2016; Ahmad, 2000). While the prohibitive cost of healthcare services is a major factor affecting the procurement of quality ANC during pregnancy, the low social status of women and the patriarchal nature of society are also believed to limit the ability of women to make choices regarding where to seek care during pregnancy (Arpey et al., 2017).

It is a widespread practice for women to receive maternal healthcare service from a place or individual with a similar values or beliefs to their own. A comparative descriptive study conducted in Cross River State in Nigeria shows that women chose to deliver in the presence of a TBA because of the various rituals that are carried out before conducting deliveries (Akpabio et al., 2014). The first point of contact for women seeking maternal healthcare services is with alternative healthcare providers such as herbalists, spiritualists, or TBAs (Sambo et al., 2013). This is mostly common among women in rural communities, who are typically farmers or homemakers, but some well-educated women in urban areas also utilise the services of an herbalist or spiritualist, in combination with the service of skilled healthcare personnel (Ugboaja et al., 2018). Therefore, it is crucial to identify the underlying factors influencing the choices of women regarding where they seek care during pregnancy since pregnant women are part of the building blocks that make up maternal healthcare as a system. The description of the pregnant woman as a system is based on the ideas of Ferdinand de Saussure, the founder of structuralism. He believed that each phenomenon should be viewed as a system, consisting of various other structures. The different structures make the complete system, thereby signifying that the various structures are more important than the complete system (Longhurst et al., 2016). This will

be explained further in the next section that explores the theoretical framework for the study.

3.7 Theoretical Framework

Theory is used to explain the process involved in any phenomena (Williams, 2016). It is further described as a form of system where similar constructs are linked together by propositions and similar variables which are linked together by hypotheses (Abend, 2008; Creswell, 2009). This definition highlights the impact of various elements that make up a system, signifying the impact of a system on another system and that a combination of various subsystems makes a complete system (Wacker, 1998). Theory, therefore, acts as a lens for interpreting phenomena based on the objectives of the study, since there is no single way to understand a phenomenon (Reeves et al., 2008). However, different theories guide different studies, based on the aim and objectives of the research (Collins & Stokton, 2018).

As noted above, the health seeking behaviour of a woman during pregnancy is influenced by numerous factors. Several models provide an understanding of the numerous factors; they include the pathway model, the determinants model (Anderson Behavioural Model), and other theories of human behaviour such as Theory of Planned Behaviour and Health Belief Model. However, they provide limited information about the impact of culture on health seeking behaviour. Because a theoretical framework is described as a lens for interpreting phenomena, the sections below will provide more understanding about the various theories related to health seeking behaviour and culture, with the description of the theoretical framework underpinning the study (Higginbottom, 2004).

3.8 Theories of Health Seeking Behaviour and Culture

3.8.1 Pathway Model

The pathway model was first used by Suchman to describe the step-by-step process involved in seeking healthcare. It starts with the individual perception about illness and continues until the utilisation of healthcare services (Mackain et al., 2004). The framework is held to provide an understanding of the logical process involved in the utilisation of healthcare services (Mackain et al., 2004). However, the argument has also been made that there cannot be a general pathway for all individuals irrespective of the illness, as a specific pathway is for a group of people over a period (Schrijvers et al., 2012). This is based on the description of pathway as the complex intervention for the mutual decision-making and organisation of care process for a well-defined period (Vanhaecht et al., 2010). The pathway model has been further criticised for not including information about the other factors influencing health seeking behaviour (Mackain et al., 2004).

3.8.2 Determinants Model

The determinants model focuses on the identification of the factors associated with the decision to use a healthcare service (Mackain et al., 2004). A useful illustration of the determinants model identified from the literature is the Anderson Behavioural Model.

3.8.3 Anderson Behavioural Model

This model was developed in 1968 by Ronald Anderson, a medical sociologist and researcher. It consists of three different components (predisposing factors, enabling factors and need factors) that are believed to influence each individual's behaviour. The predisposing factors are demographic and social factors (Petrovic & Blank, 2015); the enabling factors are the individual's level of income or support from families; and the need factors are the actual demands for maternal healthcare (Jahangir et al., 2012). All the identified factors are believed to impact on a woman's healthcare seeking behaviour during pregnancy. The Anderson Behavioural Model is a determinant model of health behaviour because it encompasses both the women seeking healthcare as individuals and the

contextual factors affecting the utilisation of healthcare services through the three components outlined above (Jahangir et al., 2012).

The predisposing factors are those factors that predispose a woman to seek healthcare; they are categorised as age, sex, education, family, attitudes, beliefs, values, and level of knowledge (Anderson, 1995). As highlighted in the findings of a Nigerian study which showed that an educated woman has a higher chance of utilising the service of a skilled birth attendant than an illiterate woman within the region. This shows the significance of education on a woman's behaviour (Fagbamigbe & Idemudia, 2015). The result of the literature review in Chapter 4 shows that a woman's cultural beliefs impact on her health seeking behaviour during pregnancy. Likewise, one of the factors listed as a predisposing factor in this model also affects women's health seeking behaviour during pregnancy.

The enabling factors affect both the patient as the consumer of healthcare and the providers of healthcare (nurses, midwives, or doctors). Enabling factors could also be the cost of healthcare services and the financial capability of the woman seeking healthcare (Anderson, 1995). It is, accordingly, assumed that a woman will seek ANC from qualified healthcare personnel if she can afford to pay for the service, although the availability of resources will impact on the form of service provided by the medical team (Babitsch et al., 2012).

Need factors are identified as perceived individual need for antenatal healthcare services; evaluated need based on the assessment of the professional healthcare provider; and environmental need based on the maternal healthcare indices within the area (Anderson, 1995; Babitsch et al., 2012). However, considering the participants in this study, access was an issue because their geographical location deprived them from some maternity healthcare services that were available elsewhere. Thus, when complications arise, or a need is identified by the pregnant woman, their first point of contact is not always a skilled healthcare worker (Ahmed et al., 2001). In addition, the first point of contact is always the local provider of maternal healthcare services within the community, which could be the herbalist, spiritualist, or the TBA. This was evidenced in a study conducted in Bangladesh by Rahman (2001), which showed that most of the participants in

the study sought healthcare first from untrained personnel before going anywhere else. As such, there is a need to understand the cultural factors underpinning the healthcare seeking behaviour of women in a rural community like Ota, since the identification of the factors associated with the behaviour is an approach to promoting a contextual form of maternal healthcare services (Tesfaye et al., 2017).

The determinants model consists of three constructs that influence an individual's health seeking behaviour. However, it has been argued that the model does not show the interaction between the three identified constructs and, thus, it may pose certain problems in a study involving the influence of culture on healthcare seeking behaviour because all three identified factors are believed to interact together to impact on a woman's way of life (Bradley et al., 2002). A more recent description of the Anderson Behavioural Model was given by Andersen, Davidson & Baumeister (2013, cited in Kominski, 2014), who amended the components of the model to include more information about access.

3.8.4 Theory of Planned Behaviour

Health behaviour was originally described as the various strategies individuals adopt in order to protect themselves from illness (Harris & Guten, 1979). It was later argued that health behaviour is not based just on behaviour, but it is a combination of human behaviour and lifestyle adopted by the individual, since lifestyle modification can also protect individuals from illness and diseases (Belloc & Breslow, 1972, cited in Dreyer et al., 1997). The initial understanding of health behaviour depicts the impact of the behaviour on disease prevention. It therefore encourages certain behaviour and discourages any form of behaviour that will compromise individual health (Cohn, 2014). However, with more research, a gap was identified between intentions and behaviour; this was explained in Bandura's self-efficacy theory (Bandura, 1977). The notion of the existence of a gap between intentions and behaviour was then adopted by Ajzen (1991). Attitude was thus described as an outcome of intentions and behaviours which are further influenced by beliefs. It was then suggested that belief may be the reason why all intentions do not lead to action (Ajzen, 1991). Ajzen then proposed the idea of a new construct, where behaviour was thought to be an action that can be controlled in the theory of planned behaviour. The

theory thereby provides an understanding of behaviour through intentions by showing the relationship between beliefs and behaviour (Fishbein & Ajzen, 2010).

The theory of planned behaviour combines different variables in order to provide an understanding of the various factors that may influence an individual's behaviour. Two main factors are identified as the intention to engage in the behaviour and the corresponding control of the individual over the action (Fishbein & Ajzen, 2010). However, intentions are believed to be different, and are controlled by three different forms of attitude: behavioural beliefs (I think attending ANC in a hospital is good for me as a pregnant woman), normative beliefs (I am expected to seek care from a skilled birth attendant as a pregnant woman,) and control beliefs (I know I can attend the PHC close by).

The theory of planned behaviour has been widely used to quantify the factors affecting behaviour (Ajzen, 2002; Fishbein & Ajzen, 2010) and it has also been adopted in qualitative research studies (Renzi & Klobas, 2008). In 2013, the theory was used to assess women's behaviour in seeking ANC from qualified healthcare personnel (Tasci-Duran & Ozkahraman, 2013). Prior to that study, it was used in other research that focused on women's behaviour towards activities that could improve maternal health during pregnancy (Conner et al., 2002; Everson et al., 2007; Jackson et al., 2003; Schaalma et al., 2009) and it was specifically used to assess the behaviour of pregnant woman towards maternal healthcare services in Kenya (Creanga et al., 2016).

However, the theory has been criticised for being too logical about human behaviour. This is because individuals can sometimes have the intention of engaging in irrational behaviours, yet the intention may possibly not result in any behaviour. Therefore, behaviour is categorised as being illogical and may be affected by environmental factors (Barber, 2012). Furthermore, the theory of planned behaviour has also been criticised for not including external factors which are likely to influence human behaviour. As such, the theory of planned behaviour will not be applied in this study due to lack of information about the external variables such as demographic factors, economic factors, and sociocultural factors, which are believed to have a significant effect on behaviour and the attitude of the individual (Jokonya, 2017).

3.8.5 Three Delays Model

Delay is categorised as an underlying factor contributing to maternal death in a low-resource economy (Nour, 2006), although eclampsia, postpartum haemorrhage, infection, obstructed labour, and unsafe abortion are the primary causes of maternal death (WHO, 2016). In 1994, Sereen Thaddeus and Deborah Maine developed a model for the categorisation of factors contributing to the delay in accessing maternal healthcare to provide more information about the underlying factors that may lead to the onset of obstetric complication (Thaddeus & Maine, 1994). Research has shown that obstetric health complications can be prevented or improved on in the presence of the required human capital and resources (Simkhada et al., 2008). The three delays model focused specifically on the three types of delay that can affect maternal health outcome; they include delay in making the decision to seek healthcare, delay in reaching the point of care, and delay within the healthcare facility (Thaddeus & Maine, 1994). However, research conducted in 2013 concluded that the best approach for tackling the problems highlighted in the three delays model was to proffer a solution to the different factors affecting both the women seeking healthcare and the provider of the service; this is because they are all needed for the improvement of maternal healthcare outcomes and the reduction of mortality and morbidity (Knight et al., 2013). Delay, in Nigeria, is classified as an entrenched issue because there are women who book late for ANC as they do not associate any benefit with early ANC booking (Aliyu & Dahiru, 2017; Ndidi & Oseremen, 2010; Warri & George, 2020). A different study in Nigeria showed that lack of knowledge about when to book for the ANC contributed to the late initiation of ANC (Ebeigbe & Igberase, 2010).

The second delay, which is delay in reaching the point of care (Thaddeus & Maine, 1994), focuses on other factors that could compromise seeking maternity care after initiating care. It is a common issue experienced mostly by women living in rural areas in low- and middle-income countries (Pacagnella et al., 2014). The delay specifically focuses on the impact of transportation on the accessibility of maternal healthcare services (Kyei-Nimakoh et al., 2017). Poor road topography and lack of suitable transportation due to the geographical location of the individual seeking care, are part of the major factors that impede physical access to maternity care. The geographical location of a woman seeking

care, thus, affects women's decision regarding where to seek care (Fagbamigbe & Idemudia, 2015).

Women living in urban areas have access to different types of healthcare facilities, including private and government-owned hospitals. Women in rural areas do not have access to the same variety of healthcare facility as their urban counterparts (Arthur, 2012). This is attributed to a wide inequality in the allocation of resources by the government (Egharevba et al., 2017). However, research has also shown that the availability of a healthcare facility does not guarantee patronage; it is the cost of healthcare that is a major barrier for women to consider before seeking care (Kalu-Umeh et al., 2013). As such, the delay in reaching the point of care is the outcome of the decision of the individual, the geographical location of the individual, and the cost of healthcare services (Arthur, 2012; Thaddeus & Maine, 1994). Thus, increasing the rate of utilisation of maternal healthcare services has been identified as part of the essential initiatives that can be used for the prevention of maternal mortality and morbidity (Aliyu & Dahiru, 2017).

Further to the lack of reliable transportation and poor road topography as factors that increase the travel time (Nour, 2006), the issue of travel costs also contributes to the delay (Atuoye et al., 2015). The last delay described in the model focuses on delays arising from hospital policy, or the impact of the process employed in the provision of care (Thaddeus & Maine, 1994). Arriving at a health facility on time does not guarantee the initiation of treatment; a patient receiving care can still experience delay as a result of inadequate resources for healthcare and unavailability of healthcare personnel (Goodman et al., 2017).

In Haiti, the three delays model was used in research on community-based action to determine other community factors contributing to maternal mortality. Participants identified all three types of delay described in the model along with a fourth: the role of the community in relation to maternal mortality. It was asserted that a critical understanding of the specific factors contributing to maternal death within a community is part of the approach that can be used to improve pregnancy outcome and reduce maternal death within a region. Community associated factors was an example of a fourth delay that contributed to maternal death (Macdonald et al., 2018; Pacagnella et al., 2014).

Prior to the community action research carried out in Haiti, the three delays model was critically reviewed by the Brazilian Network for the Surveillance of Severe Maternal Morbidity Study Group who scrutinised various factors contributing to delay in maternity care between 1980 and 2011 (Pacagnella et al., 2014). The outcome of the review showed that little was known about the underlying factors contributing to maternal mortality. It was, therefore, suggested that there might be another type of contributory delay. (Pacagnella et al., 2014). This was classified as the fourth type of delay that may contribute to maternal death and was identified in order for the members of the community to be involved in the reduction of maternal mortality and to aid the development of community strategies (Pacagnella et al., 2014).

The result of the community action research also shows that the community and its members had a huge impact on pregnancy outcomes. Due to the direct impact on the health and well-being of its members, it was classified as a form of contextual delay, which ought not to be generalised to all communities. Each community, therefore, should suggest ways to improve the maternal healthcare outcome of its own members based on the situation within the community (Macdonald et al., 2018). The solution proffered by the major stakeholders within a given area is based on the preliminary analysis of the situation within the community, although it may be challenging to communicate such outcome as an evidence base upon which to improve practice. Suggestions from the community as part of the approach to improving obstetric care may require rigorous analysis before implementation because with the increase in awareness about evidence-based practice, not all information can be categorised as evidence (Amara et al., 2004; Jack, 2006; Verhagen & Bolling, 2018).

The three delays model has been used widely in the exploration of the factors contributing to maternal mortality in different settings around the world (Barnes-Josiah et al., 1998; Kaiser et al., 2019; Sk et al., 2019). Despite its wide application in different studies, some authors are critical and maintain that there is no relationship between the onset of pregnancy complications and demographic risk factors (Rooks et al., 1989). It is, likewise, maintained that a higher standard of living does not decrease the risk of maternal death because urban women with access to well-resourced centres can also develop pregnancy

complications just like their rural counterparts (Oladapo & Osiberu, 2009; Olonade et al., 2019). Although there could be a slight variation in terms of the rate at which women experience certain types of complications in pregnancy (Lewis, 2008). Overall, women in both well-resourced and low-resourced settings are at risk of complications during pregnancy andchildbirth (Pacagnella et al., 2014).

Furthermore, attending an antenatal clinic does not guarantee the availability of healthcare personnel, since the bureaucracy within an establishment may contribute to the delay in receiving care after reaching the point of care (Alderliesten et al., 2007; Braveman et al., 2000; Kupek et al., 2003; Raatikainen et al., 2007). So too does the shortage and unavailability of healthcare personnel in some maternity centres in Nigeria affect the time care is initiated (Fagbamige & Idemudia, 2015). This is also a challenge in Uganda where the unavailability of doctors at the healthcare centres contributes to the factors affecting women's decisions to seek healthcare services in the country (Ackers et al., 2016).

Although the three types of delay identified in Thaddeus and Maine's model play a significant role in the identification of the factors contributing to low utilisation of ANC (Pacagnella et al., 2014), due to the impact of cultural factors on women's decisions on seeking ANC services, the model cannot be applied to this study because it does not provide the comprehensive approach that is needed for the exploration of the beliefs and practices associated with the choices women make when they seek ANC. It is, for the purposes of this study, crucial that delay contributing to the low utilisation of ANC is contextually defined, for pregnancy and childbirth are guided by societal norms and values.

3.8.6 Health Belief Model

The Health Belief Model is one of the most widely used social cognitive models. It was developed in the 1950s to explain why people do not participate in selected healthcare programmes. It gained popularity after the free tuberculosis screening programme was introduced in the United States.

The model focuses on people's categorisation of behaviour based on how individuals' perceptions determine their action towards illness. People respond through their behaviour to reduce an observed threat and, arguably, it is only the absolute

understanding of the consequences of their illness that will stimulate their action. When an imbalance exists in the form of a stressor that is not observed in the state of health, the health behaviour will remain the same, but the moment a stressor is observed the behaviour will be changed to counteract the effect of the threat (Conner & Norman, 2005).

The six components of the Health Belief Model are perceived severity, perceived susceptibility, perceived benefits, perceived barriers, self-efficacy, and cues to action (Lawal et al., 2017). The existence of threat in the form of health complications changes the individual behaviour because there is a threat. However, in relation to the case of a pregnant woman, it is not advisable to wait until the onset of complication before seeking ANC. Engaging in such behaviour increases the risk associated with the complication and possibly death, if treatment is not initiated early. This is classified as a form of delay affecting access to maternity care, which further increases the rate of maternal mortality and morbidity in low- and middle-income countries. Meanwhile, the early initiation of ANC, regular attendance at antenatal clinic and completing the required number of antenatal visits have been identified as key strategies to improving maternal health and reducing maternal mortality and morbidity (Haddrill et al., 2014, Nikiema et al., 2009; Titaley et al., 2010). Healthcare workers and major healthcare stakeholders encourage women to initiate ANC attendance early to aid in the early detection of risk to any woman who may be developing complications in pregnancy (Adewuyi et al., 2018; Fagbamigbe & Idemudia, 2015).

Although the onset of signs or symptoms of pregnancy complications increases the likelihood of seeking ANC from a qualified healthcare personnel, it is never advisable for a pregnant woman to wait until the development of a form of stressor that alters her health balance before seeking maternity care or initiating attendance at antenatal clinic. There are exceptional cases where women choose not to seek ANC from a hospital because they lack the funds to procure the service. They, therefore, adopt a form of care behaviour that involves seeking available and affordable forms of care. Their health seeking behaviour is based on their financial circumstances, which is likely to change if their financial status changes (Hitimana et al., 2018). This is evidenced from the literature review, which shows that the health seeking behaviour of a woman is based on many interacting factors within

the environment, as depicted in Figure 3.9. The Health Belief Model will be rejected in favour of the SEM because pregnancy is not viewed as a form of stressor or a threat to the human body in this research. This is because the nine months or so for which a woman carries a developing embryo and foetus in her womb is for most women a time of great happiness and fulfilment (Bennington & Davidson, 2013; WHO, 2018c). It might, therefore, be challenging to apply the Health Belief Model in this research because it consists of several elements which may not be applicable to understanding the health seeking behaviour of pregnant women in Ota, south-west Nigeria.

3.9 Framework Used for the Research: SEM (Socio-Ecological Model)

The SEM is a framework for understanding the effect of numerous factors within the complex external environment of the individual on behaviour (Golden & Earp, 2012). The model was developed by Urie Bronfenbrenner in 1979 to illustrate the impact of the ecosystem on the development of human beings (Adu & Oudshoorn, 2020). In 1980 it was formulated into a theory which hypothesised on the significant relationship between the individual and the environment (Golden & Earp, 2012). It also illustrates how the social environment influences the individual as a subsystem within the complex whole system (Smedley & Syme, 2001).

The individual was positioned as the centre of the SEM as continuously interacting with other structures within the external environment (Stokols, 2018). Individuals as the first element within the framework are influenced only by their activities as a microsystem (Adu & Oudshoorn, 2020). The SEM includes all the elements of the subsystem which has direct interaction with the individual. The model was also extended to include the internal elements of the individual (Stokols, 2018). Therefore, the microsystem can be described as both the internal and external subsystem interacting with the individual (Bronfenbrenner & Bronfenbrenner, 1981).

The second element within the system is the mesosystem also referred to as the interpersonal level (Adu & Oudshoorn, 2020). This level looks beyond the individual; it encompasses interaction with other people, such as close relatives. These forces affect the individual through discourse, chat, and advice (Golden & Earp, 2012). Adjacent to the interpersonal level is the organisational level, which includes the impact of work, places of worship, and the stages of formal education on the individual (Adu & Oudshoorn, 2020). However, this system cannot function without the input of the individual as the first element within it (Golden & Earp, 2012). The community level is the fourth level within the system. The various organisations within the area function together to impact on the members of the community at this level (Adu & Oudshoorn, 2020). The components of this system are exterior to the individual. This fourth level does not have direct impact on the

individual: it exerts forces on the individual through numerous factors within the community (Adu & Oudshoorn, 2020; Golden & Earp, 2012).

The final SEM level is the chronosystem or public policy (Adu & Oudshoorn, 2020). At this level the wider community influences the individual through government policy. The impact is also not direct, but the decisions of the major stakeholders within the wider group impact on the life of the individual as a member of the nation (Kilanowski, 2017). At this level, a wider group of individuals are affected unlike the first level which only affects the individual as a subsystem (Adu & Oudshoorn, 2020).

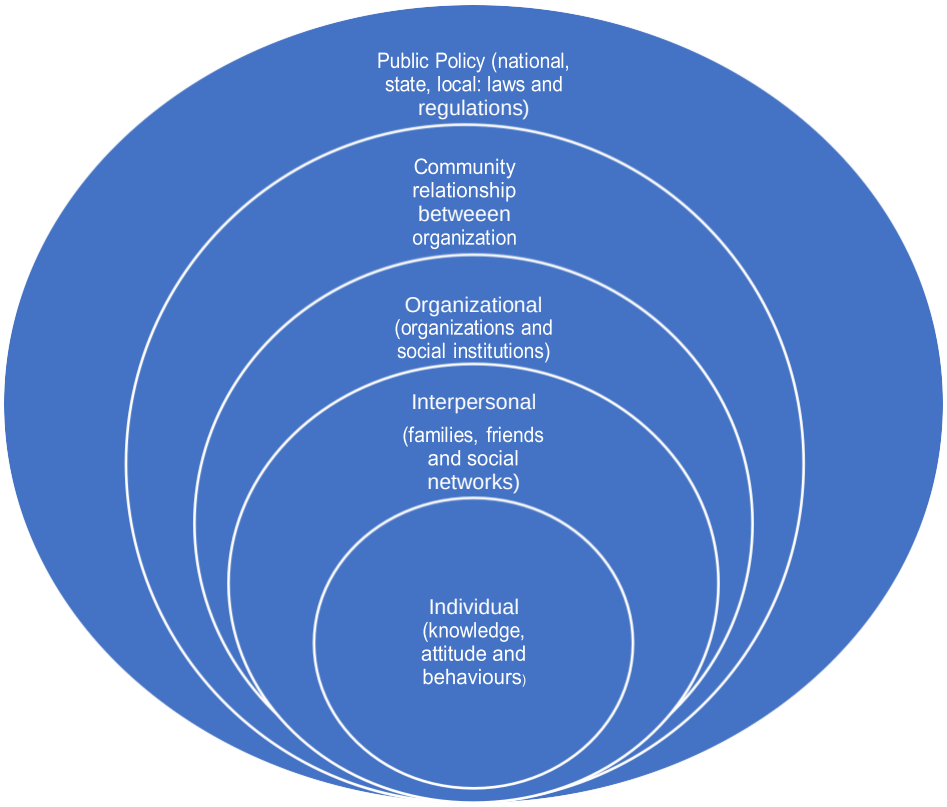


Figure 3.9: The Socio-Ecological Model (Source: Adu & Oudshoorn, 2020)

Conceptualising maternal healthcare services within the SEM shows that ANC is an important part of maternity service. The utilisation of maternal healthcare services through regular attendance at antenatal clinic, completion of the required number of visits and delivery in the presence of skilled healthcare personnel is an evidence-based approach to

improving maternal healthcare outcomes (Asundep et al., 2014; Bilenko et al., 2007). Similarly, attendance at ANC can also contribute to the reduction of global maternal deaths to under 70 per 100,000 live births, as set out in the third SDG (UNICEF, 2017). However, living in low-resource nations increases the risk of pregnancy complications because of inadequate resources or the state of maternity services within the region (Goldenberg et al., 2018). As such, there is a low rate of utilisation of maternity care within the region and a high maternal death index (Sword, 1999; Goldenberg et al., 2018).

Viewing antenatal healthcare as an element within the system suggests that it represents a major need for pregnant women due to its importance. Women are, as a result, encouraged to seek care from skilled healthcare personnel (Sumankuuro et al., 2019) but there are numerous factors, as illustrated in Chapter 4, which affect women's choices regarding seeking care in this regard. Looking at these factors from the context of the SEM forms part of the factors that affect maternal healthcare choices in relation to the individual seeking care. This can also be classified as a form of delay affecting the initiation of care (Kaiser et al., 2019).

The first set of delays that affect maternity care stem from the timeframe within which the individual initiates care (Thaddeus & Maine, 1994). All the factors that affect the individual as a member of that system also affect the care that she receives (Kaiser et al., 2019). However, relying on other members of the family, such as close relatives or neighbours for support, may also act as a barrier to women's choices about maternity care (Kaiser et al., 2019). This, in relation to the status of the individual seeking care, is classified as the second level of factors that affect seeking maternity care (Sword, 1999). In the presence of a positive interpersonal relationship, the chances of a positive childbirth experience increase due to the quality of the service (Dahlerg & Aune, 2013).

Next to the interpersonal factors are the organisational-level factors as the subsystem of the complex whole system (Bohren et al., 2014; Kaiser et al., 2019). For instance, a patient's previous negative experience of skilled healthcare personnel constitutes part of the negative experience that hinders the choices of women regarding where to seek care or when to initiate care (Okedo-Alex et al., 2019). As such, the negative

attitude of healthcare personnel affects women's choices regarding seeking ANC (Jinga et al., 2019).

Another systematic review also explores the factors affecting maternal health indexes in low-resource nations (Sumankuuro et al., 2018). The result of the review showed that shortage of healthcare workers and lack of essential medical resources are major barriers affecting the quality of maternal healthcare services (Fort & Voltero, 2004). The findings of the study further illustrated how migration of healthcare workers to other regions for better job remuneration affected the quality of service in the region (Fort & Voltero, 2004). Overall, shortage of staff leads to stress and unnecessary referral to other health institutions due to the level of workload experienced by the few healthcare workers available (Fort & Voltero, 2004; Sumankuuro et al., 2019). Along with the impact of the structural part of the organisation on maternal health, the attitude of healthcare workers has also been classified as another factor affecting women visiting clinics for maternity service. This factor includes the rate of abuse and obstetric violence experienced by women receiving care, through violation of their rights to privacy and abandonment within the facility (Bradley et al., 2016; Miltenburg et al., 2018; Vacaflor, 2017).

In relation to the fourth system within the socio-ecological framework, maternal healthcare is part of the community as a subsystem. Access remains an important part of maternal healthcare; however, lack of access has been a major factor hindering the utilisation of maternity care, most especially in rural communities. The lack of access may also be linked to the geographical location of a group of people; this may be due to the inequality in the distribution of resources. Physical access may therefore inhibit access to quality maternity services. Furthermore, the effect can also be compounded by poverty, due to the unaffordability of the cost of transportation. Likewise, gender discrimination may also limit access to maternity care due to traditional interpretations of the roles of men and women. The movement of female members is, therefore, controlled and supervised by the head of the family, who may appoint someone to travel along with mothers to clinic when needed (Jones et al., 2017; Nuamah et al., 2019).

At the top level of the SEM is policy. This segment will be linked to the major stakeholders who develop a wide range of strategies to improve maternal healthcare

services (Bohren et al., 2014; Kaiser et al, 2019). This includes amending existing policies to meet the demand of the society. However, inadequate supply of resources and shortage of staff have been classified as part of the factors that limit the implementation of healthcare policy (Lang'at & Mwanri, 2015; Jones et al., 2017).

Conceptualising women's health seeking behaviour in relation to ANC as an element within the SEM shows that a pregnant woman is an element/subsystem within the system (Kaiser et al., 2019). Thus, both internal and external factors affect women's choices regarding seeking ANC (Bohren et al., 2014). It is, therefore, crucial to consider a range of factors that could impact on women's choices when forming healthcare policies. Making education affordable to the citizens of a country and educating girls will go a long way in benefitting the individual as a member of the ecosystem. This is because education determines individual orientation and perception about issues; thus, it shapes the behaviour of people as members of the ecosystem. As such, education can aid in the reduction of the risks associated with people's choices, through their ability to make informed choices about their care (Sword, 1999). The SEM will therefore be applied in this research because it provides the opportunity to understand the intrinsic factors that shape human behaviour. Furthermore, understanding the contextual factors that shape human behaviour is a useful tool that can be used to manage the health of individual (Kaiser et al., 2019); that is to say, the information acquired through the exploration of the factors that shape the behaviour of the pregnant woman as a member of the ecosystem can be used to shape the form of antenatal healthcare services available to women within the reproductive age in a community.

The SEM is, in this research, further considered to be the most appropriate framework for exploring the beliefs and practices influencing women's choices regarding seeking ANC during pregnancy because the constituent element of the model provides more information about factors that can influence human behaviour. When compared with other theories, the SEM directly illustrates the various factors (environmental and personal) that can affect individuals as a member of the community – thereby depicting the impact of humans on all the elements embedded within the eco-systems (Ngwenya et al., 2020).

Likewise, the various subsystems within the larger system will also help in researching and understanding how behaviours are developed (Kaiser et al., 2019).

Looking at the individual as a subsystem within the complex whole system, it may be difficult to separate the individual from the environment. As such, the environment as a contextual factor can provide information about the factors that shape behaviour (Kaiser et al., 2019). Although the three delays model can also be used to explore the factors that affect the utilisation of healthcare, it has been considered by some authors as being too basic for the classification and identification of the factors contributing to low utilisation of ANC (Bohren et al., 2014; Knight et al., 2013; Sorensen et al., 2011). In contrast, the SEM can be used to illustrate a broader description of the factors that may influence individual choices regarding seeking care (Belinda et al., 2012; Kaiser et al., 2019; Onono et al., 2015; Timmermans et al., 2020). It further shows the interaction between individual culture and health outcome through the integration of multilevel approach (Golden & Earp, 2012). The model has been used as a framework to explore factors impeding the utilisation of healthcare services in different studies (Gombachika et al., 2012; Kaiser et al., 2019; Ma et al., 2017).

Furthermore, the application of the SEM will also lead to the establishment of different perceptions about healthcare as defined in behavioural theory, which emphasises the importance of context for human behaviour, since those factors influencing one behaviour are likely to be different from the factors influencing another behaviour (Gabrysch & Campbell, 2009). It is, therefore, important that women's health seeking behaviour is contextually defined to aid understanding the factors contributing to the delay in seeking healthcare among pregnant women (Coast et al., 2014).

This model will be applied in this study because research has shown that socio-ecological factors influence people's choices when seeking care (Ngwenya et al., 2020). Other theories of health seeking behaviour; for example, the Health Belief Model, provided little evidence about the impact of external factors such as norms and values on human behaviour (Sharma, 2015). Therefore, a social-ecological framework will be applied in this research because it consists of various constructs that attempt to provide more understanding about human behaviour. The SEM also provides a holistic view of all the

factors affecting human behaviour; it is culturally viable and suitable for low-resource settings (Sharma et al., 2017). In this research, the individual will be the pregnant woman seeking ANC.

Thus, the theoretical framework underpinning this study will be based on the elements of SEM because the focus of this research is to understand the factors associated with women's health seeking behaviour and not to change any part of it. As such, the SEM will be applied to this study to indicate how beliefs and practices influence the health seeking behaviour of women during pregnancy. All the different elements of culture as a complex structure will be utilised in the adaption of the SEM as the theoretical framework for the study.

3.10 Summary

This chapter provided information about the various concepts related to the study, including information about health, health seeking behaviour and culture. These three aspects of the study were explained in relation to the choices women make regarding where to seek ANC during pregnancy. The discussion on the meaning of culture in this chapter aided the exploration and identification of what constitutes culture as a factor that influences maternal healthcare. Thus, culture can be viewed as part of the factors that contribute to the first delay as classified in the three delays model developed by Thaddeus and Maine (Evans, 2013; Thaddeus & Maine, 1994). Chapter 3 also included information about theoretical frameworks; the SEM was found to be most applicable for this research because it explores the interaction and the impact of the environment of people's healthcare choices. This is significant in this study because individual health seeking behaviour is the result of the interaction of people with their environment. The next chapter will further establish the context for the study by reviewing literature related to cultural beliefs, practices, and health seeking behaviour of pregnant women in Africa, using SEM to critically analyse previous studies.

Chapter 4: Literature Review

4.1 Introduction

The previous chapter set out the concepts and theories relevant to the study; this chapter will further set out the context for the study by using the SEM to critically analyse studies relating to cultural beliefs, practices and health seeking behaviour in pregnancy in Africa. This will be carried out through a narrative review with the aim of exploring beliefs and practices influencing pregnancy – I am particularly interested in examining how cultural beliefs and practices affect women's choices and behaviours regarding where they seek care during pregnancy.

A traditional narrative review focuses on a subject area, with the aim of providing comprehensive information about the body of knowledge (Cronin et al., 2008). It also allows the researcher to summarise the different methods or theories used in existing reviews (Cronin et al., 2008) and provides broad knowledge through the number of subject areas that are covered – unlike a systematic review that focus on a question (Efron & Ravid, 2019; Van der Knapp, 2008). However, due to the large volume of literature on beliefs and practices affecting the health seeking behaviour of women during pregnancy and the range of concepts and theories which are potentially applicable (as described in the previous chapter), some techniques from systematic reviewing methods were used to provide a manageable focus for this chapter.

4.2 Search Process

The search process is described both as a science and an art because two individuals will retrieve different search results when using a similar research question. Although this is based on the search engine and search strategy that is used, overall, the database or source of information may affect the search result (Aromataris & Riitano, 2014). Throughout my PhD candidature, many searches have been undertaken. At each point, the search process started with the selection of the subject area related to the study from the search engine. My selected subject areas were Nursing, Midwifery and Social Sciences; the database related to each subject area was then selected based on recommendations from experienced researchers. The search outcome from each database was then added togetherto provide an aggregate of the total number of articles retrieved from the database. This was limited to articles published between January 2004 and March 2022. The search outcome limited by language and subject area in order to ensure the selected articles were related to the aim and objectives of the research.

4.3 Search Terms

The search strategy implemented in this research targeted reviewing published and unpublished articles relating to beliefs, practices, and health seeking behaviour of pregnant women. The search terms for this study were “cultural beliefs and practices” “health seeking behaviour” and “pregnant women” with their thesaurus terms. The thesaurus terms for “cultural beliefs and practices” are as follows: “traditional beliefs and practices”, “indigenous beliefs”, “local practices”, “health practices”, “healthcare experiences” and “family practices”, while the thesaurus terms for “healthcare seeking behaviour” are the following: “care seeking”, “information seeking behaviour”, “help seeking”, “health seeking”, “health behaviour” and “information seeking behaviour”. The technical terms given for “pregnant women” include “expectant mothers”, “women”, “women’s health”, “pregnancy”, “pregnancy outcome” and “women”.

The search terms were checked multiple times to ensure the search results were relevant to the research question (McGowan & Sampson, 2005). The Boolean operators “OR” and “AND” were used to combine the subject terms, as this tool helps broaden the result of the search or reduce the number of journal articles (Timmins & McCabe, 2005). To keep the focus of the chapter manageable, the studies that were critically analysed were those that were conducted in Africa: the context likely to be most similar to the study location of this thesis.

4.3.1 Databases

The databases used for the retrieval of journal articles for this research are specific to the three speciality areas that are related to this study. Multiple databases were used because a single database cannot be used to search all the literature about a specific research question (Grewal et al., 2016). The subject areas were Nursing, Midwifery and Social Science. Each database was then selected based on its relevance to the subject area and the potential coverage of the database. Searches of the following electronic databases were conducted:

- PubMed

- Medline
- BNI (British Nursing Index)
- CINAHL (Cumulative Index of Nursing and Allied Health Literature)
- Web of Science
- Social Sciences Database

The sociological-related database was included because some aspects of the research focus on sociological perspectives. CINAHL, which covers journals from a wider geographical location, was used because it is a larger database than BNI, which only focuses on UK journal articles (Briscoe & Cooper, 2014). Furthermore, CINAHL was also used following recommendations from nurses and other healthcare professionals (Marisa, 2007). PubMed was used in addition to Medline because it is broader and references are added more frequently than to Medline (Kelly & St Pierre-Hansen, 2008). In addition to the electronic database searches, the reference lists of the retrieved journal articles were searched by hand for further articles.

The websites of local and international organisations providing current and valuable information on improvements in maternal and child healthcare were also consulted; they included UNICEF (the United Nations Children's Emergency Fund), the WHO and UNFPA (the United Nations Population Fund). Accessing specific organisational websites also increased the breadth of the review, since relevant studies are sometimes located away from expected channels (Jahan et al., 2016). The websites of the Federal Republic of Nigeria (https://nigeria.gov.ng) and the Ministry of Health of Nigeria (https://nigeriahealthwatch.com.pdf) were also searched electronically for information about healthcare policy. Lastly, the British Library e-thesis repository was searched for PhD theses on maternal health seeking behaviour (https://ethos.bl.uk).

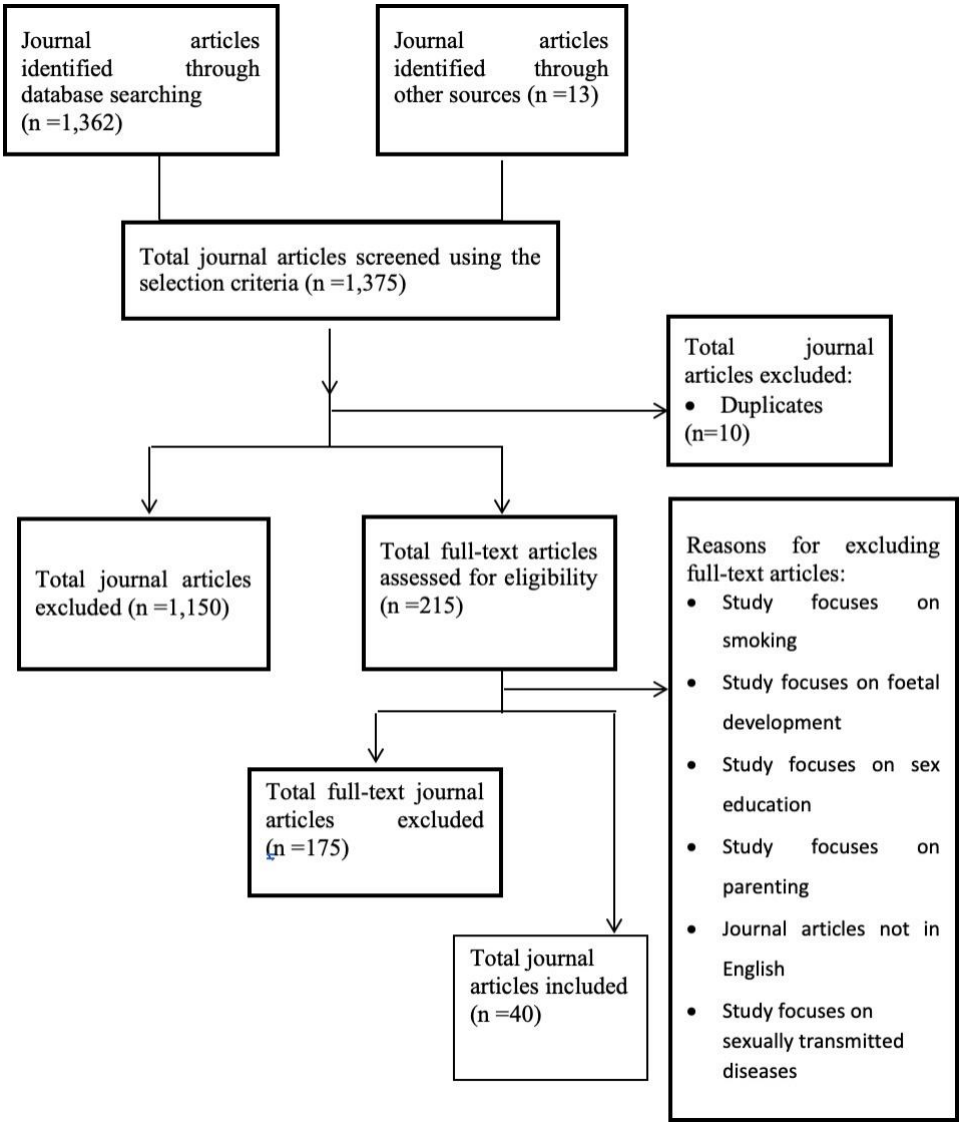


Figure 4.3: Flow diagram of the literature search outcome

4.3.2 Search Outcomes

Table 4.3 (below) presents an overview of the African literature on the topic. It identifies the gap in the literature that this study fills and helps to critically analyse the literature according to the SEM.

Table 4.3: Literature review

Key
QS: Qualitative study
FGD: Focus group discussion
Ob: Observation
POb: Participants observation
CF: Constructivist framework
TTL: Transcultural theory of Leininger
A&N: Anderson and Newman model
MET: Maternal engagement theory
F: Functionalism
ES: Ethnographic study
IT: Interpretive theory
HSB: Health seeking behaviour
ANC: Antenatal care

Beliefs			Practices		HSB		ANC	
Author Year Country	**Aim**	**Methods** **Sample Size** **Sampling** **Data Collection**	**Theoretical Framework**	**Main Findings**	**Core Elements**	**Elements of Culture**	**Elements of SEM**	**Recommendations**

Mathole et al. 2004 Zimbabwe	To explore the experiences of women about ANC routine	QS 68 participants — FGD Interviews	CF	ANC routine did not consider the views of the pregnant woman who is the main stakeholder	✓			✓	**Belief**: ANC routine encouraged early booking while the women within the region believe that women could be attacked by evil spirts during the early stages of pregnancy Spiritualists possess the power to protect that could be used to protect the pregnancy from any harm Pregnancy exposes women to attack from witchcraft **Norm**: Information about pregnancy is only disclosed to close family relations	**Individual:** The age of the pregnant woman affects their orientation about the possible complications that may arise Level of finance also deters women from initiating ANC early **Interpersonal:** Friends and family remind women about the possibility of being attacked by evil spirits. They therefore seek care from indigenous health practitioners for protection from evil spirits Seeking care from the hospital interferes with some rituals **Community:** Faith healers are believed to have the ability to predict the outcome of the pregnancy Indigenous healthcare workers are believed to offer a form of care that cannot be offered by skilled healthcare	Elimination of some parts of the traditional ANC routine There is a need to conduct research about the experience of all the stakeholders involved in ANC

Jansen, 2006 Ghana	To describe the beliefs and practices associated with childbirth in Kwame Danso, Ghana	ES 5 TBAs — POb Interview	—	Sociocultural factors have a significant effect on the choices women make regarding pregnancy and childbirth	✓	✓		✓	**Belief:** Pregnancy and childbirth is a normal process that does not need intervention of the skilled healthcare personnel The ancestors and the gods protect the pregnancy from any evil acts **Practice:** Women who deliver alone without any form of support are categorised as the strong ones Burying the placenta is an important part of childbirth **Norm**: Protection of the pregnancy is the responsibility of all the family members	**Interpersonal**: Non-compliance with advice from the family members can lead to problems The significant members of the family have a role to play, in terms of protecting the pregnancy. This is because they are the intermediary between the world we live in and the gods	

Woldemicael 2009 Ethiopia	To identify the relationship between autonomy and the use of the maternal healthcare services	Survey Data from 2002 (Eritrea) and 2005 (Ethiopia) demographic health survey 8,754 samples from Eritrea 14,070 from Ethiopia —	—	Women in Ethiopia are more involved in decisions regarding their choice of maternity care than women in Eritrea			✓	✓	**Practice**: Women's position within the household determines their level of contribution to decisions regarding maternity care	**Individual:** Women's level of education influences their ability to utilise maternity care Financial capability of women also limits them from contributing to decisions regarding maternity care	To use longitudinal data to show the relationship between autonomy and health seeking behaviour
Seljeskog et al., 2006 Malawi	To identify the different community factors that affect the choice of where to seek care during pregnancy or	Explorative study 6 women who recently delivered Randomly Interview	—	The underlying factors influencing the choice of the place of delivery is as important as the primary factors impacting on		✓		✓	**Practices**: Caesarean section is perceived as a threat There is a preference for herbal medicine Women seek	**Individual:** Previous pregnancy experience impacts on women's choices regarding where to seek care Women's perception about danger signs influences the choice	A new form of maternity service approach that considers the needs individual client is needed To increase the level of knowledge of

	Childbirth	Ob		healthcare					care from more than one facility Women are comfortable with a TBA Women do not initiate antenatal clinic early There is a preference for homebirths	of where to seek care during pregnancy There is a general delay in seeking maternity care Women do not comply with referral to other healthcare institutions They trust indigenous health care workers than skilled healthcare professional **Interpersonal:** The significant members of the family influence the decision for home birth **Organisation:** Unavailability of healthcare professionals at the health facility	healthcare workers about the various indigenous practice common in the area

									Community: TBAs conduct most deliveries within the region	
Marchie & Anyanwu, 2009 Nigeria	To explore the impact of sociocultural factors on maternal mortality	Descriptive survey 2,157 women within the reproductive age group Multi-stage sampling technique Questionnaire FGD In-depth Interview	—	Indigenous maternal healthcare services, age, level of education and geographical location are the various factors that contribute to maternal mortality rate within the region		✓		✓	**Practice**: Indigenous traditional practice is part of the independent variables identified from the research Autonomy was also identified in the two different locations selected for the study	**Individual**: women's level of education affected the mortality rate within the area Level of income has an independent variable also affects maternal mortality	
Myer & Harrison, 2010 South Africa	To explore the factors affecting the utilisation of prenatal care among women within the	Qualitative research 29 women (22 attending the clinic for the first	—	Most of the participants in this study did not associate any benefit with antenatal clinic while some others believe	✓			✓	**Belief:** It is not necessary to seek ANC during the first trimester	**Individual:** Lack understanding about pregnancy and childbirth **Community:** There is limited access to the health	Women need to be educated about the risks associated with pregnancy and childbirth

	reproductive age group in South Africa	time, 7 who are not) — Semi-structured interview		ANC is only needed for complications in pregnancy					facility	
Warren, 2010 Ethiopia	To describe the beliefs that influence women's choices regarding where to seek care during pregnancy	QS 1,000 participants (adolescents recently delivered mothers, elderly women, healthcare personnel, TBAs, 37 key informants and 17 verbal autopsies) — In-depth interview Verbal	—	The significant members of the family play a crucial role in determining women's choices regarding where to seek ANC	✓			✓	**Belief:** The consumption of herbs will aid the delivery of the placenta They do not associate any benefit with the healthcare facility Husband and family members contribute to the choice of where to seek care	**Individual:** Low level of knowledge about the maternity service **Interpersonal:** Family members and husband as the significant members of the family contribute to women's choices regarding delivery in the presence of skilled healthcare personnel	To increase the knowledge of healthcare providers about the indigenous practices common within the region

		autopsies FGD								
Abor et al., 2011 Ghana	To identify the socio-economic factors that influence maternal healthcare	Survey 10,706 participants (5,691 women and 5,015 men) — —	A&N	There is a low level of utilisation of maternal healthcare services	✓			✓	**Belief:** Religious beliefs influence women's decision when seeking ANC To seek care when there is complication Mothers with twin pregnancy have a higher chance of seeking care from skilled healthcare personnel than women with single pregnancy	**Individual:** Level of education of the individual affects the rate of attendance at ANC	Implementation of strategies that will aid the utilisation of maternity service

Farnes et al., 2011 Ghana	To examine the health seeking behaviours of women within the reproductive age group in Ghana	ES 42 childbearing women Snowballing sampling method Interview	—	Cultural beliefs have a huge impact on a women's health seeking behaviour during pregnancy	✓		✓		**Belief:** Women seek care from various providers of maternity service to prevent pregnancy complications Some women believe since they are not sick there is no need to seek healthcare from healthcare personnel working in the hospital They also believe that the medicine given to them by the religious leaders can be used to protect the baby from any	**Community**: Pregnant women seek care from a herbalist for a safe childbirth People consume herbs because it is a tradition that has been passed down to them	There is a need for research that will focus on how maternity service providers can meet the cultural needs of women seeking maternal healthcare services

									form of attack Spiritual care is important due to the vulnerability of a pregnant woman to witchcraft Herbal medicine can be consumed to protect the mother and baby		
Lori & Boyle, 2011 Liberia	To understand the contextual factors that influence maternal healthcare care among women in Liberia, west Africa.	QS 10 postpartum women 18 family members 26 community members_ _ Semi structured	IT	Several contextual factors impact on pregnancy and childbirth in Liberia	✓			✓	**Belief:** Secrecy is part of the cultural heritage in Liberia Girl child is trained to respect her partner There is preference for homebirth	**Individual:** Women practice secrecy for prevention from illness Women do not want to visit the health centre because of previous negative experience with skilled healthcare personnel	Current approach targeted at improving maternity care must be re-examined to include contextual factors affecting maternity care

		interview Ob							because of tradition Men should be excluded from the actual birth process but being the head of the family, they are contacted when need be about any decisions regarding seeking maternity care Information about pregnancy and childbirth should be kept as a secret in order to protect the mother and baby from any form of attack There is a strong belief about the existence of	The patriarchal nature of the society limit women's ability to make decisions about their health **Interpersonal**: The significant members of the community influence women's decisions during pregnancy and childbirth	

								supernatural powers by some members of the community. People believe these powers can be used to inflict illness on the woman		
du Preez, 2012 South Africa	To understand the meaning of d*ikgaba* and the health practices women engage in during pregnancy	QS 12 TBAs 4 traditional healers 4 consumers of *dikgaba* Snowballing Interview	TTL	Knowledge about *dikgaba* as a cultural practice during pregnancy is popular among women in Batswana		✓	✓	✓	**Belief**: Pregnancy is a normal part of a woman's life Any complications in pregnancy are linked to *dikgaba* Prolonged labour is an example of a *dikgaba* spell Abnormal positioning or any problem with the baby during delivery	**Interpersonal:** Women are encouraged to have a good relationship with the significant members of the family in order to drive away evil spirits A good relationship with extended family members can help prevent any form of affliction in pregnancy	More research to investigate the safety of traditional medicine used during pregnancy

								is also classified as a *dikgaba* Understanding *dikgaba* will aid early recognition of a problem in pregnancy		
Ngomane & Mulaudzi, 2012 South Africa	To examine the beliefs and practices that affect women's attendance at antenatal clinic in Limpopo	QS 12 women Purposively Unstructured Interview	—	Pregnancy is a sacred act that must be honoured by fulfilling all the expectations needed to protect the woman and baby from evil spirits Rituals are an important part of the tradition	✓	✓		✓	**Belief:** Pregnancy is viewed as a sacred act People view pregnancy as a divine favour that must be appreciated It is forbidden to share the news of pregnancy with family and friends Pregnancy is kept as a secret until it is visible	**Interpersonal:** Families are part of the significant others who contribute to decisions regarding ANC in pregnancy **Community**: Existing relationship with the indigenous healthcare providers is part of the factors considered when seeking ANC TBA is the main provider of maternal healthcare service	More research into the similarities and differences between the traditional system of care and modern form of maternity care is needed

									to others Information about pregnancy must be shared with close family members before anyone else Belief in witchcraft delays the initiation of antenatal visit **Practice:** The significant members of the family support the woman throughout pregnancy journey Herbal medicine is needed for the protection of pregnancy	

								and childbirth Rituals are an important part of the tradition		
Brighton et al., 2013 Africa	To identify the barriers affecting the utilisation of maternal healthcare services	Systematic reviews 27 studies Thematic synthesis In-depth interview FGD	—	The perception of the healthcare worker, the perception of the woman seeking care and the community all act as a barrier to the utilisation of ANC	✓			✓	**Belief**: Modern maternal healthcare services cannot proffer solutions to complications caused by spiritual or evil powers Pregnancy complications are associated with evil spirits or individual act Complications in pregnancy are associated with bad behaviour Pregnancy must be kept a secret	**Individual:** Women depend on family members for financial support towards maternity care **Interpersonal:** Elders and other significant members of the family contribute to the decision about where to seek care	Qualitative research about the impact of beliefs on ANC in other communities within sub-Saharan Africa

								Women who practise home birth are highly respected		
Evans, 2013 Developing countries	To explore the impact of culture on maternal mortality	Review 17 journal articles — —	—	Beliefs and customs influence the decision of where to seek care during pregnancy	✓			✓	**Belief:** Prolonged labour is associated with food or the non-performance of rituals Delay in seeking care due to local beliefs sometimes affects the outcome of the pregnancy Some procedures performed by skilled healthcare personnel do not comply with the cultural preference of the pregnant	**Individual:** Lack of understanding about the complications of pregnancy Level of education impacts on the women's ability to make decisions about maternity care	The development of a theoretical framework that encompasses both culture and maternal mortality To identify other underlying cultural factors that influence maternal health seeking behaviour

								Woman		
Mboho et al., 2013 Nigeria	To examine the beliefs and practices of the Ibibio and Annang ethnic groups	Qualitative research 57 Researcher judgement Semi-structured and unstructured interviews	—	Beliefs and practices contribute to delay in seeking care from qualified healthcare personnel	✓	✓		✓	**Belief:** Pregnancy is a natural physiological process experienced by women within the reproductive age group Disobeying the significant members of the family could lead to being cursed by the community Pregnancy is categorised as a period that exposes women to risk TBA has a	**Community:** The significant members of the family contribute to decisions regarding maternity care	Further research is needed to examine the impact of education on maternal mortality among the TBAs To educate skilled healthcare professionals about the beliefs and practices associated with pregnancy and childbirth

									unique way of protecting pregnancy There is a preference for maternity care in the church due to faith		
Pfeiffer & Mwaiopopo, 2013 Tanzania	To explore the reason for the choice of where to seek maternity care among women	Mixed method 200 participants (100 from urban areas and 100 from rural areas) Randomly Purposively and Convenience sampling method	—	Women in urban areas deliver in the hospital while women in rural area deliver at home in the presence of the indigenous healthcare practitioner			✓	✓	Homebirth is common among women in rural areas compared to their urban counterparts Comfort was part of the factors considered when choosing where to seek ANC Husbands play a significant role about the choice of where to receive ANC	**Individual:** There is a preference for delivery to take place in the presence of family and friends in a familiar environment Visit to the health facility is ignored to protect the pregnancy Some women decide they want to deliver in the presence of indigenous healthcare workers **Interpersonal:** Family members play	Maternal health interventions should not focus on the indigenous part of maternity care, but the healthcare system should be strengthened to accommodate parts of indigenous practices

									There is a preference for a female health practitioner	a significant role about the choice of where to receive ANC **Organisational:** Shortage of healthcare personnel hinders women from seeking care from skilled healthcare personnel Delivery with the traditional healthcare worker is faster and less stressful when compared to delivery within the healthcare facility	

Dako-Gyeke et al., 2013 Ghana	To identify the beliefs and perceptions associated with pregnancy and childbirth in Accra,	Qualitative research 35 mothers who delivered in the last 12 months 17	—	Women utilise multiple forms of care for protection during pregnancy and childbirth	✓			✓	**Belief**: The interpretation of complications in pregnancy as a threat increases the use of different forms of maternity	**Interpersonal:** Families and friends influence pregnant women's decision regarding where to seek ANC Aunts are contacted first before choosing	Research studies that focus on the health seeking behaviour of HIV positive pregnant women

	Ghana	pregnant women community members 12 skilled healthcare personnel 5 local maternity service providers Purposive sampling method In-depth interview FGD							service Pregnant women are believed to be prone to spiritual attack Women believe they can be attacked by evil eye during pregnancy Herbal medicine makes people strong Pregnancy and childbirth are viewed as a natural and stressful process The perception of pregnancy as a threat increases fear and anxiety among pregnant women	where to seek ANC **Community:** Evil spirits are the cause of attacks in pregnancy Inability to deliver by themselves increases fear among pregnant women Women seek care from different sources for safety purposes There is a general perception that spiritual attack during pregnancy is as a result of previous action of the pregnant woman Spiritual protection is considered an important part of maternity care It is believed that doctors cannot	

									provide solutions to all problems in pregnancy Faith healing is a common practice in the community	
Kumbani et al., 2013 Malawi	To explore why women are encouraged to deliver at home in the presence of indigenous healthcare workers despite attending healthcare facility for ANC	QS 12 participants from 8 different villages Purposively Semi-structured interviews	—	The climatic season, sociocultural factors and attitude of skilled healthcare personnel deter women from delivering at health facility	✓			✓	**Belief:** The participants believe they don't have control over where to deliver the baby Indigenous health practitioner is believed to maintain a high level of confidentiality with information related to pregnancy or childbirth Women believe the pregnancy	**Individual:** Women attended antenatal clinic but chose to deliver at home because it started raining Women said they would like healthcare professionals to respect them Homebirth without complications increases the preference of delivery in the presence of indigenous healthcare workers **Community**:	To increase women's level of awareness about maternal and child health To increase women's level of understanding about pregnancy and childbirth There is a need to explore the various factors affecting utilisation of maternity service within this community

								could be attacked by witches Participants were comfortable with TBAs During certain periods of the year people are not available to support you when going to the hospital	TBA was closer to them than any other provider of maternity service Sometimes previous experience does not encourage women to deliver in the presence of a skilled healthcare personnel There is a preference for skilled healthcare personnel immediately after the onset of complications **Organisational:** Distance to the health facility deters women from delivering at the healthcare facility	
Shiferaw et al., 2013	To understand the reason women, prefer	Mixed method 29 participants (8 women	—	The majority of the women do not seek care from qualified healthcare	✓			✓	**Belief:** The belief was the primary reason for those who do not	**Individual:** There is a high preference for indigenous	Research that can aid the integration of indigenous healthcare

Ethiopia	Homebirths	who recently delivered, 8 partners, 7 community health workers, 2 TBAs, 4 nurses, 1 health officer, 1 obstetrician and 909 women took part in the survey} Purposively Interview FGD		professional					deliver in the health facility Women do not deliver in the hospital because it is neither important nor does it form part of the tradition Placenta should be buried after delivery Women who seek care from the skilled healthcare personnel undergo caesarean section Indigenous healthcare workers are the primary providers of	healthcare workers There is a high preference for home birth assisted by indigenous healthcare workers due to previous experience of the pregnant women **Interpersonal**: The significant members of the family promote homebirth The family members and neighbours contribute to women's decisions regarding where to seek care **Organisational:** Shortage of healthcare facilities contributes to the decision women make regarding pregnancy and	system with the formal healthcare system

									maternity service It is believed that TBAs support women throughout pregnancy Indigenous health workers were highly respected in the community	childbirth Distance to the health facility also impacts on women **Community**: There is preference for TBAs because they are sensitive about beliefs and practices associated with the region The expectation of the significant members of the family are met with the use of traditional healthcare workers There is no relationship between the indigenous healthcare worker and the skilled health professional working within the health facility	

Aborigo et al., 2014 Ghana	To identify the factors affecting health seeking behaviour	QS 90 participants (35 women who recently had a baby, 16 community heads, 8 TBAs, 13 skilled healthcare personnel and 18 heads of household) Purposively In-depth interview FGD	—	The sources of knowledge about the various signs and symptoms of complications in pregnancy impact on the choices women make regarding seeking ANC during pregnancy			✓	✓	Mothers are advised by close family members about where to seek care during pregnancy Mothers are also advised to use both orthodox and non-orthodox medicine for obstetric complications To utilise herbal treatment for the management of certain obstetric complications	**Interpersonal:** Significant members of the family recommend the use of herbal medicine for the management of some complications in pregnancy	To integrate the indigenous beliefs and practices into the existing maternal healthcare strategic plans
Atekyereza & Mubiru, 2014 Uganda	To explore the beliefs associated with the health Seeking	Case study 45 participants (mothers and	—	The social perception of women impacts on their healthcare choices	✓		✓		**Belief:** The beliefs associated with pregnancy were passed down to them from	**Individual**: Women initiate ANC during the second and third trimester Women are	Research on the integration of beliefs and practices into the medical healthcare

	behaviour of women within the reproductive age group	expectant mothers) Purposively Interview FGD		regarding where and when to seek ANC				previous generations The various customs associated with pregnancy are needed for the protection of pregnancy The perception of pregnancy as a source of joy encourages people to seek ANC Pregnancy is viewed as a normal physiological process Cultural values define the perception of the woman To consume herbal medicine	motivated to become pregnant because of their beliefs **Community**: The patriarchal nature of society affects the behaviour pattern of pregnant woman	system

								in order to protect pregnancy		
Morris et al., 2014 Madagascar	To explore practices, beliefs and traditions associated with pregnancy, childbirth, and postpartum period	Mixed method 256 pregnant mothers of young children, community members and healthcare stake holders 373 women within the reproductive age group used for QS Purposive and random sampling method	—	The identification of the indigenous traditional health beliefs and practices impact on women's health seeking behaviour during pregnancy, childbirth, and postnatal period Interventions targeted at improving maternal healthcare should be contextually appropriate		✓		✓	**Practice:** To visit local midwives when pregnant Using herbs given to them by the local midwife Consuming herbs to speed up delivery Pregnancy is not disclosed to anyone except members of the family Women choose to deliver at home because it is convenient Women do not deliver in the hospital	**Community:** Pregnancy-associated illness is perceived as traditional and not biomedical	Maternal healthcare stakeholders should ensure that community healthcare stakeholders are included in the development of strategies for the community members Policy makers need to be knowledgeable about the sociocultural factors affecting the women

		Interview FGD							because of bad news they have heard about hospital setting Delivery with the local midwife is seen as being more convenient and cost effective **Belief:** Husbands who do not support their partner or wife during pregnancy are not allowed to be involved in the delivery of the child – the presence of the husband may delay the delivery of the baby Complications during pregnancy or		

									childbirth is perceived as the outcome of rivalry or an unsettled feud with a member of the family or an outsider who is not a member of the family It is believed that there is a high risk of being harmed through curses or poison when pregnant Haemorrhage is classified as a curse or poison that is treated with herbal drinks **Norm:** Fear of witchcraft is common among women in the		

								community		
Roro et al. 2014 Ethiopia	To explore the factors contributing to non-utilisation of healthcare facility for childbirth in south central Ethiopia	QS 81 participants (women who recently delivered, partners of the selected mothers, other people living in the community and providers of maternity service within the area) — FGD	—	The main factors contributing to low utilisation of the service of skilled healthcare personnel are centred around the pregnant woman and the healthcare professional	✓	✓		✓	**Belief:** Every woman who seeks care from skilled healthcare personnel in a health facility ends up undergoing caesarean section Women believe in divine support from God It is only God that knows the outcome of every pregnancy, the healthcare professional only cares	**Individual:** They do not associate any benefit with the services provided by skilled healthcare personnel There is a preference for a special prayer to God Women are not comfortable delivering in the presence of a skilled healthcare personnel **Interpersonal**: When utilising the health facility for delivery, the significant members of the family or friends are not allowed to be present whereas when women deliver with the indigenous health practitioner,	More research about the quality of maternity services provided by skilled healthcare personnel

									Seeking care from indigenous healthcare provider is a norm Homebirth is a tradition that was passed down from previous generations **Practice:** The husband as the head of the family makes decisions about where to seek care during pregnancy and	family members or friends can stay to provide psychological support The members of the community do not perceive home birth to be risky behaviour **Organisational:** Distance to the health facility affects women's choices regarding childbirth	

								childbirth Members of the community rely on indigenous health care workers for maternity care		

									Women only go to the hospital when the mother or baby is at risk Traditional healthcare workers are highly trusted by the members of the community Women with previous childbirth experience tend to have homebirths: new mums prefer to give birth in the health facility		

Ayotunde et al., 2015 Nigeria	To examine the influence of women's knowledge about the risk associated with obstetric complications on maternal health seeking behaviour	Cross-sectional survey 16,610 participants from 2013 demographic health survey — —	—	Non-delivery in the presence of a skilled healthcare personnel contributes to the rate of maternal death within the region		✓	✓		**Practice:** To seek ANC from unskilled healthcare personnel	**Individual:** The level of knowledge about obstetric complications affects women's choices regarding where to seek care during pregnancy and childbirth **Interpersonal**: Husband's level of education also has an impact on the decision of where to seek maternity care	Develop strategies that will aid the utilisation of maternal healthcare services among women in rural areas To explore factors that prevent the utilisation of modern maternal healthcare services
Ganle et al., 2015 Ghana	To identify the factors affecting the utilisation of maternal healthcare services	QS 94 Muslim women Purposive and simple random selection technique FGD	Religio-cultural Framework	There is a preference for delivery in the presence of a skilled health personnel, but religious beliefs hinder the choices of pregnant women		✓		✓	**Practice**: Women lack the power to make decisions about their healthcare Husbands make decisions about the wife's maternity care To protect the body from	**Individual:** Lack of halal meals affects women's choices **Interpersonal:** Mothers-in-law and husbands have a significant influence on women's choices **Community:** Skilled healthcare	To address some of the factors affecting the Muslim women seeking care

		Interview						males, particularly those they are not related to them There is a preference for a female skilled healthcare professional	personnel do not understand the significance of halal meals	
Magadani et al., 2015 Vhavenda	To explore the cultural beliefs and practices of the Venda people	Qualitative research 5 pregnant women Non-probability purposive sampling method Unstructured Interview	—	Family members influence women's decisions regarding pregnancy and childbirth Pregnancy is a natural process Belief in spirits Patriarchy Significant others	✓	✓		✓	**Belief:** Illness in pregnancy is associated with evil spirits and other supernatural forces **Practice:** Herbal medicine is used to protect the baby from evil spirits Women need to engage in any form of exercise in order to have	**Interpersonal:** The mother-in-law play a crucial role regarding the choice of where to deliver the baby	More research to explore other cultural issues related to pregnancy and childbirth

									a small baby that can be easily delivered Food portions are controlled to avoid having a large baby that may be difficult to deliver Pregnant women are advised to avoid yellow fruits because they are believed to cause jaundice **Norm**: Women must heed to all advice from mother-in-law		
Mogawane et al., 2015 South	To identify the indigenous practices common	Qualitative 15 participants Non-probability	—	Indigenous practices are widely practiced by pregnant women, close	✓			✓	**Belief**: Indigenous beliefs are passed down from past	**Individual**: There is a strong connection with the ancestors	There is a need to train more healthcare workers about the beliefs and

Africa	among pregnant woman in Limpopo	purposive sampling method Unstructured Interview		family members and traditional healthcare practitioners					generations The outcome of pregnancy is linked with indigenous beliefs and practices Women believe they can be cursed by witchcraft Belief shapes the outcome of the pregnancy Pregnancy should be kept secret in order to protect the woman from witchcraft Immediately after conception some rituals are performed to protect the pregnancy from	**Community**: The elders of the family play a significant role in the implementation of indigenous practices Churches also protect woman from evil spirits Neighbours and members of the family can also influence women's choices	practices in pregnancy and childbirth

								evil spirits The traditional health practitioner allows the performance of rituals for the protection of the baby after childbirth		
M'soka et al., 2015 Zambia	To examine the beliefs and practices associated with pregnancy	Descriptive cross-sectional survey 294 participants Systematic sampling Questionnaire	—	Women hold numerous beliefs about pregnancy and childbirth	✓			✓	**Belief:** Quarrelling with people leads to pregnancy complications Being unfaithful to one's husband can lead to obstruction of labour The use of herbal medicine can speed up delivery **Practice**:	**Individual:** Some of the beliefs create tension if not adhered to by the pregnant woman	Research to show the relationship between health beliefs and scientific evidence To provide more information about beliefs and practices

								Use of traditional herbs after miscarriage is necessary for the prevention of illness within the family Standing in doorway could lead to obstructed labour		
Solanke et al., 2015 Nigeria	To examine the relationship between religious belief and maternal health seeking behaviour	Survey 38,948 participants from the 2013 demographic health survey — —	F	Religion is part of the factors that influence women's choices regarding where to seek care during pregnancy and childbirth	✓		✓		**Belief:** Religious belief determines women's choice regarding where to seek care Homebirth is the most preferred among women within the region	**Individual:** Social status contributes to low utilisation of ANC Lack of ability to make decisions about maternity care affect the choices of where to seek care	To involve religious organisation in the development of polices/strategies for maternal health seeking behaviour

Caulifield et al., 2016 Kenya	To identify the socio-demographic and cultural factors affecting the choice of the place of delivery among the pastoralist women	Qualitative research 7 skilled birth attendants 8 key informants 4 TBAs 3 community health workers 10 women who delivered in the last two years 2 husbands of women who delivered in the last two years — Semi-structured interviews	—	Pastoralist women deliver their baby at home due to various factors related to socio-demographic and cultural factors	✓	✓		✓	**Practice**: Distance to the health facility deters pastoralist women from delivering at healthcare facilities Poor transportation contributes to women's decisions in seeking healthcare from traditional midwife Some women choose to deliver at home due to the negative attitude of healthcare workers **Belief**: Delivery is	**Individual:** Previous abuse from skilled healthcare personnel contributes to women's decisions to deliver at home without the support of skilled healthcare personnel Delivery in the presence of skilled healthcare personnel is associated with women who are educated; delivery in the presence of unskilled healthcare personnel is associated with uneducated women When a woman is sick during pregnancy, her husband does not allow her to go to hospital **Community**:	Research should also focus on identifying context-specific reasons for the choice of the place of delivery among women in other parts of the world

									believed to take place quickly in a conducive environment If a pregnant woman becomes sick, the husband is advised to kill an animal, e.g., when a woman is bleeding, a goat is killed for meat and blood Home birth allows blood loss during childbirth to be preserved for other uses later Women deliver unassisted to protect the baby from evil eye: this group is classified as brave	The experience of poor transportation increases women's adherence to traditional practices Women prefer to deliver in the presence of the TBA, because they have an existing relationship with them	

									It is part of tradition to seek care from TBA Delivering a child at home is a tradition **Others**: Women prefer to deliver at home or in the presence of a local midwife who is untrained because their bodies are not fully exposed during delivery Being naked during delivery is associated with facility-based delivery, perceived as a shameful act by women		

Munguambe et al., 2016 Mozambique	To identify the underlying sociocultural factors affecting the utilization of ANC	ES 209 participants (women within the reproductive age group, mothers, mothers-in-law, partners of selected women, nurses, midwives, medical assistants, matrons, and traditional healthcare workers) — In-depth interviews FGD	—	Women patronise different forms of service provider during pregnancy		✓	✓		**Practice:** Herbal medicine is available for the treatment of illness in pregnancy Pregnant women only seek care from qualified healthcare personnel when they are sick The traditional healthcare worker is the first point of contact for pregnant women within the community Husbands discourage their partners from seeking care when the pregnancy is considered too	**Individual**: The significant members of the family advise pregnant women on the use of herbal medicine A pregnant woman needs the permission of her partner before attending the first antenatal visit Women lack the financial capacity to procure ANC themselves **Community:** Healthcare workers do not encourage women to have homebirth Neighbours make decision on behalf of the husband	There is a need for the development of strategies that will aid integration of the local healthcare system with the formal healthcare system

								small to be discouraged		
Roberts et al., 2016 Malawi	To identify the beliefs and practices that may influence women's choice regarding where to seek ANC	Qualitative descriptive research 20 pregnant mothers 8 healthcare professionals Purposive sampling method In depth interviews	—	Beliefs and practices influence the time to seek ANC	✓			✓	**Belief:** One does not need to commence ANC until the second trimester, when the baby is believed to be matured Pregnancy must not be announced if it is not visible It is inappropriate to disclose pregnancy until a certain period Disclosing information about the pregnancy early could lead to complications	**Individual:** Women should not seek ANC during certain period to prevent miscarriage Both the healthcare worker and the pregnant women believe that pregnancy should not be disclosed until the second trimester The significant members of the family are the first set of people that advice women about pregnancy and child Some women do not attend ANC or seek care from skilled healthcare personnel because of lack of support from the	Future research should focus on beliefs and practices associated with maternal healthcare in other regions within sub-Saharan Africa

									The church can proffer solutions to problems Women also belief that one does not need to seek care from the hospital, except when one is sick Traditional healthcare workers are the only provider of maternity service who can protect the pregnant woman from evil spirits Visit to the skilled healthcare personnel is always reserved for illness	husband **Community:** Women seek care from local midwives before the professional healthcare staff working in the hospital The advice of the significant members of the family sometimes overrules the advice given to the pregnant woman by the skilled healthcare personnel	

Ariyo et al., 2017 Nigeria	To identify the sociocultural factors contributing to maternal mortality	Retrospective study 38,948 participants from the 2013 demographic health survey — Questionnaire	McCarthy framework for the determinants of maternal deaths	Religious belief and community factors contribute to high maternal death	✓			✓	**Belief:** Religious belief is identified as part of the factors affecting maternal mortality	**Individual:** Level of education, financial capability, and level of autonomy The level of education of members of the community	The implementation of SDG should encompass the needs of women within the rural parts of the country
Kifle et al. 2017 Ethiopia	To assess the maternal healthcare seeking behaviour of women in Haramaya district in East Ethiopia	Community based cross-sectional study supplemented with QS 561 women within the reproductive age group who gave birth in the last 2 years Multistage sampling technique	—	Attendance at postnatal healthcare services is relatively low The rate of utilisation of ANC declines as the childbirth experience increases	✓		✓		**Belief:** Pregnancy is viewed as a natural process Religion affects women's choice regarding where to receive maternal healthcare during pregnancy Women deliver kneeling down	**Individual:** Level of education affects utilisation of ANC Women do not attend ANC unless there they are ill Women prefer a female health practitioner to a male Previous experience discourages women from attending ANC Women do not feel comfortable	More studies to focus on identifying the role of husbands with regards to maternal healthcare services

		Purposive sampling In-depth interviews FGD							delivering in the hospital because they are only allowed to sleep on the bed for delivery	
Aziato & Omenyo, 2018 Ghana	To identify the beliefs associated with pregnancy and childbirth	Exploratory QS 16 participants Purposive sampling method In-depth interviews	—	Family members play a crucial role in the initiation of TBA Spiritual beliefs and practices guide the decision of the indigenous maternal health care provider	✓			✓	**Belief:** Information about the traditional practice is passed down from previous generous Only family members can provide indigenous healthcare provider with information about traditional practices and spiritual beliefs Prolonged labour is	**Individual:** Rituals for childbirth are performed based on beliefs and practices **Community:** There are centres within the area where prayers are offered for the safety of the pregnant woman	There is a need for a collaboration between skilled healthcare personnel and indigenous healthcare providers

									categorised as a spiritual attack where the foetus is believed to be locked in the womb Obstructed labour is associated with infidelity Herbal medicine is used for the care of pregnant women Spiritual practices are included in the care provided by indigenous healthcare practitioners because pregnant women are prone to attacks from evil spirits		

Esegbona-Adeigbe, 2018 Black Africans in the UK	To identify the beliefs and practices affecting ANC	Review 16 studies	—	Beliefs and practices affect the health seeking behaviour of Black African women in the UK	✓	✓		✓	**Belief:** Affects rate of attendance at ANC	**Community:** Individual beliefs affect the rate of utilisation of ANC	ANC services should include elements of the cultural needs of the women receiving care
Ibrhim et al., 2018 Ethiopia	To describe why there is high preference for home birth among women in Afar, Ethiopia	QS 210 participants (60 mothers, 48 grandmothers, 54 religious leaders, 6 district health officers, 6 head of women's affairs, 12 TBAs) Purposively Semi-structured	—	Women lack the knowledge about the merits associated with the utilisation of skilled healthcare professionals	✓			✓	**Belief:** Pregnancy and childbirth is a natural physiological process that does not need any form of intervention Delivering in hospital with the support of a skilled healthcare personnel does not prevent maternal death The tradition is to deliver at home with the	**Individual:** Lack understanding about the health facility available within the region of Afar Due to their pastoralist way of life, they only use what is available when they fall into labour **Community:** Lack of information about the various maternity services available for women within the region The health facility is	Quantitative research that will focus on describing the reason for the low utilisation of maternal healthcare services among women in pastoralist communities

		interviews FGD							support of family and friends It is a tradition that was passed down from their mother	not suitable for nomadic farmers, who are always moving from one place to the other During certain period of the year, the needs of the members of the community change, e.g. during drought husbands experience loss of cattle and other resources and thus move to other places in search of new grazing Distance to the health facility also affect women's choices regarding where to seek care during pregnancy Members of the community do not trust the skilled healthcare	

									professional	
Kea et al., 2018 Ethiopia	To identify factors affecting the utilisation of maternal healthcare services at primary healthcare unit in rural communities in South Ethiopia	Explorative QS 18 health extension workers, 6 women, 2 men, 12 pregnant women or women who delivered recently, 6 TBAs, 3 administrators, 6 leaders within the labour room department, 3 health extension worker coordinators, 1 zonal health department coordinator,	Three delays model	Indigenous beliefs affect the utilisation of maternal healthcare services Women visit the TBA because of a pre-existing relationship Lack of the ability to make decisions regarding the choice of maternal healthcare contributes to the delay in seeking maternal healthcare services Religious belief	✓			✓	To conceal information about pregnancy during its early stages' forms part of the common tradition among women in south Ethiopia Homebirth is also a tradition in this community It is customary to bury the placenta at home after childbirth Complication in pregnancy is the primary reason why some women seek care from	**Individual:** Some individuals are not knowledgeable about the benefits associated with the utilisation of maternal healthcare services Lack of existing relationship with the healthcare worker hinders some women from seeking healthcare from qualified healthcare personnel **Interpersonal**: Members of the family influence the choices women make regarding where to seek ANC **Organisational:** The geographical location of the women affects	Local healthcare stakeholders should focus on improving the quality of maternal healthcare services in the area Research findings should also be integrated into the healthcare system at the early stage of the intervention

		1 regional health Coordinator Purposive sampling method Interviews FGD							qualified healthcare personnel Women believe they are safer at home than in the hospital environment Belief in God for divine protection of the mother and baby encourages women to deliver at home	access to the healthcare facility Lack of a functioning healthcare facility within the region affects women's choices regarding where to seek maternity care	
Sumankuuro et al., 2018 Ghana	To identify the factors affecting the utilisation of ANC	Mixed method 330 participants (80 expectant mothers, 13 skilled healthcare professionals and 240	MET	Indigenous belief and practices contribute to the delay in seeking maternal healthcare	✓			✓	**Belief:** Losing pregnancy is sometimes attributed to non-performance of ritual Commence ANC very late in	**Interpersonal:** Lack of support from family members contributes to the non-utilisation of ANC	Further research into the beliefs affecting the utilisation of ANC

		community members) Purposively FGD In-depth interviews						pregnancy Commence ANC after spiritual cleansing Pregnancy information is not revealed early Preference of the use of indigenous traditional practice Bury placenta after childbirth		
Ababor et al., 2019 Ethiopia	To identify sociocultural factors affecting childbirth and its effect on the use of skilled healthcare professionals	QS 108 participants (women who gave birth in the 36 months prior to the study, health extension	—	The value associated with indigenous practice influences the decision to deliver in the presence of a skilled healthcare personnel	✓			✓	**Belief:** Indigenous healthcare workers have vast amount of experience about pregnancy and childbirth Homebirth is a culture that is	**Community:** There are some essentials rituals that are needed for the protection of the baby from evil spirits Healthcare facilities do not support the performance of rituals needed by the	Studies that will focus on the various approaches to encouraging institutional deliveries

		workers, community leaders, TBAs, social mobilisers, and relevant government representatives) Purposive sampling method FGD Interviews							passed down from previous generations Preference for a female skilled professional during childbirth **Values:** Home birth in the presence of unskilled healthcare personnel is preferred to other forms of maternity service **Practice**: The acceptable delivery position in the hospital is not acceptable to the women due to their tradition	pregnant woman	

4.4 Appraisal of the Selected Studies

The articles selected for review were appraised using the CASP evaluation tool. It is essential to appraise journal articles in order to validate research evidence (Aishafey, 2005). The key areas covered were geography, study type, study participants, and analysis of the results of the review.

4.4.1 Geography

The journal articles retrieved from the search of the literature covered more than 15 countries: Zimbabwe, Ghana, Ethiopia, Malawi, South Africa, Liberia, Tanzania, Malawi, Uganda, Madagascar, Vhavenda, Zambia, Kenya, Mozambique and Nigeria (Ababor et al., 2019; Abor et al., 2011; Abongo et al., 2014; Abor et al., 2011; Ariyo et al, 2017; Ayotunde et al., 2015; Aziato & Omenyo, 2018; Caulifield et al., 2016; Dayo-Gyeke et al., 2013; du Preez, 2012; Farnes et al., 2011; Ganle et al., 2015; Ibrhim et al., 2018; Jansen, 2006; Kea et al., 2018; Kifle et al., 2017; Kumbani et al., 2013; Lori & Boyle, 2011; Marchie & Anyanwu, 2009; Magadani et al., 2015; Mat hole et al., 2004; Mboho et al., 2013; Mogawane et al., 2015; Morris et al., 2014; M'soka et al., 2015; Muguambe et al., 2016; Myer & Harrison, 2010; Ngomane & Malaudzi, 2012; Pfeiffer & Mwaipopo, 2013; Roberts et al., 2016 ; Roro et al., 2014; Seljeskog et al., 2006; Shiferawu et al., 2013; Solanke et al., 2015; Sumankuuro et al., 2018 Warren, 2010; Woldemicael, 2009).

All the articles selected for the review were conducted in sub-Saharan Africa. This region was selected because research has shown that the rate of maternal death is high and the region accounts for two-thirds of the global maternal death rate (Brighton et al., 2013; WHO, 2019). Furthermore, sub-Saharan Africa still has the lowest mortality reduction rate when compared with other countries. A total of 19 of the 20 countries with the highest rates of maternal mortality are in sub-Saharan Africa (Alvarez et al., 2009). Presently, the annual rate of maternal death within the region is estimated as 2.9% – a figure that is less than half of what is required to achieve the set goal of 70 maternal deaths per 100,000 live births, as stated in goal three of the SDG (UN, 2019). Although the rate of maternal mortality is also high within South Asia, sub-Saharan Africa accounts for the highest global rate of maternal death, and Nigeria as a country located in West Africa accounts for 20% of

global maternal deaths (UN, 2019). Clearly, as this study is set in Nigeria (within sub-Saharan Africa), it is appropriate to restrict the focus of the review to studies that have been undertaken in this area.

One of the articles included in the review was not conducted in sub-Saharan Africa but was included because the study participants were Black African women living in the UK who had been categorised as being at greatest risk of maternal death – partially attributed to poor or low utilisation of ANC services as a result of the influence of cultural factors on the women's ANC choices (Eseigbona-Adeigbe, 2018). This study was also included in the review for its exploration of the experiences of women with background knowledge about countries with poor maternal health indexes (Eseigbona-Adeigbe, 2018).

Research has shown that the low rate of utilisation of ANC increases the risk of complications experienced by women seeking maternity care (Alvarez et al., 2009; Mboho et al., 2013). While women are encouraged to complete the required number of antenatal visit and deliver in the presence of a skilled healthcare practitioner (Farnes et al., 2011; Lori & Boyle, 2011), the literature has identified numerous factors (economic, sociological, geographical, and other associated underlying factors) which hinder the utilisation of ANC (Ariyo et al., 2017; du Preez, 2012; Ganle et al., 2015; Magadani et al., 2015).

Different strategies have been implemented to tackle the rate of maternal death and increase the rate of attendance at antenatal clinics, yet the set target has not been met, and women are still not delivering in the presence of skilled healthcare personnel. Since research has shown that a single intervention cannot be used to improve maternal health, increase the rate of attendance at ANC, and reduce the rate of maternal death (Alvarez et al., 2009), it is of paramount importance to identify other associated factors that shape women's decisions about where to seek care during pregnancy

4.4.2 Study Type

All the studies included were written in English; none were translations. Although the selected articles have different aims and objectives, they all focus on factors affecting women's health seeking behaviour during the perinatal period. A total of 40 studies were identified from the literature search: 26 were qualitative studies (Ababor et al., 2019.,

Abongo et al., 2014; Abor et al., 2011; Aziato & Omenyo, 2018; Caulified et al., 2016; Dayo-Gyeke et al., 2013; du Preez, 2012; Farnes et al., 2011; Ganle et al., 2015; Ibrhim et al., 2018; Jansen, 2006; Kea et al., 2018; Kifle et al., 2017; Kumbani et al., 2013; Lori & Boyle, 2011; Magadani et al., 2015; Mathole et al., 2004; Mboho et al., 2013; Mogawane et al., 2015; Muguambe et al., 2016; Myer & Harrison, 2010; Ngomane & Malaudzi, 2012; Roberts et al., 2016; Roro et al., 2014; Seljeskog et al., 2006; Warren, 2010), four were mixed-method studies (Crockett & Wang, 2018; Morris et al., 2014; Pfeiffer & Mwaipopo, 2013; Shiferaw et al., 2013), five were descriptive studies (Kumbani et al., 2013; Magadani et al., 2015; Marchie & Anyanwu, 2009; Mogawane et al., 2015; Roberts et al., 2016), three were cross-sectional surveys (Ayotunde et al., 2015; Kifle et al., 2017; M'soka et al., 2015), two were systematic reviews (Brighton et al., 2013; Esegbona-Adeigbe, 2018), four were ethnographic studies (Farnes et al., 2011; Jansen, 2006; Mboho et al., 2013; Muguambe et al., 2016) and one was a retrospective study (Ariyo et al., 2017).

Three out of the five selected studies carried out in Nigeria were conducted using secondary data from demographic health surveys (Ayotunde et al., 2015; Marchie & Anyanwu, 2009; Solanke et al., 2015). Methodological issues associated with the articles will be discussed because this research is conducted in Nigeria. Research has shown that data collected for retrospective studies were obtained for other purposes and not research per se. It also records an existing outcome unlike prospective studies that look forward to outcomes. The sources of data for retrospective studies are existing databases such as admission notes, discharge notes, nursing notes, doctor's record, or the medical records of a patient (Gearing et al., 2006; Suchmacher & Geller, 2012). However, the approach of retrospective studies has been undervalued due to its limitation, which includes the lack of ability to recover some information (Gearing et al., 2006). Although the information obtained through retrospective study can be used for quality assessment and professional development, researchers have at times had trouble interpreting parts of information obtained (Gearing et al., 2006; Pan et al., 2005) and, as such, it is imperative to carry out more research within the region that is not retrospective.

Research has also shown that retrospective studies are less costly to carry out than prospective studies (Tofthagen, 2012). In a country like Nigeria, such studies may be missing

out crucial information due to poor data management systems. This failing is evidenced in recent descriptions of the health information system in Nigeria, in which various authors highlight a lack of communication between the different health information systems facilities across the country. Therefore, current documentation may not be reliable data for estimating the maternal death index in a region with high maternal death (Welcome, 2011; Meribole et al., 2018; Nwakwo & Sambo, 2018). Likewise, in rural areas, where most deaths occur in Nigeria, there is also poor management of health records; this has been attributed to low levels of knowledge about data management systems (Nwakwo & Sambo, 2018).

4.4.3 Study Participants

All the participants in the reviewed studies consisted of both maternal healthcare service providers and the clients receiving the care provided. The study participants were mostly women, since they were the primary receivers of maternity care, except for those studies that included male participants with roles as partner, husband, father-in-law or a significant other (Caulifield et al., 2016; Culhane-Pera et al., 2015; Kea et al., 2018; Lori & Boyle, 2011; Mboho et al., 2013; Roro et al., 2014; Shiferaw et al., 2013).

There was also slight variation due to some studies including mothers who had recently delivered (Ababor et al., 2019; Aborigo et al., 2014; Caulifield et al., 2016; Dayo-Gyeke et al., 2013; Jansen, 2006; Kea et al., 2018; Kifle et al., 2017; Roro et al., 2014; Seljeskog et al., 2006; Shiferaw et al., 2013; Warren, 2010), while other studies did not specify the characteristics of the women included. These women were either not classified as having recently delivered, or they were classified as family members (Abor et al., 2011; Ariyo et al., 2017; Atekyereza & Mubiru, 2014; du Preez, 2012; Ibrhim et al., 2018; Kumbani et al., 2013; Lori & Boyle, 2011; Marchie & Anyanwu, 2009; Mathole et al., 2004; Mboho et al., 2013; Morris et al., 2014; M'soka et al., 2015; Munguambe et al., 2016; Myer & Harrison, 2010; Ngomane & Malaudzi, 2012; Solanke et al., 2015). Some studies included pregnant women as participants: (Magadani et al., 2015; Mogawane et al., 2015; Morris et al., 2014; Roberts et al., 2016; Sumankuuro et al., 2018). While one study focused specifically on a group of people with similar beliefs (Ganle et al., 2015). The largest number of maternity service providers included in the reviews were the TBAs as illustrated in the following

articles: (Ababor et al., 2019; Abongo et al., 2014; Aziato & Omenyo, 2018; Caulifield et al., 2016; du Preez, 2012; Ibrhim et al., 2018; Jansen, 2006; Kea et al., 2018; Mboho et al., 2013; Munguambe et al., 2016; Shiferaw et al., 2013; Warren, 2010). Some authors included other maternal service providers such as health extension workers, skilled healthcare professionals, health extension worker coordinators, district health officers, midwives, nurses, medical assistants, matrons and health officers (Ababor et al., 2019; Aborigo et al., 2014; Caulifield et al., 2016; Dako-Gyeke et al., 2013; Ibrhim et al., 2018; Kea et al., 2018; Mboho et al., 2013; Morris et al., 2014; Munguambe et al., 2016; Roberts et al., 2016; Roro et al., 2014; Shiferaw et al., 2013; Sumankuuro et al., 2018; Warren, 2010).

It is to be noted that none of the studies included spiritualists or herbalists as participants. It is, therefore, imperative to explore the role of herbalists and spiritualists along with pregnant women being the consumers of maternity service in a community like Ota. Their role cannot be disregarded when their interpretations of some illnesses in pregnancy ascribe such conditions as a threat to pregnancy, clearly impacting on the behaviour of women seeking care. This research has emphasised in previous chapters the need to explore the contribution of this group of maternal health providers because some women depend on this form of maternity service (Iyaniwura & Yussuf, 2009). It is also important to consider how spirituality affects the provision of maternity services, for it is a factor contributing to the low utilisation of ANC and its expression in certain practices is prevalent in prayer houses and mission homes (Adanikin et al., 2014).

4.4.4 Analysis and Synthesis

The search strategy implemented in this research focused on identifying journal articles with information on different indigenous practices affecting women during the perinatal period in sub-Saharan Africa. A total of 40 articles that directly or indirectly illustrate the association of indigenous practices on maternal health was retrieved. Table 4.3 summarises the total number of articles that focus on cultural factors affecting the utilisation of maternal healthcare services during the perinatal period. This will be analysed critically using four different elements of the SEM as follows: individual-level factors, interpersonal-level factors, organisational-level factors, and community-level factors.

4.4.4.1 Individual-Level Factors in Relation to Health Seeking Behaviour

The individual-level factors are the characteristics of an individual that can influence behaviour (Adu et al., 2018). They include factors such as an individual's level of education, age and financial capability; these factors are intrapersonal to the individual because of their nature (Abbaor et al., 2019; Abor et al., 2011; Ariyo et al., 2017; Atekyereza & Mubiru, 2014; Ayotunde et al., 2015; Aziato & Omenyo, 2018; Brighton et al., 2013; du Preez, 2012; Ganle et al., 2015; Golden & Earp, 2012; Ibrhim et al., 2018; Kea et al., 2018; Kifle et al., 2017; Kumbani et al., 2013; Lori & Boyle, 2011; M'soka et al., 2015; Mathole et al., 2004; Mogawane et al., 2015; Munguambe et al., 2016; Myer & Harrison 2010; Ngomane & Malaudzi, 2012; Pfeiffer & Mwaipopo, 2013; Roberts et al., 2016; Roro et al., 2014; Seljeskog et al., 2006; Shiferaw et al., 2013;Solanke et al., 2015; Ugwa, 2016; Warren, 2010; Woldemicael, 2009). A good illustration is the impact of maternal age and maternal level of education on women's choices regarding where to seek ANC (Abor et al., 2011; Marchie & Anyanwu, 2009; Mathole et al., 2004; Myer & Harrison, 2010; Ugwa, 2016; Warren, 2010). The financial capability of the woman can also limit the choice of where she receives care during pregnancy due to the cost of healthcare services (Munguambe et al., 2016; Woldemicael, 2009).

4.4.4.2 Maternal Age as an Individual-Level Factor

Maternal age is an individual-level factor that affects women's choices regarding where to seek ANC (Abosse et al., 2013). Age has been described as a critical factor that determines a woman's ability to make decisions regarding her healthcare (Ariyo et al., 2017; Brighton et al., 2013; Evans, 2013; Ganle et al., 2015). Although things are changing, not all women are able to make decisions about their healthcare due to norms and stereotypes that are transferred in the form of cultural beliefs and practices from one generation to the next (Ganle et al., 2015; Mathole et al., 2004).

Some adolescent pregnant women are not able to make decisions regarding their health due to their age. This is significant when one considers that pregnancy in adolescence (between the ages of 10 and 19) is estimated to comprise one-tenth of all pregnancies globally, with over 90% occurring in developing countries (Doctor, 2011; Gross et al., 2012; Kassa et al., 2018). This ties in with the ideas of some researchers who categorised age as a

demographic factor for health behaviour (Dunlop et al., 2018). According to such research, rich, young, and educated people with an elevated level of social support have a higher chance of engaging in behaviours that will enhance their health, whereas children from poor backgrounds and who lack social support are more likely to engage in behaviours that may compromise their health (Dunlop et al., 2018).

Older women with high parity are considered more likely to deliver at home, unassisted or in the presence of unskilled healthcare personnel, because they have enhanced experience of childbirth and labour (Moyer & Mustapha, 2013). However, it is also argued that there is no significant relationship between age and the utilisation of ANC, but that it is the socio-economic factors that are the significant determinants of women's decisions to seek ANC (Ndidi & Oseremen, 2010). It is further argued that age may not be a medical cause of maternal mortality, but that it is an underlying factor that determines the decision women make regarding ANC choices (Ganle et al., 2015). Decisions may be hindered by age due to norms and values within a community wherein significant others within the family make the decision on behalf of young pregnant women (Marchie & Anyanwu, 2009). Decisions are, therefore, made with respect to family traditions and values; the families of young pregnant women are the external loci that control the decision of teenagers. Their health seeking behaviour is thus based on the advice from other individuals (Yakubu & Salisu, 2018; Mekonen et al., 2019). The response is subjective to an extent, since the decision to get married early is sometimes the choice of the parent and, culturally, children are expected to obey their parents irrespective of the kind of decision they are making. The child is expected to obey without questioning a parent's actions (Ariyo et al., 2017). A female child in Nigeria may, therefore, lack the ability to question her parents' decision.

Some authors are of the opinion that such decisions regarding early marriage can be attributed to poverty because parents may believe that encouraging their young daughter to get married early increases their chances of acquiring part of the inheritance of their son-in-law (Igberase et al., 2009). This way of life may be linked to the economic state of the nation, which somewhat subjects' people to view marriage as a tool for the survival of the entire family (Igberase et al., 2009; Marchie & Anyanwu, 2009). Despite any associated

benefit with early marriage, the girl's education is affected because she will have to drop out of school (Nour, 2006; Ujah et al., 2017). However, the financial status of a girl in such a scenario is likely to improve, depending on the level of poverty within the family. Still, the young woman is at risk of death during childbirth due to the complications associated with early childbearing in low-resource nations (Salami et al., 2014; Yaya et al., 2019). This could be avoided if high-quality maternal healthcare were available; in some well-resourced nations, where there is also a high rate of early childbearing among young adults, all the necessary support for reducing the risk associated with such pregnancy is provided (Kim et al., 2014). The risk of death among young mothers during childbirth in industrialised nations is thus reduced when compared with their counterparts in low-resource nations such as Nigeria (Darroch et al., 2001; Gaudie et al., 2010). Therefore, age can be classified as a compounding factor that predisposes the woman to a high-risk pregnancy because of the decision regarding her care during pregnancy, part of which is based on the cultural beliefs and practices of the people within the area. Age and potentially related levels of education may, therefore, culturally limit a young pregnant woman's ability to make decisions regarding her health seeking behaviour.

4.4.4.3 Level of Finance as an Individual-Level Factor

Financial cost is a crucial factor that affects the demand for maternal healthcare services (Kalu-Umeh et al., 2013; Munguambe et al., 2016; Olonade et al., 2019; Woldemicael, 2009). There is a huge variation in the cost of healthcare among the various providers of maternity services in Nigeria. Costs are based on the location of the facility, the type of service provided, and the resources used for healthcare (Kalu-Umeh et al., 2013). Part of the cost associated with maternal healthcare service is the user fee (Babalola & Fatusi, 2009) which, research shows, affects the rate of utilisation of ANC, the time of booking and the rate of attendance at antenatal clinics (Kea et al., 2018; Munguambe et al., 2016).

In Nigeria, the financial capability of women may contribute to delays in seeking healthcare services (Akeju et al., 2016). In cases where some women or family members may be knowledgeable about the signs and symptoms of pregnancy complications, they might still lack the funds to procure healthcare services (Sambo et al., 2013). They,

therefore, rely on their husbands to provide the funds needed to procure maternal care services. Even in cases where a woman has the capability to procure services without financial assistance from her husband, she may still need to obtain permission from him before procuring the service (Aliyu & Dahiru, 2017; Lanre-Abass, 2008; Sambo et al., 2013).

The health seeking behaviour of a woman will be influenced by the cost of healthcare services because among different providers of maternity services within the same locality there are variations in costs (Amutah-Onukagba et al., 2017; Kalu-Umeh et al., 2013). Cost is important, but it is not the only factor women consider before seeking care, as evidenced in a study conducted in Nigeria where despite the availability of free maternal healthcare services in selected areas, 47% of women within the reproductive age group residing in those areas still did not receive ANC from qualified healthcare personnel (Emmanuel et al., 2013; NPC & ICF International, 2018). This was partly attributed to the levels of education and other cultural factors common to women in the area (Ntoimo et al., 2019).

The removal of the user fee is an evidenced-based approach that could be applied to help increase the rate of attendance at antenatal clinics in Nigeria (Edu et al., 2017; Okedo-Alex et al., 2019). As seen in Nepal, Bangladesh, Thailand, Ghana, Swaziland, Uganda, and South Africa, the removal of user fees increases attendance at antenatal clinic (Edu et al., 2017). Even in critical situations, when a woman is in pain due to complications associated with pregnancy, the pregnant woman and her family member consider the cost of healthcare along with other factors associated with healthcare before accepting a referral to other advanced medical facilities within the area. When incapable of paying for the service of the centre they are being referred to, women sometimes opt for a cheaper provider with hope and belief that a solution will be delivered (Kea et al., 2018).

4.4.5 Interpersonal-Level Factors in Relation to Health Seeking Behaviour

The interpersonal-level factors are factors which influence the woman as a member of a community. They include family traditions, mothers-in-law, and the influence of other significant members of the family on the woman (Aborigo et al., 2014; Brighton et al., 2013;

Dayo-Gyeke et al., 2013; du Preez, 2012; Evans, 2013; Jansen, 2006; Lori & Boyle, 2011; Mathole et al., 2004; Mboho et al., 2013; Ngomane & Malaudzi, 2012; Pfeiffer & Mwaipopo, 2013; Roro et al., 2014; Seljeskog et al., 2006; Shamaki & Buang, 2015; Shiferaw et al., 2013; Warren, 2010).

4.4.5.1 Mothers-in-Law

In different countries around the world the inter-relationship between daughters-in-law and other members of the family, such as mothers-in-law, sisters-in-law, and fathers-in-law, may affect a pregnant woman's healthcare choices (Akeju et al., 2016). The findings of a qualitative research conducted in Ghana, for instance, show how the relationship with her extended family members affected a woman's decisions regarding where to seek maternity care (Ganle et al., 2015). The study further indicates that mothers-in-law had the greatest ability to influence their daughters-in-law's decisions about healthcare choices (Ganle et al., 2015). Research has also shown that the mothers-in-law's perceptions of pregnancy as a natural process influences the form of advice they give to other women – in this case, their daughters-in-law (Akeju et al., 2016). This is because beliefs were passed down to them from their great grandmothers. A pregnant woman's choice over where to seek ANC is, therefore, affected by what they have been told by their family members (Lori & Boyle, 2011).

Furthermore, the elders of the family are highly respected, and it is a norm to obey their orders because they are held in high esteem; women believe that if they do not adhere to their orders, any complications arising during pregnancy or labour will be blamed on such transgression (Magadani et al., 2015). However, in a study conducted in two rural districts in Ghana, the influence of significant members of the family, such as mothers-in-law, was not categorised as part of the factors that act as barriers to ANC as some members of the family did not feel it was their responsibility to provide social support for the pregnant women (Sumankuuro et al., 2019).

The level of education attained by mothers-in-law is also part of the factors affecting their perceptions about pregnancy. Educated women and those of a high social class are observed as encouraging their daughters-in-law to seek care from qualified healthcare personnel, while uneducated mothers-in-law only support seeking care from skilled

healthcare personnel after the onset of pregnancy-related complications (Sumankuuro et al., 2019). In a country like Malawi, however, it is not the level of education that matters but the number of pregnancies, because women cannot initiate ANC until they have been permitted to do so by a husband – which is most often granted with a first pregnancy (Chimatiro et al., 2018).

4.4.5.2 Husband

The spouse or partner is categorised as a significant member of the family that influences a woman's decision regarding where to seek care during pregnancy (Adeniran et al., 2015; Akeju et al., 2016; Atekyereza & Mubiru, 2014; Ayotunde et al., 2015; Caulfield et al., 2016; Ganle et al., 2015; Munguambe et al., 2016; Pfeiffer & Mwaiopopo, 2013; Roberts et al., 2016; Shamaki & Buang, 2015; Warren, 2010). This has been attributed to the patriarchal nature of some societies (Atekyereza & Mubiru, 2014; du Preez, 2012; Lori & Boyle, 2011; Oguntunde et al., 2019; Pfeiffer & Mwaipopo, 2013; Warren, 2010). The impact of decision-making wielded by spouses is compounded by women's inability to afford the cost of maternal healthcare services and their attendant dependency on a husband for financial support (Akeju et al., 2016). In Nigeria, men are the main decision makers as evidenced in a qualitative study conducted among 112 participants in the northern part of the country (Adeniran et al., 2015). Likewise, a study conducted in south-western Nigeria also shows that the husband contributes significantly to women's choices regarding where to seek care during pregnancy (Akeju et al., 2016). The result of the study highlights that the participants needed the approval of their husbands before seeking care; therefore, the point in time at which a woman initiates care is determined by her husband, as her role within the family gives her only limited power to make decisions regarding her healthcare, (Akeju et al., 2016). It has also been argued that the level of education of the husband is the primary factor affecting his decision. This is because a well-educated man may be knowledgeable about the risks associated with pregnancy and why it is important to seek care early, while an uneducated man who lacks the basic knowledge about healthcare may only believe that a woman does not need to seek care unless she experiences a pregnancy-related complication (Fawole & Adeoye, 2015).

4.4.6 Organisational-Level Factor in Relation to Health Seeking Behaviour

The organisational level factor affecting healthcare services is centred around the facility providing free or paid services for people. One of the factors embedded within this level in relation to maternal healthcare services is the geographical location of the healthcare centre within the community (Kumbani et al., 2013; Pfeiffer & Mwaipopo, 2013; Shiferaw et al., 2013).

4.4.6.1 Geographical Location as an Organisational Factor

The distance between a health facility and where a woman resides affects accessibility to maternal healthcare; this is especially common in sub-Saharan Africa. It is a major factor affecting the uptake of maternity service, especially among women in rural areas (Kumbani et al., 2013; Shiferaw et al., 2013; Tanou & Kamya, 2019). Previous research conducted in Nigeria shows that there is inequality in the distribution of public health facilities, with more hospitals in towns and cities than in rural areas (Nwakeze & Ngianga-Bakwin, 2011). This disparity affects the rate of utilisation of healthcare services in rural and urban areas (Arthur, 2012). Another study concluded that hospitals located in urban areas have more human resources and infrastructure than hospitals located in rural areas (Ebuehi & Campbell, 2011). However, research conducted on the impact of transportation on healthcare behaviour shows that financial capability is a crucial factor impacting on women's behaviour towards ANC since all the activities involved in seeking healthcare require a certain amount of money (Ogunbodede, 2008). However, poor transportation and bad road conditions are the underlying factors that increase the cost of transportation. This, therefore, prevents some women from travelling to a health facility, since it is unaffordable (Onasoga et al., 2012). More recent research argued that women in Nigeria attend one antenatal visit but discontinue with the care due to the cost of transportation and distance to the maternity centre (Ajayi & Osikanle, 2013). Geographical location can, therefore, be classified as the second delay affecting the utilisation of antenatal healthcare services (Aliyu & Dahiru, 2017; Nour, 2006).

4.4.7 Community-Level Factor in Relation to Health Seeking Behaviour

The literature review shows that there are many different cultural practices across the world and that many of the elements of the SEM are affected by cultural norms, traditional practices and religious beliefs regarding pregnancy and childbirth (Ababor et al., 2019; Caulifield et al., 2016; Dayo-Gyeke et al., 2013; Esegbona & Adeigbe, 2018; Farnes et al., 2011; Morris et al., 2014; Ngomane & Malaudzi, 2012; Roberts et al., 2016; Roro et al., 2014; Shiferaw et al., 2013). Part of the community-level factors affecting women's health seeking behaviour is the use of indigenous traditional practices.

4.4.7.1 Indigenous Traditional Practices

The use of herbs during pregnancy is a widespread practice for childbearing women in Nigeria, Ghana, and other African countries (Ababor et al., 2019; Aziato & Omenyo, 2018; Ibrhim et al., 2018; Kea et al., 2018). Herbs are consumed during pregnancy to promote the health of the mother and foetus, to prevent complications, and for the treatment of minor illness such as malaria. Some herbs are taken for safe childbirth (Ibrhim et al., 2018). Visiting an herbalist or any other local maternity service provider within the community is deemed a form of autonomy for women: they can consume herbs without the need to visit a hospital for any form of care. However, some study participants specifically consumed herbs as a tradition that must be adhered to during pregnancy, with one highlighting a respect for herbs being the discovery of past ancestors and in existence before the advent of modern medicines or hospitals (Farnes et al., 2011). Another participant pointed out that something that is owned and produced by God can never have any form of adverse effect on the pregnancy or the baby (Farnes et al., 2011). However, some of the participant in the study declined to use herbs because of concerns with the quality of the herbs and the non-regulated required dosages (Farnes et al., 2011).

Women's beliefs about the consumption of herbs influence their decisions regarding who to visit for care during pregnancy. A study conducted in Malawi among 20 pregnant woman and eight healthcare providers showed that pregnant women do not go to the clinic unless they are ill (Farnes et al., 2011). Therefore, they rely on local traditional healers for advice or treatment during pregnancy. This varies among the women based on their

religious belief that prayer is the most important form of treatment. Some women, therefore, resort to faith healing during pregnancy. This is a frequent practice in Malawi with many churches organising special services for pregnant women. The study concluded that women who relied on divine intervention did not attend hospital for any form of care; they relied solely on going to churches (Farnes et al., 2011).

Religion is therefore classified as a major factor that impacts women's health seeking behaviour during pregnancy (Solanke et al., 2015). This is also evidenced from a study conducted in predominantly Muslim northern Nigeria where a low rate of utilisation of ANC services is ascribed to religious beliefs (Babalola & Fatusi, 2009). The women in this region are four times less likely to attend antenatal clinics or deliver in the presence of a skilled birth attendant when compared with their Christian counterparts elsewhere in Nigeria (Babalola & Fatusi, 2009). One of the factors affecting the choice of the Muslim women in the study is a preference for a female maternity service provider (Kifle et al., 2017). Muslim women do not like to be attended to by male healthcare workers because their religious belief stipulates that their body must not be seen by a male individual other than their husband. It therefore becomes, a major concern when Muslim women attend clinics in hospitals because they are not sure which individual will attend to them. Their religious belief, therefore, influences their decision regarding where to seek care during pregnancy (Kifle et al., 2017). Religious belief as a factor encouraging women to deliver at home was also identified in another study. Here, some women believe that giving birth at home is the norm and that women who go to a health facility for delivery are weak. Such a belief is based on the notion that hospital is a place for managing illness and not normal conditions such as pregnancy (Kea et al., 2018).

Religion has thus been classified as a community-level factor that influences the worldview of women through teachings and doctrines (Kifle et al., 2017). It is noted that beliefs within the same religion vary according to the religious group to which women belong; for instance, ultra-conservative churches in Nigeria encourage faith healing and total adherence to church practices (Solanke et al., 2015), Jehovah's Witnesses do not accept any form of blood transfusion, while contemporary Pentecostal churches preach a liberal form of health teachings to their members. Thus, religion is an integral part of

women's lives, especially within African settings where religion as a sacred mandate guide women's action (Solanke et al., 2015). Therefore, spiritual belief cannot be uncoupled from women's choices regarding ANC because it is a form of identity (Stewart et al., 2013). It was therefore suggested by some authors that an element of spirituality can be incorporated into healthcare services, to improve the utilisation of healthcare services among women during pregnancy (Isaac at al., 2016).

4.4.7.2 Burying of Placenta

The disposal of placenta is an important part of placenta management after childbirth. Due to beliefs associated with the disposal of placentae, some women prefer to deliver in places that will aid the disposal of a placenta in a traditional way. Burying of the placenta is the most common way of disposal in some communities in Africa (Kemoi et al., 2020). In Ghana, burying the placenta is an important tradition that is used to determine the future of the newborn. Many women engage in this tradition by ensuring that foetal side of the placenta points up so that the child will be successful in life. When the placenta is buried with foetal side downwards, it is believed that the child may become a prostitute later in life (Aziato & Omenyo, 2018). In another study conducted in a village in Ghana, the placenta was described as the older twin of the baby that has just been delivered. It is believed that the older twin, that died during childbirth, should be accorded the same respect given to older people who died within the community. This involves burying the placenta with the same funeral rites accorded to elderly people. The area where the placenta is buried is considered as an important spot that must not be forgotten – when a problem arises later in life, the child can visit the spot for support (Jansen, 2006). Families allocate a particular area of their land for the burial of placentae (Shiferaw et al., 2013). The placenta is also believed to have a grandmother, called *asamando*; when it is buried according to the tradition of the land, it is believed that the placenta will meet its grandmother (Jansen, 2006).

Although hospitals and related facilities with skilled healthcare personnel are considered the most appropriate settings for childbirth (care is based on scientific evidence), these settings are seen as incomplete because they do not have provision for the traditional disposal of placenta. Such settings are further considered to be unfriendly,

Thereby hindering the uptake of such service for maternity care during pregnancy (Jansen, 2006; Kemoi et al., 2020).

4.4.7.3 Belief in Spirits

Individual beliefs about spirits are among the community factors that affect the utilisation of maternal healthcare services by women within the reproductive age in sub-Saharan Africa (Brighton et al., 2013). In some communities in Africa, complications during pregnancy or childbirth are associated with evil spirits (Brighton et al., 2013). This cannot be ignored because it is part of indigenous practice that has been passed down from previous generations. In Madagascar, for example, it is believed that witchcraft could afflict pregnant women with illness due to jealousy (Morris et al., 2014). In this region, it is also believed that the various indigenous practices or rituals women engage in during pregnancy determine the outcome of a pregnancy. TBAs and family members encourage women to carry out these rituals or procedures during pregnancy to chase away evil spirits and to preserve the pregnancy (Mogawane et al., 2015). When women fail to perform the necessary ritual during pregnancy, it is believed that there may be negative consequences such as miscarriage, complicated pregnancy, or difficulty during childbirth and even death (Lori & Boyle, 2011; Morris et al., 2014; Mogawane et al., 2015).

It is further argued that not only might the mother be attacked by evil spirits, but the unborn child may also be afflicted with a disability, a mental health-related healthcare issue, or even death (Mogawane et al., 2015). In Ghana, a spiritual form of care is also encouraged because it is believed that spirituality is important for the prevention of spiritual threats among childbearing women (Farnes et al., 2011). Women use special types of food and herbs for protection from evil spirits because they believe they are more susceptible to spiritual attack during pregnancy than any other period in their life. They seek help to protect themselves and the unborn child (Farnes et al., 2011). Attendance at church is also encouraged for spiritual protection to ward away evil spirits (Mboho et al., 2013). Women who believed that a spiritual form of care was more important than any other form of care did not seek care early from skilled healthcare personnel (Roro et al., 2014).

4.4.7.4 Secrecy surrounding pregnancy

Secrecy surrounding pregnancy is a cultural norm that has been passed down over the generations. It involves hiding information about pregnancy until around the second or third trimester (Lori & Boyle, 2011). Information about pregnancy and the expected date of delivery is not disclosed to non-family members, due to a fear of being poisoned or being cursed (Morris et al., 2014). In a community studied in South Africa, women engaged in this practice because pregnancy was a sacred event that must be protected from evil spirits and witches (Ngomane & Malaudzi, 2012). Similarly, in two communities in Ghana, pregnant women were not allowed to disclose any information related to pregnancy or childbirth until after cleansing rites had been performed. This affected the time a woman could commence ANC because she was obliged to complete all the rituals before leaving the home to seek care. The primary purpose of the rites was to prevent the woman from experiencing miscarriage or any other form of pregnancy-related health complication (Sumankuuro et al., 2019). Even though early attendance at antenatal healthcare clinic has been identified as an evidenced-based approach for improving maternal health outcomes, indigenous beliefs, and practices, as described above, cannot be ignored because they are aspects of tradition that must be carried out before commencing ANC. Engaging in such practices, however, delays the initiation of care (Atekyereza & Mubiru, 2014).

4.4.8 Summary

This chapter provided a literature review, with a focus on studies conducted in Africa. It provided a critical analysis of the main idea presented (health seeking behaviour) using the various elements of the SEM as a framework to organise and analyse the studies. This includes the description of individual, interpersonal, organisation, and community factors in relation to health seeking behaviour. Examining the literature in this way shows the following to be pertinent:

- The health seeking behaviour of women within the reproductive age group in relation to ANC is affected by many different factors. These factors have been studied in relation to maternal health.

- Medical and non-medical factors determine women's healthcare choices during pregnancy.
- There are a range of stakeholders involved in ANC: nurses, midwives, TBAs, spiritualists and herbalists.
- Indigenous beliefs and practices are an important part of pregnancy; different regions and areas have different norms, values, and traditions.
- There is a wide gap between the form of ANC widely experienced in the Western world and that which exists in different communities in Africa.

Identifying the indigenous traditions affecting women's healthcare choices is important, as isolating beliefs and practices is to side-line the everyday activities of women seeking care. Women's behaviour was studied in relation to the non-medical factors affecting healthcare choices. Therefore, this research will aid in greater understanding of the cultural factors affecting health seeking behaviour. It will be of intrinsic value to the existing literature on maternal healthcare by providing information about all the different factors affecting health seeking behaviour in relation to ANC. To date, cultural factors have been studied in isolation or in relation to other aspects of pregnancy and childbirth, rather than in relation to ANC.

This research will provide comprehensive information that will aid the description of the underlying factors affecting antenatal healthcare outcome within the region. The research will thereby encourage the implementation of local measures for the improvement of maternity care.

The provision of culturally appropriate care that meets the needs of women within the reproductive age group has been classified as an evidenced-based approach to improving maternity care. Since incorporating the cultural preferences of pregnant women as part of their basic needs is deemed to be an approach in improving maternal health outcomes, the findings of this research will further provide information that will aid the achievement of the WHO recommendation for culturally appropriate care.

This research will be useful in identifying shortcomings in the existing forms of ANC, thereby highlighting the gap between the ANC that is available and the type of ANC that should be available. Identifying such gaps will help the major healthcare stakeholders with essential information and resources that should be considered when developing new strategies for the improvement of ANC.

This research will also be the first study to provide a realistic picture of the pattern of ANC in south-western Nigeria, by considering the needs of pregnant women who may have been left out in the planning of strategies for maternity care. The next chapter will present a detailed discussion of the methodology applied to this study.

Chapter 5: Research Methodology

5.1 Introduction

This chapter presents a critical discussion and justification of the research methodology used in this study. To enhance this discussion, an overview of different research approaches aligning to differing ontological differences are presented. The chapter concludes by summarising the justification of the ethnographic approach used.

5.2 Research Aim and Objectives

5.2.1 Aim of the Study

The aim of the study is to explore the cultural beliefs and practices that may influence the health seeking behaviour of women in Ota, southwest Nigeria, during pregnancy, especially in relation to ANC.

5.2.2 Objectives of the Study

- To identify the cultural beliefs and practices influencing the healthcare choices of women during pregnancy in Ota.
- To explore what is considered to be care in pregnancy among women within the reproductive age group in Ota.
- To identify who influences the choice of where to seek care during pregnancy.
- To explore the role of TBAs, spiritualists, and herbalists in the community.
- To understand how cultural beliefs and practices affect women's decisions regarding ANC.
- To gain an understanding of what influences health seeking behaviour of women during pregnancy.

5.3 Philosophical Underpinnings of the Study

Research philosophy can be described as the conceptual root that guides the search for current ideas about a particular phenomenon (Ponterotto, 2005). Information about research philosophy shows how the thoughts of the researcher impact the study in terms of the methodology (Crossan, 2003). However, it is to be acknowledged that there are different approaches to research studies and that one approach is not superior to another. The quality of research is based on the integrity of the philosophical underpinnings of the study, which depends on the relationship between ontology, epistemology and the methodology applied.

5.3.1 Research Ontology

The belief that provides the theoretical underpinning for research relates to what can be classified as reality and the nature of reality (Corry et al., 2018). Ontology is the branch of philosophy that is concerned with the concept of existence and nature of reality (Crotty, 1998): every individual has a personal and unique view of what constitutes truth and reality. The two different ontological positions are idealism and realism.

In idealism it is believed that reality is somehow controlled by the mind. Although an individual mind may not be the direct source of control, traditional ontological idealism holds that reality is a product of an individual thought. Thus, idealism separate us from the realistic understanding of being (McManus, 2017).

In realism, conversely, it is believed that reality exists without the influence of the mind of the individual. However, an individual as a social and conscious being has the tendency to make meaning of the existence of the world, through interaction (Crotty, 1998), although it has been argued by some philosophers that not making meaning about the existence of the world does not imply that complete understanding of the world exists without some level of consciousness of the individual about the universe.

The best approach, according to Crotty (1998), to understanding the true meaning of existence is not only by explaining the concept of “being” in relation to similar terms like “to be” indirectly, but also by tackling the problem in relation to the metaphysical issues that

emerge along with it. However, if we continually explain the meaning of reality or existence through the diverse types of things that exist, we will not be able to have a complete understanding of the true meaning of the existence of being (Crotty, 1998). Therefore, it has been posited that the world can exist without an individual as a being making sense of it, as proven through the existence of different human species before the evolution of homo sapiens on the seventh planet in the solar system (Macquarrie, 1973, cited in Crotty, 1998). Although the true existence of reality continues to be questioned, it is maintained that reality only becomes true after interaction with the senses and, therefore, it can only become real when there is a relationship between objects and consciousness (Crotty, 1998).

5.3.2 Research Epistemology

Whilst there can be different approaches to social enquiry, it is also important to understand the nature of knowledge. Epistemology is the branch of philosophy that is concerned with what researchers may term as knowledge (Holloway & Wheeler, 2009). When an individual is in pursuit of current information about a particular phenomenon, the individual's action is influenced by their beliefs regarding knowledge (Hofer & Pintrich, 2004). This is different from ontology because where epistemology focuses on the source of knowledge with an in-depth clarification of the different beliefs, ontology focuses on reality (Rodriguez & Smith, 2018). Two salient questions emanating from the pursuit of knowledge for educational purposes are: how do people acquire knowledge about a phenomenon, and what can we consider as valid knowledge around the world? A useful response is to consider the two epistemological positions, positivism and interpretivism, as the main paradigms for guidance when collecting and analysing data.

In positivism, all forms of metaphysical thinking are excluded; the individual believes that human behaviour can be measured using the scientific method of enquiry (Bowling, 2009). Therefore, a whole subject is reduced to smaller fragments to be studied, without considering the process involved or the relationship between the smaller fragments (Durham & Hancock, 2006). Similarly, it has been argued that the phenomena be broken down into smaller fragments because each fragment signifies the truth, based on the ontological position that there is only one truth: a reality that is objective and independent

of the social world (Levers, 2013). However, social scientists also believe that there is more than one reality. This is because humans cannot be objective without considering the environment around them. It may, therefore, be difficult to apply a situation that totally separates this human factor from the actual phenomenon since scientific knowledge, as espoused by positivists, is based on the premise that non-human activity relies solely on its environment to yield results (Holloway, 1997).

In interpretivism, reality is believed to exist in numerous forms – unlike positivism, which relies on one single reality (Hudson & Ozanne, 1988). The multiple forms of reality are believed to have an impact on one another because no single reality can exist without interaction from another system. The interaction between the different subsystems is the multiple reality that has an impact on human beings as a complete system (Graue & Trainor, 2013). As such, the research paradigm for a study is the result of the combination of the worldview of the researcher and the method of knowing how knowledge is acquired (Schwandt, 2001).

Although positivists also believe that scientific knowledge can be tested, researchers argue that the objective study of the social world does not depict the meaning of science (Holloway, 1997). Objectivity is, therefore, classified as a partial search for scientific knowledge because science cannot be separated from the social world (Holloway, 1997). On the other hand, interpretivism was developed to study humans from a perspective that is entirely different from the naturalistic scientific approach (Hammersley, 1989, 2013). Thus, interpretivism allows individuals to see the world from more than one perspective – a dimension that views the world differently based on the intervening factor, where actions are not judged based on cause and effect, but rather they are analysed using a multiple systematic approach. Knowledge is generated based on the human construction of the social world (Chowdhury, 2014; Harrington, 2000 cited in Hammersley, 2013). Therefore, it is advisable to consider and treat study participants as human beings and not as objects of research (Holloway, 1997).

Without doubt, this research, conducted as qualitative research, takes an interpretive stance as it relies on the fact that truth depends on the subjective experience of the individual. Since interpretivism is described as an approach that involves associating

meaning to people's lived experiences from the perspective of the subject (Higgs & Jones, 2000), such a philosophical underpinning would provide insight about some of the underlying factors affecting the utilisation of ANC. Interpretivism is, therefore, relevant in this research because we can understand the way of life of people by studying what is important to them (Whitley, 1984). Therefore, to understand the health seeking behaviour of women during pregnancy in Ota, an interpretivist stance is taken because it will provide more information about the phenomenon under study by not merely enquiring about women's attitudes towards receiving ANC from healthcare personnel, but by providing an understanding of the underlying cultural beliefs and practices that guide the healthcare choices they make regarding where to seek care during pregnancy (Chowdhury, 2014).

5.4 Qualitative and Quantitative Research

Qualitative research is a generic term that can be used to describe a wide variety of approaches (Saldana et al., 2011). The literature provides numerous definitions of qualitative research, but only a few of the definitions provide an understanding of the primary characteristics of research to be qualitative (Aspers & Corte, 2019). It can be defined as any type of research that studies people using a naturalistic approach without numerical interpretation of the data collected (Saldana et al., 2011). Qualitative research has its roots in anthropology, sociology, and philosophy, thereby implying that it provides a deep understanding of people's views about the world around them, based on the meaning ascribed to the collected data by the study participants (Holloway & Wheeler, 2010; Saldana et al., 2011).

Quantitative research is conducted with the aim of testing hypotheses for the prediction of human actions (Holloway & Galvin, 2016). In quantitative research, external variables are controlled to minimise the effect on the experiment whereas in qualitative research, context is considered as part of a crucial aspect of the research which cannot be separated from the participant (Holloway & Galvin, 2016).

Qualitative research is relevant in this research as the crucial aspects of human phenomena, such as values and beliefs that are the central focus of this research, cannot be measured easily with numerical data – the main resource for quantitative research (Krasner, 2001). Furthermore, qualitative research does not focus on the objective truth to be the same for all individuals, rather it focuses on the subjective interpretation of each person. This is, therefore, a useful resource for eliciting information about people's norms, values, beliefs, and way of life due to its uniqueness (Al-Busaidi, 2008). This approach supports some of the recommendations listed by Patton, which include making enquiries about the contextual meaning of people's experience in order to have adequate knowledge about the phenomenon (Patton, 1998).

Since maternal mortality remains one of the major challenges affecting women within the reproductive age group globally, and empirical approaches have not been able to proffer solutions to all the factors contributing to maternal death, it is crucial to answer

some of the questions from another perspective using a different approach such as qualitative research (Thorne, 1991). Furthermore, previous research has shown that conducting research in maternal healthcare through qualitative methods increased the level of awareness of the maternal healthcare providers about other associated barriers affecting maternal healthcare (Al-Busaidi, 2008). However, when a researcher is attempting to interpret or observe human activity using the qualitative approach, they are at risk of being close to the study participants and this may increase the level of bias, but such a risk can be managed appropriately by being self-aware to minimise the impact and not being objective. Closeness between researchers and participants has been used to gain insights into various phenomena in the past; for example, Piaget's closeness to his children provides insight into the different stages of child development (Patton, 1990). Although the research for this study could be carried out through either a quantitative or qualitative approach, the findings would be different; for example, if the research was to seek how many people held such beliefs/values, each approach would answer different research questions (Al-Busaidi, 2008).

5.5 Approaches in Qualitative Research

There are several approaches that can be used in qualitative research. These include grounded theory, phenomenology, and ethnography.

5.5.1 Grounded Theory

Grounded theory can be described as an approach used for the collection and analysis of data, with the aim of generating a theory that is totally grounded in the data. It originates from symbolic interactionism, which means that one can understand a phenomenon by acquiring information and developing a relationship with those involved in the social process: social process has existing structure and a well-defined method of operation that can be used to elicit information about how interactions develop (Jeon, 2004; Starks, 2007).

The grounded theory approach is applicable to both quantitative and qualitative research, but it is mostly applied to the latter (Chapman et al., 2015). People, for instance, behave in a particular way due to the influence of the significant others around them; the expectations of significant others, thus, shape their behaviour. Therefore, data can be generated through the observation of the different people involved in the interaction. The theory that emanates after the application of grounded theory is deeply rooted in the perception of the study participants, thus signifying that hypothesis are formed from the research data and not from already existing data. However, when developing hypothesis from the collected data, previous knowledge about the topic will be concealed, to prevent it from altering the result of the study (Chapman et al., 2015).

It has been argued that during the analysis stage in grounded theory, there is a high chance that knowledge generated from the review of the literature may be unconsciously applied in the analysis of the collected data. Therefore, it cannot be described as a complete inductive approach, free from the impact of the researcher (Elliot & Jordan, 2010). In addition, when utilising the grounded theory approach, the collection and analysis of data are done at the same time. Therefore, collected data form the basis for other data that will be collected in the study. Due to the level of subjectivity that is involved in giving accounts

of the data collected from the research participants, it is important that the researcher (being the main tool for analysis) is honest about their own knowledge or beliefs about the phenomenon under study (Chapman et al., 2015; Starks, 2007). This will prevent the existing knowledge about the subject area from influencing the analysis of the collected data (Hunter, 2010).

5.5.2 Phenomenology

Phenomenology is described as the study of phenomenon and may involve focusing on one part of participant experience (Rodriguez & Smith, 2018). It also uses scientific knowledge to provide an understanding of human problems around the world. In phenomenology, there are two different schools of thought: one is based on the philosophy of Edmund Husserl, the other is rooted in the concepts espoused by Martin Heidegger.

Husserl's school of thought is referred to as descriptive phenomenology; it is based on the lived experience of the individual. When adopting this form of phenomenology, the researcher's perception is bracketed in order to ensure there is objectivity, thus minimising the impact of pre-existing knowledge on the phenomenon under study (De Chesnay, 2015). Heidegger's school of thought is slightly different because of its focus on being. It is believed that when making enquiry about other people's lived experience, we must first understand ourselves, because as human beings we have the tendency to understand the way of life of beings. This does not mean the individual making the enquiry has a comprehensive understanding about what is yet to be, but rather this assumption is based on the premise that humans, as beings, understand what it means to exist on the seventh planet in the solar system. Therefore, it is crucial that we start the creation of knowledge by first understanding the nature of being, from our own perspective (Cerbone, 2014: Rodriguez & Smith, 2018).

The other difference between the two schools of thought is that for Husserl consciousness is the central focus of his form of phenomenology, while for Heidegger the subject of being and time is the primary focus. In addition, Heidegger also believed that one could understand humans by acquiring more information about the subject of being, but he did not support the separation of the preconceived ideas of the researcher from the

research, when conducting a study. Instead, he believed that there is a close connection between individuals and the existence of being, and that it may be impossible to study humans without exploring factors that make up the being. He also believed that if bracketing is not employed in research, there will be an incomplete interpretation of phenomenon, since it allows complete interpretation of individual lived experience (Rodriguez & Smith, 2018). It is to be anticipated that the application of Heidegger's phenomenology may lead to anxiety because in the process of searching for the true meaning of life, so many things are revealed and as humans we will respond either in a good or bad way (De Chesnay, 2015). Therefore, phenomenology as an approach is not a doctrine that is taught by a particular group of people, rather it is a body of knowledge that is aimed at enumerating the meaning of the term consciousness (Martin et al., 2015).

5.5.3 Ethnography

Ethnography is defined by Brewer (2005) thus:

> The study of people in naturally occurring settings or fields by means of methods which capture their social meanings and ordinary activities, involving the researcher participating directly in the setting, if not also the activities, in order to collect data in a systematic manner but without meaning being imposed on them externally (p. 18).

Therefore, this approach focuses on understanding people's behaviour, through familiarity with the study field based on the premise that one can understand the reasons for people's actions by associating meaning to their lived experience with the aim of understanding how individual worldviews influence behaviour (Brewer, 2005). It is important to consider choosing the right approach for research, since applying the right method of enquiry serves as a guide to the study.

When attempting to generate knowledge about a particular phenomenon, it is important to consider the meaning of reality according to the different school of thoughts. This varies due to the impact of external environmental factors on the way of life. However, there is a universal notion that the cultural beliefs and practices of individuals vary; the belief an individual associate with any phenomenon is the result of the political, economic, social and epistemology of the individual. Therefore, when trying to associate meaning to people's experience, the individual conducting the study should consider the phenomena

from the world of the host, which is also that of the study participants (because such a construct determines the individual notion of reality). In doing so, the study will produce the contextual meaning of individual action. In addition, the researcher will be able to situate the experience as a text to be read through an interpretive method and will be able to show how the ideas about the world are constructed based on the structure of the environment of the ethnographic host (Desmond, 2014a). Although an ethnographic approach may be limited to a particular environment due to location and the social group selected for the study, the provision of all the information about the entities considered before commencing the study will show that each social group is best understood by considering the different dynamics of the social world (Desmond, 2014b).

One of the epistemic views of ethnography is that people's experiences and stories form part of the sources of information. It is important to consider the epistemic views of people because not everyone is able to express themselves very well without telling stories, and storytelling is a method of expression that allows the individual to verbalise their feelings. Other approaches may not be able to capture the experience of the people involved. Therefore, when an ethnographic approach is applied to a study, it is conducted based on a particular premise about knowledge, with the aim of acquiring information about the phenomena regarding the culture being studied from the study participants. This objective serves as a guide to all the different forms of ethnography (Green et al., 2012).

A research study is classified as ethnography in the following contexts:

- The collection of data is neither fixed nor structured in order to avoid imposing a particular form of categorisation on people's experiences
- It focuses on exploring people's actions in their natural setting without any form of modification, such as the creation of a new environment for the purpose of minimising the effect of external factors on the study.
- The aim of the study is to conduct research in a particular area and among a small group of people.

5.5.3.1 Autoethnography

Autoethnography is one of the different types of ethnography. It has the approach of storytelling as its primary feature. The approach involves the researcher understanding themself before engaging in the analysis of the data collected from the research participants (Chang, 2008, cited in Rashid et al., 2015). The contextual understanding of one's personal experience is the tool that is used for analysis and the individual personal experience will be compared with similar experiences within the same environment, using the culture common to all the people involved (Ellis, 2004, cited in Rashid et al., 2015). The researcher literally focuses on how the analysis of the individual experience impacts on the reasoning of the individual.

Autoethnography differs from institutional ethnography due to the variation in the focus of the study. According to Walby (2013), institutional ethnography is a method of enquiry that investigates how everyday experiences are coordinated by work done within an institution. Thus, institutional ethnography focuses on how individuals are affected by the institution around them. The main tool used for analysis is the organisation, while the collected data emerges from the experience of people, the institution where the experience emerge, and the situation of things within the institution (Given, 2008). Data dialogue is a common practice among institutional ethnographers; it involves looking for similar themes from the experience of the people who are grouped together. This is akin to the method of analysis used by conventional ethnographers. However, the entire approach occurs in two phases: the first is between the researcher and the study; the second is between the researcher and the transcript (Rashid et al., 2015).

5.5.3.2 Visual Ethnography

Visual ethnography is another form of ethnography; it involves the collection of data using photographs (Pink, 2013). However, this approach has been criticised due to lack of objectivity and structure (Pink, 2013). Although photographs were the primary method of data collection used by ethnographers in the early 1990s (Pink, 2013,), the analysis of the data collected from study participants cannot be verified as having been in-depth or not, because of the complex nature of the analysis involved in this form of ethnography (Pink, 2013). Videos are also used as a source of data in visual ethnography because they provide

comprehensive information about different aspects of participants' experience; they allow the researcher to capture non-verbal clues expressed by the participants. However, this form of ethnography is criticised because of the cost of the equipment required to conduct such research (Rashid et al., 2015).

5.5.3.3 Critical Ethnography

Critical ethnography is another form of ethnography and according to Thomas (1993, p. vii), "it is a way of applying subversive worldview to the conventional logic of cultural inquiry". It is like conventional ethnography in terms of the methods through which data are collected from the study participants and the methods of analysis of the collected data. However, there is a slight variation because rather than opposing the views of critical ethnographers, it provides more information about how the external human environment, such as political issues within the society, affects individual knowledge (Thomas, 1993). In addition, conventional ethnographers focus only on defining the culture of the people, while critical ethnographers focus on identifying the underlying factors associated with a particular issue within the society and then proffering solutions that will change part of the culture (Dharamsi & Charles, 2011). Critical ethnographers also focus on understanding the population under study from the participants' perspectives and they are aware of the likely impact of the researcher on the research. Therefore, the subjective opinions that may likely affect the study are explicitly documented (Muecke, 1994, cited in Rashid et al., 2015). This is slightly different to focused ethnography due to the objective of the study.

5.5.3.4 Focused Ethnography

Focused ethnography is defined as focusing on people who are socially and culturally differentiated (Knoblauch, 2005). The approach therefore focuses on the experience of well-defined groups of individuals: a specific group of people that share similar beliefs within a particular geographical area for a short period of time. The primary characteristic of focused ethnography includes collection of data for the study through observation. Time spent in the field is reduced when compared with other types of ethnography (Higginbottom et al., 2013).

Focused ethnography also relies on insider perspectives which focus solely on a particular aspect of culture; for example, the present study focuses only on exploring the factors affecting the health seeking behaviour of women during pregnancy. In contrast, a researcher using traditional ethnography is not familiar with the study setting and does not have specific or well-defined objectives for initiating the study (Morse & Richard, 2002). A focused ethnographic method also differs from traditional ethnography because the latter requires the individual conducting the research to remain within the study area for a certain period for total immersion in the culture of the people.

Although both traditional and focused forms of ethnography have been widely used in health-related research, focused ethnography does not regard the broader aspect of culture, rather it focuses on the specific aspect of the culture that is related to the research, due to the complexity and broader nature of culture. For the reasons enumerated above, the focused ethnographic method will be used in this study to elicit information about the aspect of the culture that affects the health seeking behaviour of women during pregnancy.

The focused ethnographic approach has been widely applied in different aspects of healthcare such as nursing-related healthcare issues, global healthcare issues and public healthcare issues. Examples of the approach may be found in a study conducted among major healthcare stakeholders in Ghana (Ayanore et al., 2017) and a study on medical history misinformation practices as strategies against healthcare providers' domination and humiliation in maternal care decision-making interactions in southern Ghana (Yevoo et al., 2018).

Focused ethnography allows healthcare professionals such as nurses, midwives, and doctors to gain a broad knowledge about all the different aspect of care, thereby empowering skilled healthcare professionals to provide a form of care that meets the need of the individual and improves the overall state of health. The findings of a study based on a focused ethnography enables healthcare professional to focus on improving the health and well-being of their clients while also considering essential needs of their clients, such as cultural needs (Rashid et al., 2015). A focused understanding of the factors affecting maternity care is crucial for the improvement of the health and well-being of women within the reproductive age group and, therefore, for the purposes of this research, a focused

ethnographical approach is deemed most appropriate for the exploration of the factors affecting the utilisation of maternal healthcare services.

5.5.3.5 Features of Focused Ethnography

The features of focused ethnography employed in this research include a small-scale study conducted within everyday settings, in which the study participants share common practices (Higginbottom et al., 2013). This is applicable in this study because this study is conducted among a target member of the study population: women within the reproductive age group attending antenatal clinics, sharing context-specific common cultural beliefs and practices.

Another feature is that I, as the researcher, started the study with a background knowledge about the issues affecting the utilisation of maternal healthcare services. While most ethnographers start their research as outsiders, I started as an insider with preconceived ideas about the study area. My background knowledge was employed in this research to achieve the aim and objectives of the study and to provide greater understanding of the various choices of ANC services available to a selected group of people. In a similar manner, focused ethnography also involves understanding the participants or the different individuals involved in the study. However, a researcher cannot have a good understanding of the individuals involved without building a relationship. Thus, a good relationship is considered an integral part of focused ethnography because it forms part of the means through which the needs of the participant can be understood when carrying out research (Rashid et al., 2015).

5.6 Data Collection in Ethnography

While collecting data from the participants, I was conscious of the elements of the socio-ecological framework, such as significant others (categorised among the interpersonal-level factors affecting women's choices when seeking healthcare), but I remained open to new constructs that may emerge. Therefore, data were collected through semi-structured interviews and observations to provide more insights about the factors influencing the health seeking behaviour of women during pregnancy. As ethnography provides a deeper understanding of people's behaviour (Reeves et al., 2008), based on the assumption that human being is both an object and a subject, ethnography was appropriate for this study, as women have the right to choose where to receive ANC during pregnancy. However, this choice is a product of many interrelated factors within the individual environment (O'Reilly, 2012) due to the interaction between humans and the social environment (Reeves et al., 2008).

5.6.1 Field Notes

Field notes, also called scratch notes, are a method of data collection that comprise one of the essential components of qualitative research (Emerson et al., 2011). Initially, field notes were not categorised as part of the data collected during research until around 1980, when they were then evaluated as a means to relevant ideas that could be analysed along with the data collected. Since then, qualitative researchers have been encouraging others to utilise the information from field notes to enhance the analysis of the collected data (Creswell, 2013; Philippi & Lauderdale, 2018). However, inclusion is only regarded as a recommendation and not as a compulsory tool to be used in qualitative studies (O'Brien et al., 2014; Tong et al., 2007). Field notes are not generally available as secondary data used for further studies.

Field notes have also been used to increase the contextual meaning of the data collected from study participants, thus providing thick description of the topic under study (Phillippi & Lauderdale, 2018). Therefore, field notes can be used to assess the studies included in a review; for example, in the meta-synthesis of qualitative research field notes can be disclosed to provide more information about the journal articles included in the

meta-synthesis, but lack of space may affect the publication of field notes in published articles (Jensen & Allen, 1996; Phillippi & Laudderdale, 2018). However, other authors have argued that field notes may be irrelevant because they may lack useful information to contribute to the aim of the research. This opinion is especially common among early researchers who did not know exactly what to include in field notes. I will be using field notes in order to provide more contextual information about the research.

The use of ethnography, while providing a unique contribution to maternal healthcare (Bandyopadhyay, 2011), is not without criticism. Firstly, sample size is a general limitation of qualitative research because there is no specific formula for calculating the sample size as there is with quantitative research. This is also applicable to an ethnographic study due to the length of time that is required for the collection of in-depth information from the research participants. It thus limits the number of participants selected for the research (Goodson & Vassar, 2011).

The generalisation of findings is another limitation of the ethnographic approach. When exploring the way of life of a group of people with a common culture, the findings generated from the project cannot be applied to other members of the population with a different culture (De Chesnay, 2015; Goodson & Vassar, 2011; Savage, 2000). Meanwhile, the focus of this research is not to generalise its findings but to provide a deeper understanding of the phenomenon under study as asserted by other authors (Currie, 2005; Murphy et al., 1998). Due to the lack of generalisability of the findings from an ethnographic study, it is difficult to find sponsors to fund this type of research (Goodson & Vassar, 2011). Despite the limitations associated with the use of ethnographic approach, it is still one of the approaches that has been used to elicit information about the behaviours of clients seeking healthcare – parameter that cannot be measured in depth with a quantitative approach. An ethnographic approach will be employed in this study to provide an in-depth understanding of the various factors affecting the healthcare choices of women seeking healthcare during pregnancy.

5.6.2 The Researcher as an Insider and an Outsider

Throughout this study, I was both an insider and outsider researcher. Being an insider researcher is an important and useful feature in qualitative research because it can aid the smooth establishment of positive relationships between the researcher and the study participants (O'Connor, 2004). I was at risk of missing out some information with participants not providing complete and detailed information about their experience due to an assumption that I was already well acquainted with what was happening in the area (Dwyer & Buckle, 2009). However, I was able to avoid this potential loss of information by explaining to the participants that although I was familiar with Ota and its environs, I have never lived among the people of Ota, nor have I ever had personal experience of maternity services within the community. An incongruity such as this is not unusual, as noted by Asselin (2003) who suggested that although a researcher might be a member of a culture being studied, they may not have comprehensive knowledge about the minor cultures being practised by the people. Therefore, it is important for me as an insider to collect data with openness to all information acquired from the participants, without assuming to be well-grounded in the culture of the people.

A researcher's identity as an insider is also useful because an insider perspective can further provide an inner perspective that may be ignored by an outsider (Hamdan, 2009; Lumsden, 2009). The insider perspective is also attributed to the establishment of a sense of belonging in the participants because the researcher will be able to understand the participants more easily than an outsider who has never worked in the area. However, the risk of generating excessive information increases because such a relationship reassures the study participants and increases the level of trust, thereby encouraging the participants to open up more and to share more information (Dwyer & Buckle, 2009).

I describe myself as an insider because of existing ties with the study area. I am a member of the community by birth, and I have family members who still live in the community. Identifying with the study area therefore translates to identifying with the population through language. A shared language is seen as advantageous to a study as, according to Wuestenberg (2008), it allows the researcher to interact with people without a language barrier impeding understanding of questions and answers by all the parties

involved. Introducing a third party to help with communication may lead to the loss of vital information or even to the loss of the main content of the interaction. Although a prior relationship with the community is a useful tool when conducting qualitative research, challenges may arise through prior knowledge about the study area. Examples of such a challenge include the inability of the individual conducting the study to identify patterns in the environment they are familiar with, and difficulty giving a full description of phenomena with which they are acculturated (Wuestenberg, 2008).

As a researcher, I would also assume the role of an outsider because it is sometimes challenging to separate the researcher's prior experience from the experience of the study participants (Kanuha, 2000). Assuming an outsider role, therefore, emotionally separates the study from the participants (Chawla-Duggan, 2007). Still, it is believed that it is sometimes challenging to analyse the experience of the study participants as an outsider because one cannot truly understand some elements of a culture until one has experienced it. Therefore, in this research the role of the researcher is based on the demands of each situation. I assumed the role of an insider when needed and reverted to an outsider role when needed – based on the study participants and the goal of each moment. Some parts of the study, such as my mother language, can never be changed, but they can be adjusted according to the situation because, as noted by Mercer (2007), in practice the researcher's identity is subject to change. For this reason, the researcher then moves beyond assuming a fixed role as an insider or an outsider to a more flexible state described as "the space between" (Mercer, 2007, p. 60). Therefore, the relationship I have with the participants is based on each situation. As ascertained by Fay (1996), all researchers irrespective of the relationship with the study area occupy the space between an insider and an outsider. This is because some of a researcher's identity, such as religion, can be outweighed by education. I was, therefore, able to modify my manner to meet the demands of each situation (Dwyer & Buckle, 2009; Mercer, 2007; Serant-Green, 2002).

Whether the researcher is an insider or an outsider they, as an individual conducting the study, are an essential part of the experience (Dwyer & Buckle, 2009). Although I am conducting the study and am familiar with the study area, the memories I have about the study area may be irrelevant because of the various transition programmes that have been

carried out within the country (Wustenberg, 2008). Therefore, even as an insider one may need to adapt to the present situation to function effectively within the community.

5.7 Background of the Researcher

The background of the researcher is crucial in qualitative research because of its subjective nature. It is, therefore, important to include information about one's background since ethnographic interpretivist study involves self-reflection. I am a registered nurse–midwife with a Bachelor of Nursing Science (BNSc) obtained from the University of Ibadan in 2009. In 2016, I completed a master's degree from the University of Salford. I worked as a nurse–midwife within the maternity and ANC unit in a federal medical centre in Bayelsa, Nigeria, before relocating to the UK. I also worked as a health and safety officer in the health department for West African Portland Cement Company (WAPCO-Lafarge Ewekoro 1 & 11 plants now Lafarge Africa, in Ogun State. Being a member of the Red Cross Society, I worked with various health organisations within the country and provided healthcare training and advice to members of the public nationwide.

5.8 Summary

This research explores the beliefs and practices that may influence the health seeking behaviour of women during pregnancy in Ota, Nigeria. As this behaviour is likely to be impacted by a wide range of sociocultural factors, an ethnographic approach was decided upon to explore a particular phenomenon that socially and culturally differentiates a well-defined group of people. It was selected to provide a holistic view of the various external factors within the human environment that affect women's decisions regarding the healthcare choices made during pregnancy. The next chapter describes the methods employed in the collection of data from the participants.

Chapter 6: Research Methods

6.1 Introduction

This chapter presents the research methods used to undertake the study. They include a detailed description of the study area, as a community located in the south-western part of Nigeria; a description of the participants and their recruitment; data collection processes; data analysis methods; and the ethical issues considered in the research. Data were collected through semi-structured interviews and observations to increase the credibility of the study.

In collecting the qualitative data, I made use of all the mandates suggested by John Lofland (2006). This included getting close to the participants to understand the situation being studied. The first mandate was applied by attending various antenatal sessions before initiating actual data collection and included a visit to the Sango-Ota PHC (Primary Healthcare Centre) and other local providers of maternity services within Ota. The second mandate stipulates that a qualitative researcher must aim at capturing what takes place. I captured all the essential elements by observing the study participants and digitally recording the interview to ensure that no part of the interview was missed. The third mandate, according to Lofland, stipulates that qualitative data must incorporate a pure description of people's activities. This was done by documenting the choice of pregnancy care of each woman participating in the study. The last mandate emphasises the need to include direct quotations from the study participants (Lofland, 2006).

Applying all four parts of Lofland's mandates brings the researcher closer to the participants, thereby increasing the vulnerability of the researcher. Although previous qualitative research shows that the researcher has the capability of controlling the relationship between the researcher and the participants (Karnieli-Miller et al., 2009), the researcher being an outsider does not always have the capability to control some aspects of the research. I, therefore, negotiated throughout the study by moving up/down based on the situation, since this increases a researcher's knowledge about the study (Raheim et al., 2016). Studying up as an insider increases the superiority of a researcher, thereby enabling more control of the research. However, in this research there were times when I was in a low-level position due to issues related to gaining access to the study area. As an outsider, I did not have control over this but was able to negotiate my way in by speaking a local

dialect of Ota. Language was, therefore, a powerful tool that paved easy access to obtaining approval from the local government (Nader, 1972).

6.2 Study Aim

The aim of the research was to explore the cultural beliefs and practices that may influence the health seeking behaviour of women in relation to ANC during pregnancy, in Ota, south-west Nigeria.

6.2.1 Study Objectives

- To identify the cultural beliefs and practices influencing the healthcare choices of women during pregnancy in Ota.
- To explore what is considered as care in pregnancy among women within the reproductive age group in Ota.
- To identify who influence the choice of where to seek care during pregnancy
- To explore the role of TBAs, spiritualists, and herbalists in the community.
- To understand how cultural beliefs and practices affect women's decision regarding ANC.
- To gain an understanding of what influences health seeking behaviour of women during pregnancy.

6.3 Description of the Study Area

Ota is in one of the 20 registered LGAs (Local Government Area) in Ogun State. It is 16.4 km from Lagos State, the most developed city in Nigeria. Ota lies between longitude 30° 02' and 30° 25' E, and latitude 60° 30' and 60° 50' N (Omole and Longe, 2008). It is categorised as the most industrialised, most populous and the second largest LGA in Ogun State(Anthonia & Mchunu, 2019; Musah, 2016).

6.3.1 People

The present total population of the people of Ogun state is not available, but according to the 2006 census, the estimated population of people resident in Ogun state is 3,728,098 (Omole & Okunowo 2016). The indigenes of Ota are predominantly Yoruba, and they are referred to as the Awori people. The people in Ota are mostly traders and this is included in this study, as socio-economic factors are part of the primary factors that determine the financial capability of individuals thus affecting the level of affordability of the cost of healthcare services among women within the area.

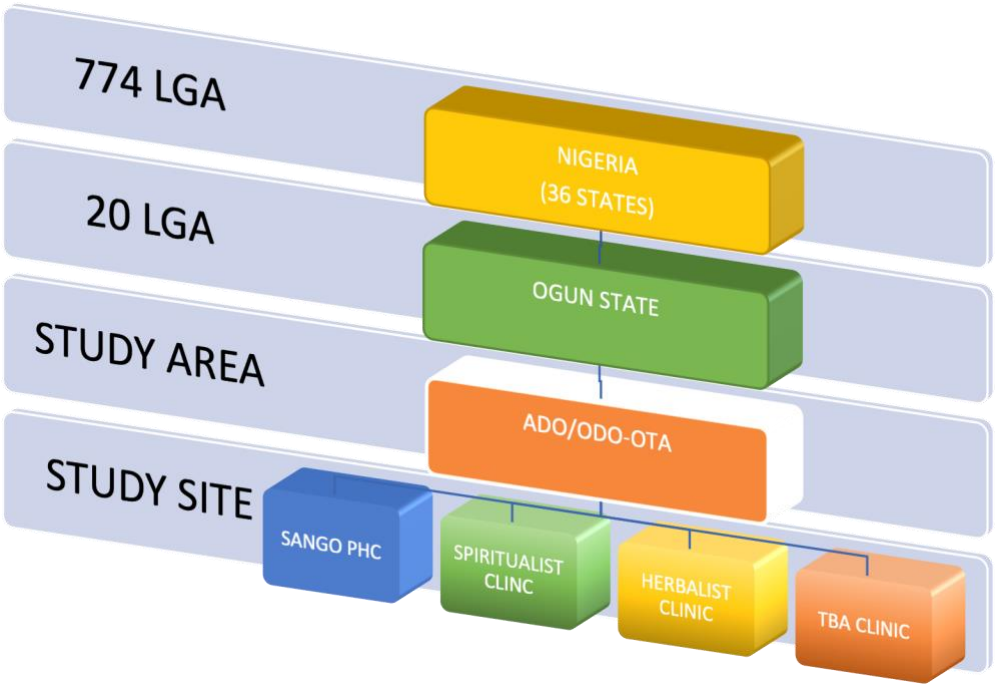


Figure 6.3a: Description of the study area

Ota is a community located in a region with a maternal mortality rate that is higher than the expected number required to achieve the SDG. The exact maternal death rate for the study area is not available, but the estimated death rate for a secondary healthcare facility located within Ado-Odo/Ota local government is 816 per 100,000 live births (Sageer et al., 2019). Given that only 38% of women in Nigeria deliver in the presence of a skilled birth attendant (Adedokun & Uthman, 2019), the rate of utilisation of the service of a qualified healthcare professional is considerably low, especially in rural areas (Adewuyi et al., 2018; Onyeajam et al., 2018). In remote communities like Ota, where socio-economic factors such as little formal education combined with cultural factors affect women's healthcare choices regarding where to seek care during pregnancy, not all women utilise the service of skilled healthcare personnel. Most of the research on maternal healthcare in Nigeria is conducted in urban areas (Adegoke et al., 2012); therefore, conducting a study in a rural area such as Ota is vital for the improvement of pregnancy outcomes within and outside the community, since more than 70% of maternal deaths are avoidable (Maswime & Buchmann, 2016).

6.3.2 Healthcare Services in Ado-Odo/Ota

PHCs, secondary healthcare facilities such as general hospitals and state-owned hospitals along with privately owned hospitals, are spread across the 16 wards of the Ado-Odo/Ota LGA (Musah, 2016). These wards are Ota 1, Ota 2, Ota 3, Ilogbo, Alapoti, Atan, Ere Igbesa, Ado-Odo 1, Ado-Odo 2, Ketu Adie Owe, Iju, Agbara 1, Agbara 2, Ijoko and Sango-Ota. Each ward comprises at least one primary healthcare centre (Azuh & Chinedu, 2014). The number of primary healthcare centres in each ward provides information about the likely number of hospitals per individual in the area.

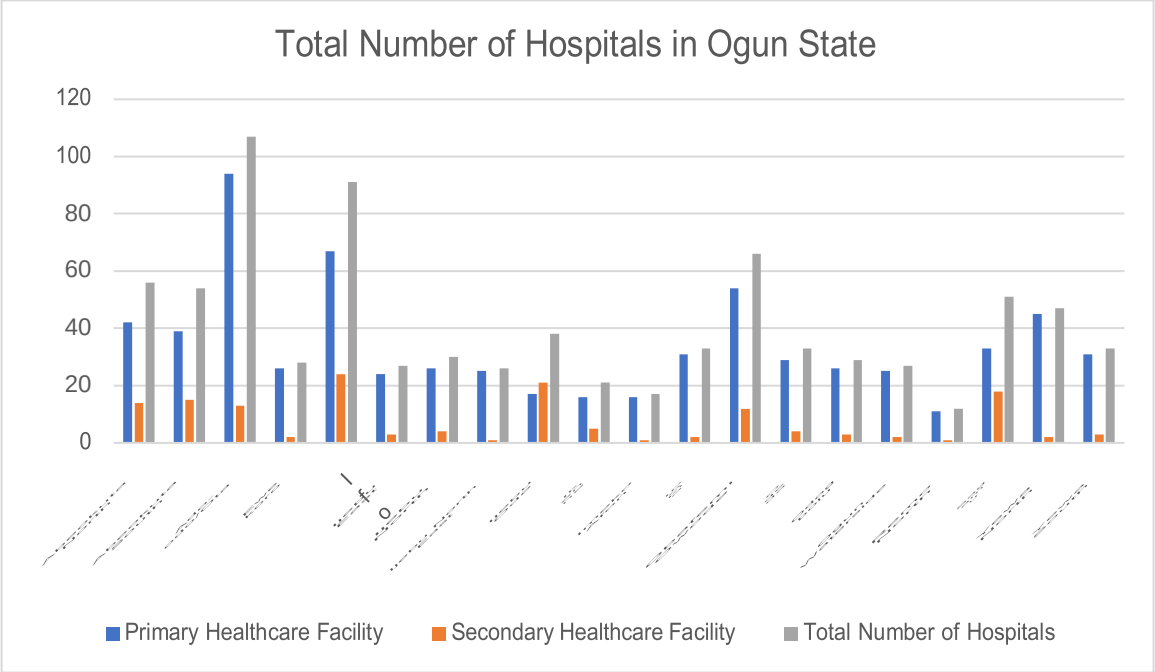


Figure 6.3b: Total number of hospitals in Ogun State, Nigeria (Source: Federal Ministry of Health, 2020)

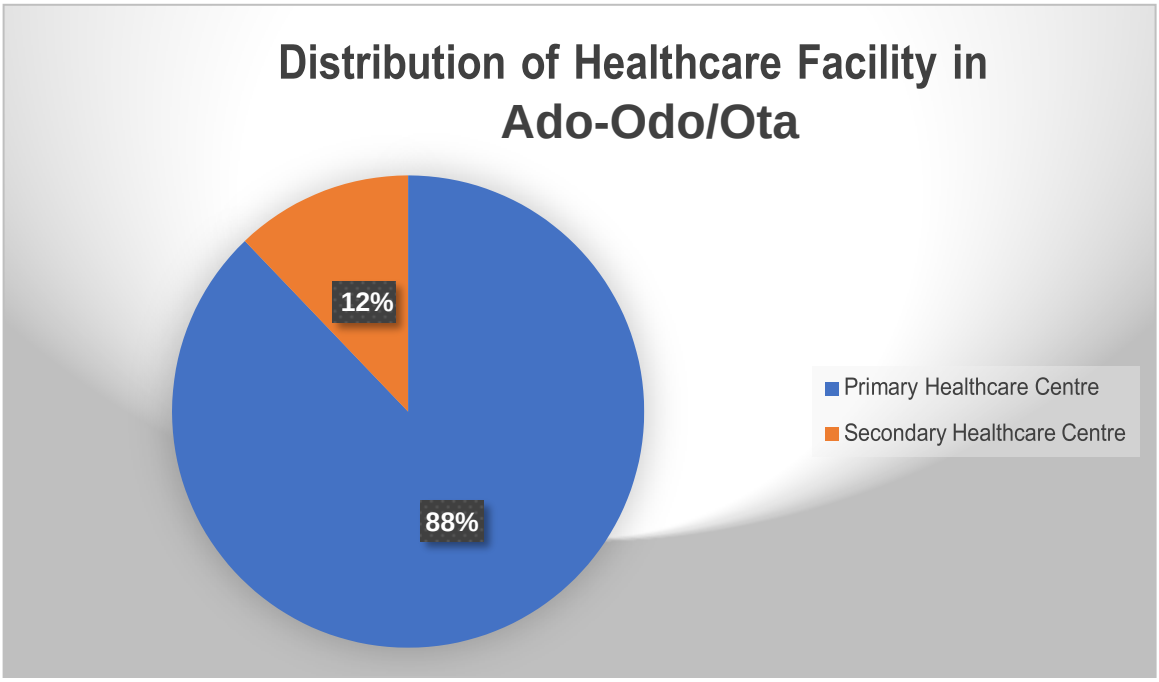


Figure 6.3c: Distribution of healthcare facilities in Ado-Odo/Ota (Source: FMH, 2020)

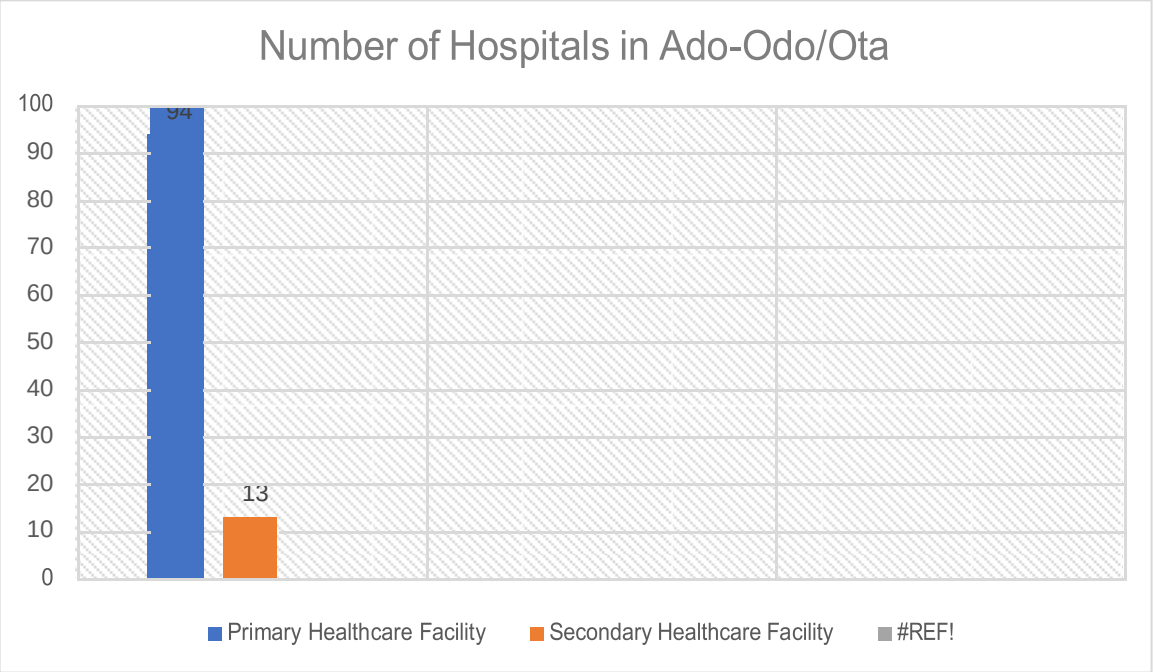


Figure 6.3d: Number of hospitals in Ado-Odo/Ota (Source: FMH, 2020)

6.3.3 Providers of Maternal Healthcare Services in Ota

Women in Ota seek maternal healthcare services from both the hospital setting and other local service providers from the community. The skilled healthcare worker provides maternity service within the hospital setting, while the unskilled maternity service provider is categorised as an alternative form of health provider available within the community (Ebuehi & Akintujoye, 2012). Thus, women in this area seek care from both skilled healthcare personnel within the hospital setting and unskilled individuals who provide care for women during pregnancy within the community.

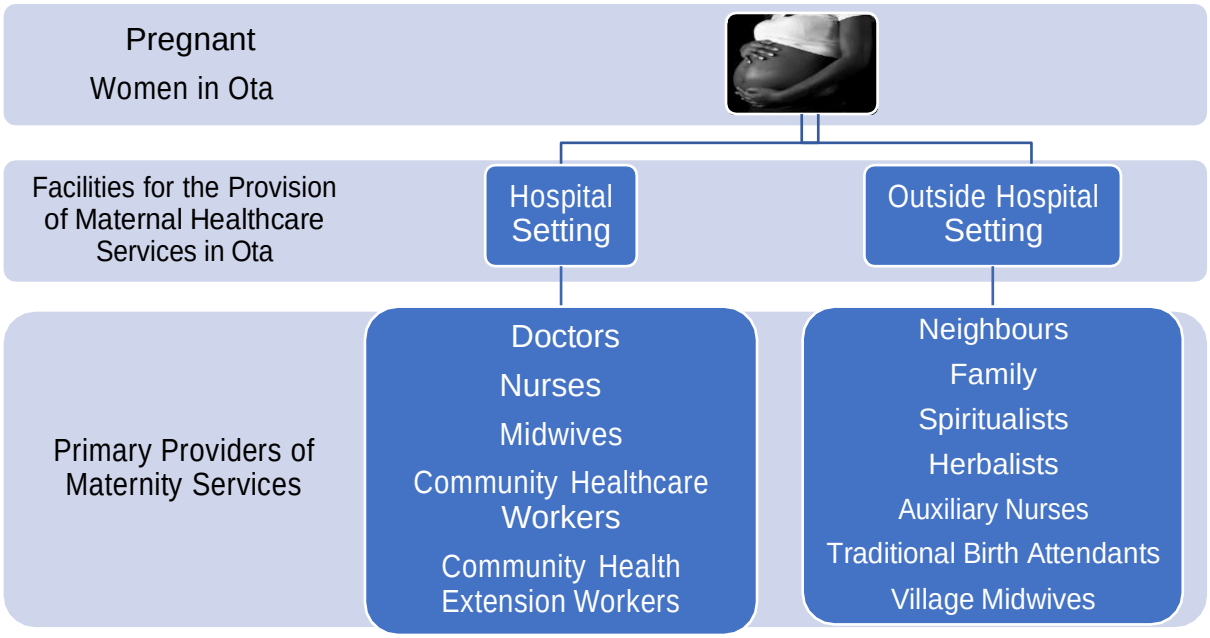


Figure 6.3e: Providers of maternal healthcare services in Ota (Source: Ebuehi & Akintujoye, 2012)

6.4 Justification of the Study Area

This study was conducted in one PHC and three local clinics located in Ota. This study area was primarily chosen because it is my hometown. Familiarity with the setting was part of my decision because it would enable easy access and an easier data collection process. Although this might expose a researcher to some form of distraction away from the research project, I was able to minimise interventions or demands from family members by making it known to everyone that the purpose of the visit was solely to carry out fieldwork and that the visit was not a personal trip, but part of the requirement for my doctorate. (Wustenberg, 2008).

Ota was also chosen due to its geographical location; studies in the review of the literature show that the significant location of an individual is one of the crucial factors affecting healthcare choices. There can be a great disparity in the form of healthcare available to people within the same region despite the proximity between the communities. This is evidenced in a community like Ota where the distance to Lagos is about 29 miles and the time taken to travel between the two settings is less than an hour (although the travel time is supposed to be less, but due to the road topography there is always heavy traffic on the Lagos–Abeokuta expressway, which is the main road that links Ota to Lagos State).

Ota is classified as a rural community and Lagos is described as an urban area and the centre of the country. Lagos is the only state where one may find the optimum resources and facilities available within the country, after Abuja, the capital. A study conducted in the United States showed that geographical location can be a major factor leading to health disparities among communities. However, in the US the disparity in healthcare is attributed to the difference in access to healthcare services and the economic status of the residents of the different regions. A woman in an urban area in Nigeria is likely to earn more than her counterpart in a rural community. Although resources are supposed to be equally available to all the citizens of FRN irrespective of the location, unfortunately this is not the case. Each state's contribution to the economy should determine the allocation from government (Thomas et al., 2014), but it appears to be the case that policy makers and other major stakeholders in the country distribute resources based on the benefit associated to their career development (Welcome, 2011). In contrast, other authors

have argued that the disparity in the distribution of resources in Nigeria is due to the uneven distribution of natural resources in the different regions (Raheem et al., 2014). Although Ota as a community in Ogun State has contributed significantly to the economy of the nation, it still cannot be compared to Lagos in terms of healthcare and infrastructure.

Ota was also selected as the study area because as a member of the Nigerian Red Cross Society, I have carried out various volunteering duties within the area. Hence, I am familiar with some of the healthcare issues in the area. Furthermore, as an executive and an active member of the Nigerian Red Cross Society, I have also provided various assistance and support to women in need of emergency care within the community.

6.5 Study Sites

Sango-Ota PHC, a spiritualist clinic, an herbalist clinic, and a TBA clinic were the four sites selected for the study. Sango-Ota PHC, a hospital-based healthcare facility, is geographically located within Sango Ward and offers provision to 14 rural communities within the area. A total of 2,000 women attended the healthcare centre every four weeks (Anthonia & Mchunu, 2019). It was selected because it is located within Ado-Odo/Ota LGA: an area classified as the second largest of the 20 LGAs in Ogun State. Due to its central location, Sango-Ota PHC is utilised as the point of referral for other healthcare facilities within the area. The selection of this study facility, therefore, provided the opportunity to meet participants who came from the entire LGA.

6.6 Access to the Study Site

After obtaining approval to conduct the research from the Ethical Committee of the School of Health and Society, University of Salford, an official letter was sent to the Ado-Odo/Ota Ministry of Health in Nigeria to obtain permission to conduct the study. Access was obtained through both formal and informal approaches because gaining access involves a series of negotiations with different individuals. Permission from the local heads of the community was also obtained, gatekeepers were then chosen based on the referral from the community heads. The gatekeepers were an integral part of the research due to their ability to delay, avoid or allow access to study participants. It was, therefore, crucial that they were involved from the beginning of the research process; their level of understanding about the research could influence their decisions to grant or withhold access to the participants within the study area.

Prior to initiating research in the study area, the aim and objectives were explained to the gatekeepers and the associated benefits of the research were clearly stated. This was done to avoid any issue that may impeded access to the area – preconceived ideas and levels of understanding about the subject area are the main factors identified through reflection as those that may affect the decision of the gatekeeper (McFadyen & Rankin, 2016). Thus, despite a researcher being familiar with the area, a gatekeeper can still affect the success of the study with the latter potentially presenting the researcher with new challenges despite permission to conduct the research have been granted.

A researcher should ensure that the gatekeeper understands the purpose of the study (McFadyen & Rankin, 2016). Therefore, despite being an indigene of the community, I ensured that at the beginning of the study I clearly stated that the findings would not affect the integrity of the study participants or the gatekeepers but would be used to improve the maternal and child healthcare policy in the area (McFadyen & Rankin, 2016). This is because the gatekeepers may have feared that the dissemination of the research findings would lead to criticism in the future (one gatekeeper sold herbs and herbal products within the community). Access is therefore described as a prerequisite for conducting research (Shenton & Hayter, 2004). Research has shown that there are different strategies that can

be used to gain access to the study area. These include phased entry tactics, reciprocity tactics and the exploitation of past links as tactics.

6.6.1 Tactics for Gaining Access to the Study Area

The exploitation of past links was used to gain access to the study area as it was the easiest approach I could use. With this approach, it was necessary to inform the people involved in granting access about my connections and existing ties with the community. In this study, past links included reference to previous voluntary work and the people I worked with in Ota. I started by informing the staff of the local government about the various community activities that I had carried out as a member of the Nigerian Red Cross Society. This was received positively, and the officials I spoke to were ready to offer their support for the success of the study. I also referenced the people I had worked with in the community, which demonstrated my strong ties with important people in the community. This paved the way for easy access to conducting the study in the chosen study area (Shenton & Hayter, 2004).

Access was also obtained from the hospital management board, the local government council, and the council of elders within the community. Since this research uses an ethnographic approach, I was expected to participate in various activities within the community. However, I was not totally immersed in the activities to avoid being biased or affecting the quality of the research. This was achieved by ensuring that there was no deep relationship with any single individual within the community. Although I developed relationships with some of the members of the community due to my prolonged stay in the area, it did not affect the quality of the research because I was conscious of the purpose of my visit, and I ensured my interaction remained a casual working relationship needed for the success of the research.

6.7 Access to the Study Participants Within the PHC (Hospital Setting)

Prior to the selection of study participants from the chosen study area, I developed a working relationship with the healthcare workers at Sango-Ota PHC: all the medical and non-medical staff in the antenatal department. I visited the antenatal department every day, from 8am until 4pm, for three weeks to get accustomed to the facility where the study would be conducted, since the study is qualitative research (Hammersley & Atkinson, 2007; Berg, 2009). During this period, I learned about the various routines, and then initiated relationships with the staff within the antenatal department. This was a vital element of the research; without such a relationship, it may have been a challenge to conduct the study smoothly (Casey, 2004). This approach was helpful because carrying out research within a healthcare facility, whether in rural or urban areas, is different and more difficult than theoretical explanations learned in classrooms. It is therefore crucial to minimise potential problems by developing good relationships with the staff of the facility, since it is part of the approach for the smooth conduct of studies in healthcare facilities

I endeavoured to sustain a good working relationship by timing my interactions with staff at 8am – a suitable time as it was before duties commenced and did not interrupt ongoing activities. Noting my commitment, the staff allowed me to access planning and rosters in the antenatal department. I was also allowed to assist the staff with recording the weight of the women attending the clinic and giving health talks as requested. However, my daily duties were not fixed; they varied depending on the number of staff on duty and the number of women attending the clinic for that day. This approach was useful; becoming a familiar presence prior to selecting participants paved the way for easy access to study participants because every member of staff was willing to help.

6.8 Access to the Study Participants Outside the PHC (Outside the Hospital Setting)

The first approach in gaining information about the study setting was employed informally by moving around the different areas in the community. I visited different strategic places such as the town hall, local market, and the royal palace. I also visited the different healthcare providers spread across the community. This was done as part of a mapping strategy to acquire more information about the area before recruiting participants outside the PHC. The mapping process involves identifying the various assets, actions, valuable resources, values, and beliefs within a geographical area (Brennan et al., 2012). Mapping is carried out in advance of selecting the participants to identify some of the predominant behaviours of the community members. Although I had a good knowledge and understanding of the area, I relocated more than five years prior to conducting the study. It was important to acquire information about some of the activities within the community that might have changed. The ideas from the outcome of the area mapping would be useful when conducting the interviews (Barley, 2011).

Similarly, other authors also engaged in a form of walk as a mapping technique prior to conducting the research, to explore more information about the study area (Salway et al., 2007). It is important to build strong and reliable relationships at the initial stage of the fieldwork because these will be useful during subsequent phases. After obtaining access to conduct the study from the local government, the gatekeepers then guided me on how best to visit the local providers of maternity service in the area. We started with the visit to the most popular TBA in the community who advised on how reach other local providers of maternity services in the community.

6.9 Sampling

Generally, in research the total population cannot be studied due to limitations on time and resources. Therefore, it is crucial to use a sampling process when selecting participants from the total population; this method is applied to ensure the selected participants will be able to answer the research questions. Sampling is described as the population from which samples are selected, with a characteristic feature that each sample must be a representation of the entire population (Emmel et al., 2013). In qualitative research, there are numerous types of sampling, but the two main types are theoretical and purposive sampling (Coyne, 1997).

Theoretical sampling emerges from grounded theory and is used to generate theory. It also involves collection and analysis of data in preparation for the next data to be collected. According to Becker (1993), information about this form of data cannot be determined prior to the collection of data from the study participants. Rather, data is collected and analysed for the generation of a theory that is deeply rooted in the data. Thus, when adopting theoretical sampling for the selection of the study participants, it is necessary to have basic knowledge about the participants for the study at the initial stage of the research. However, one may not have an idea about the likely outcome, that may precede the selection of group of people (Coyne, 1997). In contrast, purposive sampling process involves selection of participants purposively from the population. This approach has also been described as the primary method of selecting participants in qualitative research (Coyne, 1997).

Other methods commonly employed for the selection of participants are convenience and snowballing sampling methods. Convenience sampling involves talking to people who may likely be suitable participants for the study because they are easily accessible. The criteria for the selection of participants in convenience sampling includes geographical location of the participants, accessibility of the participants and willingness to participate in the study. Although convenience sampling is applicable to both quantitative and qualitative research, it is frequently used in quantitative research (Etikan et al., 2016). In purposive sampling, all the participants have equal chances of being selected since each participant is expected to provide a unique contribution to the research, based on the aim

and objectives of the study (Etikan at al., 2016). Snowballing involves the selection of participants by referral where initial participants are asked to suggest other potentially knowledgeable participants for the study (Holloway et al., 2010; Streeton et al., 2004). Snowballing is used when potential participants cannot be accessed easily, or when it is a challenge to identify potential participants for a study. A common feature among all the different strategies is that they all focus on selecting participants who can provide rich information and will be able to answer the research question, but there is a slight variation in terms of the strategies employed in the selection of participants.

The participants for this study were selected through the purposive sampling method because of the gap identified in the literature. This approach was selected to ensure that the participants selected were those that could provide the information that needed to be ascertained based on the aim and objectives of the study (Patton, 2002). This method was also applied because it considers the quality of the study participants – quality is a crucial factor in helping to provide information about the gap in the literature (Etikan et al., 2016). Although the study participants could have been selected through the convenience sampling process, it was not applied in this research because it involves selecting study participants accidentally due to their availability in an area at a time (Etikan et al., 2016). Furthermore, if applied, convenience sampling may have led to the inclusion of participants who did not meet the criteria expected in the study. Thus, it may have increased the likelihood of including participants with diverse qualities in terms of the objectives of the study. This contrasts with the purposive sampling method where all participants share similar qualities (Etikan et al., 2016).

For the reasons outlined above, the purposive sampling method was used in the selection of participants for the study. Women within the reproductive age group were categorised as the target population because they were the most appropriate to provide information that could assist the researcher to meet the set objectives – due to constraints on time and resources, the entire target population could not be studied. A non-probability sampling approach was applied in the selection of part of the population for the study. Selection can be carried out through the purposive sampling method itself, or a researcher

can employ any of the different strategies of purposive sampling by using the snowballing sampling method (Holloway et al., 2010).

Snowballing was used in this study as it was considered an appropriate approach for investigating individuals who may be hard to reach (Streeton et al., 2004). It was used to select local providers of maternity services outside the hospital setting. Study participants selected in this way included the spiritualists, herbalists and TBAs, as well as the pregnant women attending their respective clinics. All the providers selected outside the community also supported the selection of the suitable participants for the study. Therefore, all the main providers of maternity services outside the hospital assisted in the identification and selection of participants for the research.

The purposive sampling method was employed in the selection of pregnant women outside the healthcare facility because information about such local providers of maternity care services is not known by everyone within the community. Generally, maternity service providers outside a hospital setting have information about co-workers in their area because they help each other when patients attending their clinic suffer any complications or have any challenging health-related issues in pregnancy. They, therefore, provided a form of communal support for each other and were also useful for this research because each service provider was able to signpost me to other providers of maternity services in Ota.

Although the purposive sampling method saves time and resources, while the snowballing probability method takes more time, it was necessary to apply the former in the selection of the maternity service providers outside a hospital setting because the initial contact was the one that forwarded me to other providers of such services within the community (Etikan et al., 2016). Furthermore, there have also been numerous arguments about the process of selecting study participants in qualitative study, in this study it will be applied differently because ethnography as a methodological term does not have a well-defined taxonomy. It is, rather, applied based on the situation in each study setting. However, it has been argued that it is highly significant to identify the various ways ethnography can be applied and not to merely have specific boundaries around its description.

In this study the participants were selected purposively from their natural setting to indicate how ethnography was applied in the research (Higginbotton, 2004). There was no random selection of participants using the statistical formulae of quantitative research (Sargeant, 2012), as it would increase the chances of excluding information-rich participants who could provide the experience that answered the research question (Kuper et al., 2008). This study also used two different methods as flexible approach in the selection of participants because non-utilisation of a good process in the selection of participants will affect the quality of the study (Johnson et al., 2001). The participants for this research were selected through a logical process from both the hospital setting (Sango-Ota PHC) and outside the hospital setting (local providers of maternity service within the community). This approach was adopted to acquire an in-depth understanding of the phenomenon under study (Suri, 2011). A lack of specific criteria for the selection of participants could have led to confusion in terms of who to include or exclude from the study.

6.9.1 Sampling Technique

The sampling technique for this research will be explained because there have been numerous criticisms about the inclusion of too little information, or the non-inclusion of the process employed for sample selection in qualitative studies. The non-inclusion of such information will make the interpretation of the study difficult (Coyne, 1997). In practice, the selection of participants for qualitative studies does not really involve any form of analytical process like quantitative research, which has a well-defined approach for the sampling process. It is, rather, based on the methodology of the research (Higginbottom, 2004). As noted above, purposive sampling was employed, which was done with the assistance of the nurse in-charge at the antenatal department of the selected PHC (Sango-Ota PHC). Pregnant women attending the clinic during the period of the study in the area were, therefore, the population for the study, but these were restricted to only the pregnant women who met the inclusion criteria as described below.

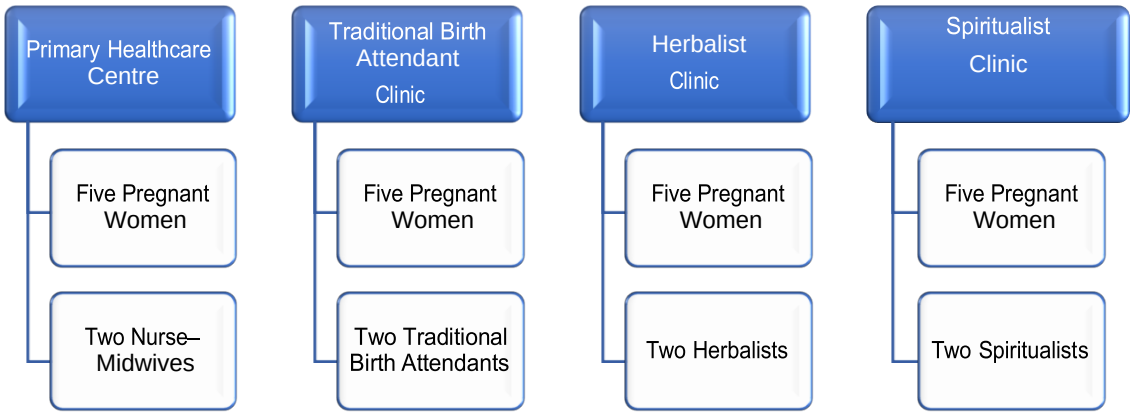


Figure 6.9: Participants selected for this study

At Sango-Ota PHC, I was able to have access to the participants through the nurse-in-charge at the antenatal department, who was therefore the gatekeeper that aided access to the pregnant woman within the clinic. The selection of study participants in this study started with the gatekeeper as the key informant in the research. At the PHC, the gatekeeper was the first skilled healthcare staff member the pregnant woman met upon arrival. After booking into the clinic for the day, the staff nurse informed the women about the research taking place in the clinic. After a health talk given by the matron of the antenatal department, I was then introduced to the pregnant women attending the clinic. I shared some of my background information with the women and explained my research. At the end of the clinic, the nurse-in-charge suggested some women as potential participants, based on her experience working within the department. The inclusion criteria were therefore further used for a definitive confirmation that suggested participants were appropriate for the study as follows:

- The pregnant woman is registered at the clinic
- The pregnant woman has been attending the clinic on a regular basis
- The woman is not pregnant for the first time

The inclusion criteria for the pregnant women selected from TBA clinics, herbalist clinics and spiritualist clinics are as follows:

- Pregnant women who have been attending the clinic
- Women with previous pregnancy experience

The exclusion criteria are as follows:

- Non-pregnant women between the reproductive age group
- Women attending postnatal clinic
- Women with no experience of ANC
- Women attending the clinic for the first time
- Women with no previous childbirth experience
- Healthcare providers not providing maternity service

In line with the objectives of the study, I focused on exploring the beliefs and practices that may have influenced the health seeking behaviour of women during pregnancy.

As an insider within the study area, there was the possibility that the participants could be easily accessible to me, yet such accessible women might not be right for the study because they might only qualify as a member of the population by location, as opposed to being a member of the group required for the study according to the inclusion criteria. Therefore, a participant might be convenient for the study, but not right for the study. Purposive sampling technique was, therefore, used with the support of the service provider to select appropriate study participants from both the PHC and clinics of the local providers of maternity services. The selected study participants were willing to take part in the research and ready to share their experiences (Palinkas et al., 2015).

6.9.2 Sample Size

The sample size for this research was not defined prior to the data collection stage. It was, however, defined in terms of the specific characteristics the participants should possess before being selected to participate. This was determined based on the aim and objectives of the study, but it was not quantified in terms of how many individuals I was

expected to select, which only emerged as the study progressed. For instance, the maternal healthcare providers that took part in the study were selected from different clinics, but they shared many similarities in terms of the care they provided, the resources they used in the care of women, the importance of protecting the pregnant women from evil spirits and the various beliefs they should uphold for a positive childbirth experience.

Likewise, the pregnant women in the study also shared similarities in terms of protection from evil spirits, using a safety pin and not going out during certain times of the day. They also talked about the need to seek divine favour and the importance of consuming a special soup for the protection of the mother and baby. Thus, there came a point at which there was no need to ask the maternity service provider to direct me to other maternity services providing similar care as the beliefs they would be sharing would be the same as those expressed by other participants. Prior to reaching that point, all participants had been sharing similar beliefs and practices. Thus, when no added information was forthcoming from the participants, the collection of data was stopped since no added information was forthcoming.

The point of data saturation was employed in this research because failure to reach the point of data saturation has a huge impact on the quality of research (Bowen, 2008; Fusch & Ness, 2015; Kerr, 2010). However, data saturation has also been described as a complex term that is difficult to define (Marshall & Rossman, 2011). This is because the data saturation for all studies cannot be the same. It largely varies due to the difference in study design, although there are universal characteristics (which include no new information being forthcoming, the lack of new themes or codes, and the replication of collected data), there is no universal technique for reaching the point of saturation in qualitative research (Guest et al., 2006). Furthermore, data saturation has also been described by some authors as the gold standard through which the sample size is determined when study participants are selected through purposive sampling (Denny, 2009; Saunders et al., 2018; Sparkles et al., 2011). However, saturation is an issue in a PhD programme because of general limitations posed by the rules and regulations of the programme. Time is a limitation in a PhD because the programme must be completed within a specified period. This then affects the duration the researcher can spend in the field because there is a plan which must be adhered to.

6.10 Recruitment of Study Participants

Participants in this study were recruited from a range of settings and using various techniques in line with a flexible approach.

6.10.1 Selection of Study Participants from the PHC (Hospital Setting)

The participants for this study were recruited after several visits to Sango-Ota PHC. During each visit the purpose of the research was explained, and questions were allowed for a detailed explanation of the research to ensure that the participants understood the nature and rationale for the research (Khan, 2014). The study participants selected from the hospital setting were women with childbirth experience who had previously attended the antenatal clinic. They were selected purposively from women attending the antenatal clinic with the support of the matron of the antenatal department based on her working relationship with each person. Prior to conducting the research, the matron had expressed that some of the participants may be reluctant to disclose information about the stage of their pregnancy. This was not considered an issue in this research because the focus was not on identifying the stage of pregnancy but rather to identify the beliefs and practices influencing the health seeking behaviour of women during pregnancy. A reluctance to divulge how far a pregnancy has progressed has been identified as an element of the folklore surrounding pregnancy and childbirth in Africa.

The participants selected from the PHC included nurse–midwives working within the antenatal department and pregnant women attending antenatal clinic. Nurse–midwives were selected as participants for this study because they were the skilled providers of maternity service in hospitals and have been trained and certified by the appropriate regulatory body, the Nursing and Midwifery Council of Nigeria.

6.10.2 Selection of Study Participants Outside the PHC (Local Clinics)

Study participants were also selected from outside the hospital setting, this included various providers of maternity services from the local community and some pregnant women. The selection of pregnant women attending local providers of maternity services

was undertaken with the support of both the primary provider of maternity services and the support staff working with the clinic. As the selection of the participants may have affected the quality of the study, the personnel working in the study setting assisted with the selection of participants, to ensure a selection of participants who would aid the achievement of the aim and objectives of the study (Sargeant, 2012).

These participants were an important part of the study because they were the primary providers of maternity services within the community. Research has shown that they are the first point of contact for pregnant woman within the community, especially for those who reside in rural areas lacking a functioning PHC (Fagbamigbe & Idemudia, 2015).

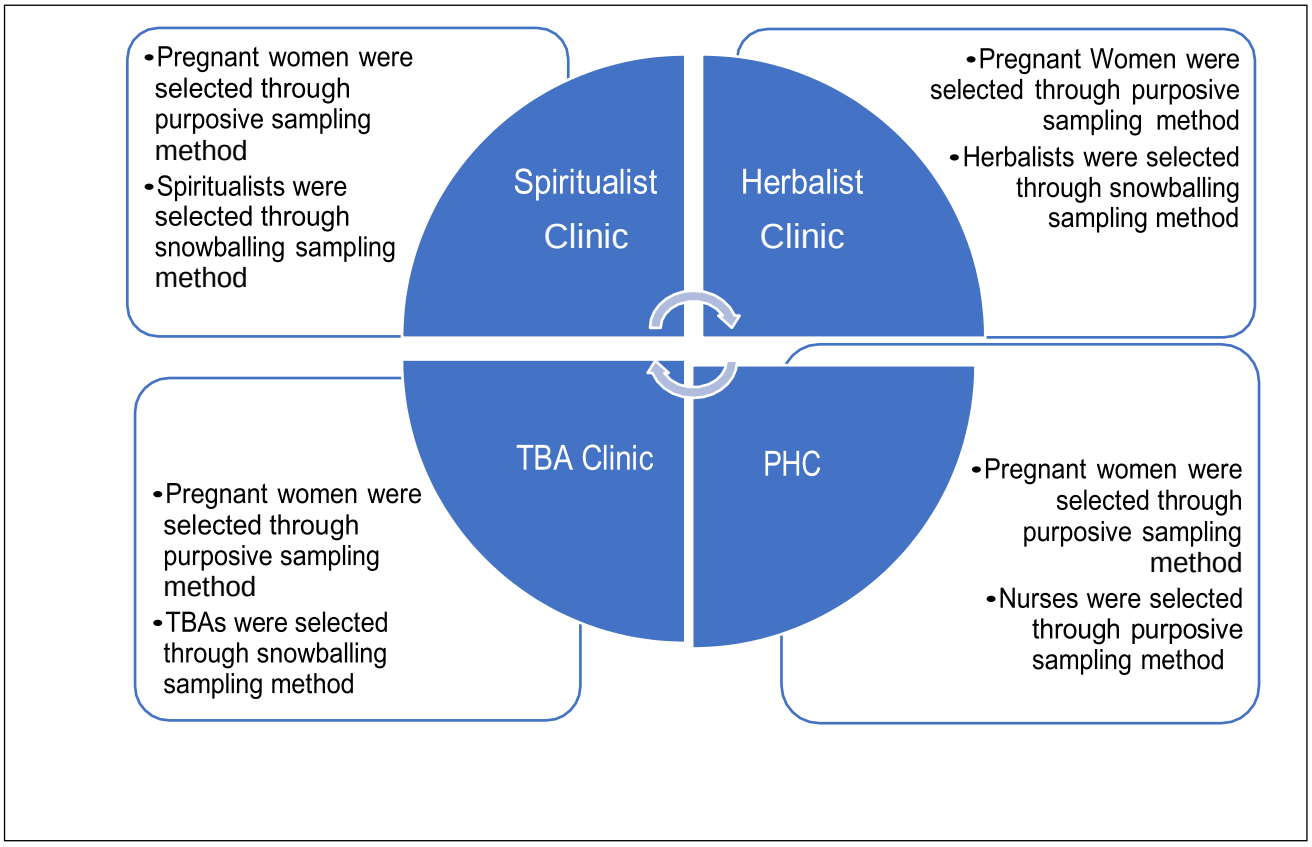
The participants selected for this study outside the PHC include TBAs, herbalists, spiritualists and pregnant women seeking care from the various local providers of maternity service. TBAs were included because they are the custodians of culture within the community and are also the most widely used maternity service providers in rural communities (Adanikin et al., 2017; Ayede, 2012; Udoma et al., 2008). The utilisation of TBAs as maternal healthcare providers has also been attributed to the relatively more affordable costs involved and the influence of extended family members on pregnant woman (Akeju et al., 2016; Edward, 2011).

The local maternity service participants were selected through the snowballing method. Here, selection was not selected based on levels of education, religion, or social status, but on the aim and objectives of the study, as the identification of appropriate study participants is crucial in qualitative research. Since the focus was to be able to recruit participants who were knowledgeable about the subject of enquiry (Sargeant, 2012), this aspect was also justification for each participant selected for the research (Collingridge & Gantt, 2008). This is because the fewer the participants, the higher the risk of losing vital information necessary for the study; a greater number of participants, would allow for a higher likelihood of the repetition of a similar or same account. The data collection was stopped at the point of saturation, when no new information was forthcoming (Cleary et al., 2014).

Overall, the study participants for this research consisted of two trained and registered nurse–midwives, two TBAs, two spiritualists, two herbalists and 20 pregnant

women. Since there is no specific rule or appropriate sample size for qualitative research, the selected number of participants was thus made to acquire the information that was needed to meet the aim and objectives of the study. Although the sample size was small compared to quantitative research, the small number of participants would be studied in-depth to elicit information about the cultural practices and beliefs of pregnant women in Ota (Mason, 2010). Furthermore, the small sample size would not affect the quality of the research since the study participants were studied in-depth until no new information was forthcoming (Fusch & Ness, 2015).

Figure 6.10: The process employed in the selection of participants for the research



6.11 Data Collection

In qualitative research there are different methods that can be used for the collection of data from research participants. Prior to choosing any tool, the aim and objectives of the study are considered, as is the theoretical framework which is important for the achievement of the aim and objectives of the study. In this research, the SEM was used to elicit information about the numerous factors within the individual external environment that were likely to affect women's healthcare choices during pregnancy. In order to obtain in-depth information about the beliefs and practices influencing women's health seeking during pregnancy, semi-structured interviews and observations were used for the collection of data from the participants.

6.11.1 Interviews

Each interview involved the collection of the participants' experiences in the form of raw data from the preferred place of the study participants. It was an in-depth interview to allow flexibility and the opportunity for retrieving information related specifically to the individual participants (Ryan et al., 2013). There are three types of interviews: unstructured, semi-structured and structured. Comparing the semi-structured interview with the structured interview, the former is different in terms of follow-up questions. This is because in structured interviews the researcher lacks the opportunity to ask the participants further questions that will aid in the elaboration of a previous point that has been raised. Although structured interviews may require less time in terms of how long it takes to complete the entire data collection process, when compared with structured interviews they are only useful when the researcher is attempting to clarify an aspect of the study, without the need for an in-depth understanding of the phenomenon (Gill et al., 2008).

Structured interviews involve asking well-defined questions, with little or no possibility of discussing issues emanating from the research. They take less time than other types of interviews and are relatively beneficial when clarifying information (Gill et al., 2008). In contrast, unstructured interviews take more time to gather all the information and are mostly used in long-term research because they involve a form of conversation with no prior idea about any form of question. Instead, they are aimed at eliciting information that

will aid an in-depth understanding of the phenomenon being studied (Jamshed, 2014). They usually start with open-ended questions and can sometimes be challenging to moderate (Gill et al., 2008). Therefore, because this research is a short-term project, semi-structured interviews were used.

6.11.2 Semi-Structured Interviews

Semi-structured interviews are described as a method of enquiry that uses pre-existing open-ended questions, which may lead to other questions during the data collection process. This was chosen in place of focus group discussion for the traditional maternity service providers for several reasons. Firstly, even though the providers were located within the same community, it was not feasible to bring them together to meet at a venue – given the different schedules that maternity service providers operated, none of them were prepared to forfeit their clinic day for a meeting. Secondly, the approach was deemed to be relevant to the selected group of women who would respond better to a semi-structured interview. For women with no formal education and limited interaction in formal settings, it was important for exchanges and expressions to allow a degree of flexibility where the participants clearly understood the questions and did not need someone to assist them; open-ended questions allowed for free expression of experience in a way that suited the participants. A third advantage to a semi-structured approach was that this group of participants were able to communicate in their own vernacular, using proverbs that could only be understood by an insider with a background knowledge of some of the practices common in the area (Gill et al., 2008).

I was later informed that local maternity service providers hold joint meetings once every three months, but that none of the participants would discuss their practice in the presence of another colleague within the community – each participant was, effectively, in competition with their peers and none would wish to divulge the secrets to other service providers. I was also informed that business practices would not be discussed in the presence of other participants. Semi-structured interviews were the most appropriate method in this context.

Semi-structured interviews were used because they have been described by authors as a combination of both structured and unstructured interviews. The questions for the interview are formed using preconceived ideas about the research as a tool to guide the interview, but the researcher moderates the discussion based on the aim, which might hinder the participants from expressing themselves deeply as desired, since the question already has a format that must be adhered to (Bryman, 2016). A further justification for the use of semi-structured interviews for the study context is complex in nature. For instance, it may be challenging for an outsider with no background knowledge to understand the cultural contexts that influence the decision contributing to low utilisation of ANC despite increase access to various ANC healthcare services. Thus, it can be concluded that it may be a little bit difficult to use a structured tool to understand the issues surrounding seeking care during pregnancy in a rural community like Ota, where majority of the women are illiterate. Their healthcare choices are also the result of various interrelated factors within their environment (Jamshed, 2014).

Each interview session lasted for about half an hour or more, depending on the participants. I used the interview guide (Appendix 6) that was developed prior to the interview to ensure I was asking the right questions and to guide the discussion. The interview guide for pregnant women covers both the ANC services and the cultural practices affecting antenatal healthcare. This includes previous history of antenatal healthcare services and choices of ANC.

I conducted the semi-structured interviews with minimal interruptions, to allow the participants as much time as needed to discuss their experience. However, I guided the interview by ensuring that it focused on the topic. This is important when conducting interviews because participants may go off the topic while talking about their experiences (Dörnyei, 2007). To obtain deep and rich information from the participants, I also employed an effective communication technique, which involved listening more than speaking. This was helpful because it allowed the participants to volunteer more information. Although background noise from the venue of the interview may have affected the clarity of the interview, it was mostly kept to a minimum by choosing a quiet venue with minimal noise – I was aware that location has been known to disrupt the interview experience (Bolderston,

2012). To ensure I captured all the essential content of the interview, each session was recorded on a digital audio recorder (Dicicco-Bloom & Crabtree, 2006).

6.11.3 Observations

Observation is described as "the systematic description of events, behaviours and artefacts in the social setting chosen for study" (Marshall & Rossman, 1989, p. 79). It involves watching the subject, which is usually an individual, and in this study, it involved the maternal healthcare providers, and recording the characteristics of the participants (Polkinghorne, 2005). Observation was applied in this study because it allowed me to have a fuller understanding of a social phenomenon, namely the cultural beliefs and practices associated with women's health seeking behaviour during pregnancy (Erlandson et al., 1993).

The description of events in this study, however, was different from the way it was used by Marshall and Rossman (1989) to account for human daily routines. This is because it involved the description of each participant's experience using all the five senses based on the aim and objectives of the study, a feature which is absent in human daily observations where activities are described using the five senses but without a focus on any objectives, as outlined in this research (Corbin & Strauss, 2015). Similarly, observation was used in this research because it enabled a comprehensive understanding of the phenomenon under study; it can uncover other aspects of the research that may not be visible through interviews. Observation was, therefore, used for further discussion, clarification an elaboration during the interview. Thus, providing more opportunities for the understanding of the various practice's women engage in during pregnancy (Kawulich, 2005; Polkinghorne, 2005).

Observation was also applied in this research because it provides comprehensive information about the dynamic nature of the natural environment of people. It therefore provides more evidence about how things have evolved over a period, thereby aiding in the critical understanding of the impact of the environment on human behaviour. Since culture as a product of the environment can also be regarded as a form of physical environment that acts as a barrier to healthcare, it is crucial to identify this part of the culture because

there is limited information about culture as a physical barrier to healthcare (Mulhall, 2003). It is worth noting that the information people provide during interviews may not be accurate. An example was seen when the participants could not always explain why they chose a particular place to receive ANC; therefore, in order to really understand why women opted to receive care from a maternity service provider, it was not sufficient merely to ask the question, but to also observe them (Kawulich, 2005). Participants' stories may also be incomplete as information about cultural practices, such as rituals performed for women during pregnancy, were sometimes not included during the interviews because they were not seen as part of the story (Kawulich, 2005).

Using observation as part of the method of data collection along with interviews in a natural setting differentiates this study from others. While my presence as researcher with the members of the community may have directly or indirectly changed the behaviour of the people being studied (Strudwick, 2020), research has shown that the impact of researcher's presence within participants' natural settings can be minimised when each session is carried out for a reasonable period (Strudwick, 2020). The reasoning behind this is that the presence of the researcher can only affect the behaviour of the participant for a limited period before the authentic behaviour of the individual emerges (Nieswiadomy, 2013), as evidenced by the ideas of Wolcott (1999) who states that "people can sustain an act or maintain their best image only so long" (p. 49).

Therefore, using observation provides the opportunity for further interactions with the participants and, thus, the study will be able to provide greater understanding of the norms of the group of people being studied (Strudwick, 2020). When observation is not used as part of the method of data collection, the duration of time spent in the field is minimised, but the information obtained may be incomplete because interviews will only provide what is considered as essential by the participant (Strudwick, 2020). Consequently, the stories of the participants in this study are their actual experiences because the length of time I spent with each participant ensured that any pretence or acting was impossible to maintain. Thus, the long duration of time afforded me the opportunity to see the actual way of life of the participants (Strudwick, 2020).

Observation can be applied in research either as a structured or unstructured approach. Structured observation is mostly applied in positivist research due to the application of an existing theory into the development of the content of the observation. This is formed before the actual observation begins, whereas unstructured observation is mostly used by interpretivists to understand the way of life of people and focuses more on the contextual experience of the participants. Although structured observation is mostly applied in nursing research, unstructured observation was applied in this study as it is the main approach in many ethnographic studies (Bragadottir et al., 2017; Laging et al., 2018; Mulhall, 2003). Being unstructured does not categorically means that the observation has no pattern, but rather that it does not involve observing the participants against a set of existing behaviours.

As an observer, I went into the field with no pre-existing information about the exact behaviour to expect from the participants during the observation. While it is believed that a researcher may have basic ideas about what to observe while in the field, as the researcher commences with the collection of data, some of the basic ideas will be modified. In addition, researchers conducting structured observation intend to separate themselves from the collected data. Despite a pre-existing notion about the behaviour, researchers believe that it will be challenging to separate the researcher from the participants, especially when studies are conducted within the natural environment of the participants (Giske et al., 2018; Mulhall, 2003).

This research further incorporates participant observation because it is widely used in most anthropological and sociological studies. Participant observation is described as a method that involves the researcher taking part in people's activities in order to learn about their culture. However, some believe that participant observations can be used to denote all the observations and interviews conducted in ethnographic research (Musante & Dewalt, 2010), while others regard participant observation as the beginning of ethnographic research because it is aimed at initiating interaction with the participant in order to understand what is important to a group of individuals, and to avoid asking questions that may not be culturally appropriate to the set of people in the group (Bernard, 1994; Musante

& Dewalt, 2010). It is therefore regarded as a non-scientific method that is, arguably, only valuable at the preliminary stage of the research.

Participant observation was therefore used in this research because it is deeply rooted in ethnographic studies, and it could also further enable me to deduce more information about the maternity service available in the study area (Marshall & Rossman, 2011). Nevertheless, previous researchers have argued that the information collected by the researcher during participant observation is incomplete because it is not a true representation of the individual since the researcher is at risk of only focusing on the aspect of the culture that relates to the project under study (Kawulich, 2005). However, to minimise the risk of losing vital information during the observation, I observed the participants by keeping an eye on every aspect of the routine; no part of the culture was irrelevant since the aim of the study was to identify the cultural practices and beliefs affecting antenatal health seeking behaviour.

The level of participation of the researcher also varies depending on the situation at the study site. Sometimes the researcher might be an active participant where there is opportunity to join in some activity, but at other times the researcher's role changes to a passive participant because there is no opportunity to engage directly with the individuals involved in the activity. This is based on the individual being observed not wanting to expose to the researcher the main resources they used in the care of pregnant women. With their source of living under scrutiny and having spent years learning the processes of their skill from their parents, they would wish only to disclose confidential information to their siblings, whom they believed would be taking over their role (Morrel-Samuel et al., 2016; Wartman & Purves, 2018). This implies that the role of the researcher is based on the situation within each setting, and therefore varies from the researcher adopting the role of a complete observer, to be a participant.

The field observation for this study was conducted using both participant and non-participant observation, based on the situation within the field. This is because in some instances I was able to observe as an insider actively participating in the care of the women attending the clinic when, for example, with my nurse–midwife background I gave health talks to pregnant women attending antenatal clinic. In other cases, I was only able to

observe from the outside without interrupting the situation in the ANC department and not involving myself in discussions or care within the clinic.

There were certain points in the study when I felt conflicted because I had intended to sit and observe without taking on a task, but due to the unavailability of someone to fulfil the task, I had to change my role to that of a participant while still observing. Ethnographic researchers described this as a normal part of conducting ethnographic studies because when in practice as an ethnographer, there may be times the researcher has to adopt two different roles concurrently to address some of the problems in the field. When the researcher does not experience any of these challenges while in the field, it may be attributed to being too aware of the routines within the community, and thus nothing seems difficult or challenging to the researcher (Hammersley & Atkinson, 2007; Jan, 2015; Morse, 1991).

It is also crucial for the researcher to plan the mode of participation in activities within the study area. This is because too much participation may affect the accuracy of the collected data by increasing the chances of the researcher being tempted to integrate due to their previous experience in the study area. Furthermore, the researcher is also at risk of enjoying the participation more than the actual purpose of the research. Therefore, the researcher loses vital information that may affect the quality of the study. This may also affect the perception of the participants about the researcher, because they may start to believe that the researcher is participating in their activity to change part of their practice. In this study, my participation was reduced to the bare minimum by ensuring that my role only changed in some activities when it was needed and requested. I adopted this approach to minimise the effect of excessive influence on the study result (Bjerknes & Bjork, 2012; Rosenthal, 1989). However, to clearly understand the situation, all the different approaches in observation were used and all the maternal healthcare providers that participated in the interviews were also observed to ensure a comprehensive understanding of the phenomenon.

An observation guide (Appendix 18) was used while in the field, which lists the different activities within the clinic, what each activity entailed and the different sections within the clinic. I also captured the actual maternal healthcare information providers

sought from pregnant women regarding their beliefs and practices and did not rely solely on what was said during the interview. Some of the codes from the clinic observation are pins, prayer, God, water, and leaves. Observation was used as an additional tool in this research since interviews cannot provide information about women's behaviour that happens beyond the level of consciousness (Bandyopadhyay, 2011; Kawulich, 2005).

6.11.4 Field Notes

In this study, I had a plan for the technique to use in the collection of field notes. It was based on the theoretical framework applied in this study because the framework serves as a guide to the research. Ideas about the approach to making field notes were developed prior to collecting the data but modified while in the field based on the experience of each participant. Each field note consisted of five columns, with each column representing a level in the SEM. The third column, representing the organisational level, was further divided into another sub-section to represent geographical location. This forms part of the content of the field notes and it contains a brief description of the location of each provider of maternal healthcare services within the community. There were also notes on the non-geographical factors affecting access to the service of each maternal healthcare provider within the community. Information about the norms common within the community was also included, since the research is aimed at identifying the cultural factors affecting women's antenatal health seeking behaviour (Phillippi & Lauderdale, 2018). One of the major challenges that arise when using field notes in ethnographic studies is when to write the field notes; it may be difficult to observe and record notes at the same time. I therefore ensured that field notes were written immediately after observation, to avoid missing out salient information (Cope, 2014; Koch, 2006; Noble & Smith, 2015).

6.12 Ethical and Institutional Approval

Two primary areas pertaining to research in qualitative studies are procedural ethics and ethics in practice. It has been pointed out that professional codes of conduct have been excluded from the classification, since neither of the two primary areas included information about the organisation's code of practice. It was further argued that the professional code of conduct is not applicable in actual ethical issues that may arise while conducting the research (Mason, 2005, 2017). This is believed by some authors to be due to the non-flexibility of professional codes of conduct, thereby limiting their relevance to the actual research practice. The professional code of conduct was not totally disregarded because it is a useful resource that can be used as a guideline when conducting research (Guillemin & Gillam, 2004).

The procedural ethical approval for this study was obtained from the Postgraduate Ethics Review Committee for the School of Health and Society, University of Salford (Appendix 10) and Ado-Odo/Ota Ministry of Health in Nigeria (Appendix 11). I ensured that all the appropriate institutions and regulatory bodies were contacted before commencing data collection in the study area.

The ethical issues considered while conducting this research include informed consent, confidentiality, and anonymity. This is not just applicable to qualitative research or studies involving humans as subjects, but it is also applicable to all research irrespective of the type of participants involved (Guillemin & Gillam, 2004). Nevertheless, ethical issues were part of quantitative research prior to inclusion in qualitative studies in the 1960s (Orb et al., 2001; Voltelen et al., 2017). The following section will focus on some of the ethical issues related to ethnographic study.

6.12.1 Difficulty in Establishing Rapport

It is not an easy task to establish rapport with pregnant woman in a community like Ota, where people are always reluctant to talk to strangers due to a spate of crimes related to using pregnant woman for money rituals. Therefore, it is common for pregnant woman to resist talking to people they do not know because they fear being used for such rituals. I

therefore, ensured that the gatekeeper was always present when meeting a participant for the first time and that the gatekeeper informed the participants of the purpose of the visit and what I would be doing. Difficulty in establishing good rapport could also be due to participants' lack of trust in the healthcare system stemming from previous experience of care provided by a particular healthcare centre. The findings of the Tuskegee Study in the United States demonstrate why it may be challenging to develop good rapport with participants who had previous negative experiences after volunteering to take part in research (Brandon et al., 2005).

6.12.2 Unwillingness to Disclose Information

I noticed that some participants were unwilling to disclose some information about their pregnancy even after I had explained the purpose of the research and obtained informed consent to conduct the interviews. This was predominantly during the initial phase of data collection when participants were especially sensitive regarding the kind of information, they might disclose related specifically to pregnancy, such as the stage of pregnancy and the sex of the unborn child. This hesitance was considered when selecting the participants for the study, and after the first meeting the participants were relaxed and able to discuss extensively about their health seeking behaviour during pregnancy.

6.12.3 Social Media Effect (Facebook)

I noticed that some of the women who participated in the study were concerned about their information appearing on social media platforms, with one woman asking if the information I obtained would be shared on Facebook. It was not uncommon for the women to end discussions quickly when the issues under discussion were not directly health-related, as viewed by the women involved. In response to the concerns raised, I explained more about the purpose of the research, how their information would be stored, and what it would be used for. I reiterated that all the discussions would be recorded using a digital audio recorder to ensure that their experiences or stories would clearly and faithfully documented. I clarified that the discussions would be translated from Yoruba to English. I noted that the more transparent I was about the process involved in the research, the more

the participants were ready to share more information about their health seeking behaviour during pregnancy.

6.12.4 Informed Consent

Although consent had been obtained at the start of the study, I was aware that this was tentative and that as the study progressed and I gained familiarity with the setting, the need to seek consent again would arise. Initial consent alone may not have permitted my access to certain areas within the study setting. Obtaining new consent after spending some time considering the study setting shows a form of respect for the participants in demonstrating that the researcher is not intruding into their privacy without seeking their consent. It is also good practice to periodically renew consent after obtaining the initial consent because the first consent obtained is not likely to provide the researcher with access to enter sensitive areas. This is to be expected where the two parties involved are still strangers. Even if continuous interaction with the participants may be the key to accessing key areas that the researcher has been denied the right to enter, during this period the researcher must ensure that they abide by the rules and regulations stated before granting access. This is important because failure to comply with the norms of the society may affect the overall objective of the study (Guilemin & Gillam, 2004).

Informed consent in ethnographic studies is described as a systematic process. This is because despite being agreed upon at the beginning of the research, consent extends until the end of the project, although this largely depends on the level of trust between the researcher and the participants involved in the study. It is also regarded as a process because it is more than just signing a consent form but entails also explaining the content of the research to the participants in a language that is completely understood by them. Therefore, all the content in the participant information sheet (Appendix 7; Appendix 8) was explained to the study participants in their local language (Yoruba) to ensure that the purpose of the study was clearly understood (Nijhawan et al., 2013).

Despite the benefit associated with extensive stay in the study area, a researcher may face some ethical dilemmas. Therefore, when conducting ethnographic studies, the researcher can reduce their impact by minimising the level of interference in selected

activities in the study area, thereby reducing the chances of changing some part of the research area. This is a common approach in ethnographic studies because the research is intended to be conducted in the natural setting of the participant without changing any part of it as employed in quantitative research, where some characteristics or the quality of the sample are intentionally modified. It is also common for study participants to disclose other information to the researcher, which may not be directly related to the study but may represent useful information that will aid in achieving some parts of the objectives of the study. However, the concern is whether the initial consent obtained when commencing the study justifies the use of such information as part of the data obtained while conducting research in the field.

Recent research shows that informed consent is not actually complete consent because participants still sign consent forms without understanding all the essential parts of the study (Xu et al., 2020). This is because most studies conceal vital information about the research and participants only sign based on their understanding of the available information, which therefore favours the researcher over the participants. Advancements in technology have also changed the context of informed consent. These days research is being conducted online, without the physical interaction between the researcher and the participants, which therefore minimises the level of exposure of the participants to some of the risks associated with the research. It has been questioned whether consent is still necessary to collect data obtained virtually, since technology has directly reduced some of the associated risk. Platforms such as Facebook allow the secondary organisation to use individual customer data without directly obtaining the direct consent of the people involved (Grady et al., 2017; Johnstone, 2011). This is not applicable in this research since the research was not conducted online.

As informed consent was required for and during the study, I provided comprehensive information about the study and there was an opportunity to clarify some parts of the study. This is important because previous research has shown that people consent to participating in research when they believe it will benefit their family and friends. It was therefore crucial that I, as a researcher, informed the participants that the study

would not directly benefit them, but that the findings would inform the healthcare policy within the jurisdiction (Holloway et al., 2010; Sanjari et al., 2014).

The study participants were also informed that the interviews would be recorded on a digital audio recorder. I obtained verbal consent from those who agreed to participate, because most of the women in remote communities like Ota are not educated; they can neither write nor read. Despite their lack of formal education, they were a good resource for this study because research has shown that education and geographical location are two of the factors that determine a woman's health seeking behaviour during pregnancy, as evidenced from the summary of the themes outlined after conducting the systematic literature search. It was, therefore, significant to consider this group of people who had been neglected due to their location. More importantly, their low literacy levels did not impede their ability to consent to providing information, since education does not affect the human capacity to make decisions. These participants were able to show their willingness to participate in the study by verbally giving their consent and by making a mark on the consent form. The content of the research was also explained to the participants in the local language used in the community, to ensure accurate and total understanding of the content of the research.

6.12.5 Confidentiality

Although qualitative research provides rich information about study participants, it also increases the risk associated with acquiring too much information. However, I avoided this risk by ensuring that there was no deductive disclosure of any information related to the women participating in the study. This included any specific information that could be used to trace the women who participated in the research. Although I still had to provide a detailed report about my experience in the field, none of it could expose the participants to any form of harm (Kaiser, 2009). All the data obtained were kept strictly confidential and pseudonymised. All the data will be stored for three years after the completion of my research and then destroyed. The names and addresses of the study participants were not included in any part of the research. They were anonymised and represented with a code, and none of this was changed. Hard copies of files containing data obtained during the

research were kept under lock and key in a cabinet accessible to me and the research team members only. Publications from the study will not include any personal details of the study participants, and any names and addresses will be anonymised.

6.13 Data Analysis

Data analysis can be described as the systematic interpretation of collected data. The collected data for this research was the information from observations, field notes or interviews. Data analysis therefore symbolises the interaction between the researcher and the study participants (Miles & Huberman, 1994; Richard & Morse, 2007; Seers, 2012). At the beginning when I started analysis of the data collected from the study participants, it was quite descriptive because good analysis requires experience. However, after attending several trainings on data analysis, I was able to provide a detailed systematic research analysis. It is crucial to carry out systematic data analysis because this increases the reader's understanding of the research project (Strauss, 1987; Nowell et al., 2017).

The thematic method of data analysis was used in this research because Braun and Clarke's model of thematic analysis can be easily understood by early career researchers (Braun & Clarke, 2006)This method has been used for the analysis of ethnographic data in healthcare research as evidenced in a study that was conducted with the aim of exploring the work life of registered nurses in relation to what makes them to continue to work in a particular setting (Ahlstedt et al., 2019). I started the analysis by first listening to the data several times to aid understanding, familiarisation, and the establishment of a relationship with the data. The data were then sorted out and saved based on Braun and Clarke's six phases of thematic analysis as follows:

- Become familiar with the data
- Generating initial codes
- Search for themes
- Review the themes
- Defining the themes
- Reporting the findings

Become Familiar with the Data

This is the first and most significant phase of the analysis because it begins with the transcription of the collected data. The collected data were transcribed after listening to the audio recordings several times. I undertook this task to avoid missing out important parts of

the data. The transcriptions were then read and re-read several times for me to be immersed in the data and to initiate the development of patterns and meanings about the collected data. Each entire transcript was read before coding in accordance with advice that more ideas are likely to develop as the researcher becomes familiar with the data (Braun & Clarke, 2006). The researcher, it is suggested, also makes notes about any impression or thoughts that develop while reading the transcript (Nowell et al., 2017).

Generating Initial Codes

At this stage the researcher starts organising the collected data. In this study it was done manually at first, using highlighters, then a qualitative analysis software (NVivo) was used to generate initial codes. This phase started after I was familiar with the content of the collected data (Braun & Clarke, 2006) and involved going back to the data to generate the initial codes. This is an approach which involves self-reflection about the data and the purpose of the study (Savage, 2000), thereby enabling the researcher to focus on specific aspects of the data, particularly the interesting parts of the collected data.

The important parts of the transcribed data were coloured and coded. A good code is believed to capture the essence of the research (Nowell et al., 2017). The researcher thereby focuses on generating only important codes and not too many codes because it can be challenging to clarify the difference between the codes (Nowell et al.,2017). Although some text was coded several times in this study, I was aware that there must be limit to the number of codes generated because too many codes can also become counterproductive (Braun & Clarke, 2006). All the identified codes as shown in Table 6.1 were transferred to create a node within the software. The NVivo software package was used because it helps to organise the collected data; however, it has some limitations because it cannot complete the conceptualisation of the collected data without input from the researcher (Nowell et al., 2017). This limitation of the software is an important feature in this study because subjectivity is crucial in interpretivism.

Search for Themes

At this stage of the analysis, all the data input into the NVivo software had been coded. There was now a long list of codes. The initial codes generated were first sorted out,

with similar codes being grouped together as themes. Part of the themes were classified as parent node, while other codes were classified as sub-themes under the parent node as child node based on the SEM. None of the nodes was discarded at this stage; they were saved and kept as temporary nodes (Braun & Clarke, 2006). Examples of codes generated are as follows: anointing oil, catfish, church, concoction, evil spirits, in-laws, prayer, previous pregnancy, snail, and herbs.

Review the Themes

During this phase of the analysis of the collected data, themes formed from the initial code were reviewed for accuracy and suitability. Those themes that did not have enough code extracts or duplicates were removed and repositioned. In such a review, some codes may be better positioned under other themes, themes emerge, and some old themes are broken down into smaller chunks. The themes were also reviewed in relation to the focus of the study using the elements of the SEM in order to assess if the existing themes accurately provided information about the data generated. Some new data were also coded for existing themes or under new themes. The coding process was further repeated until I was satisfied with all the themes generated (Braun & Clarke, 2006) (Appendix 20).

Define the Themes

At this stage I was satisfied with the themes that emerged from the collected data. The themes were clearly defined to show what part of the study they focused on; this aspect was further assessed to ensure it did not capture too much information to render the themes complicated. This was done by checking the themes against the collected data, to ensure they captured what was essential for studying the data. For a researcher, this is an important part of the analysis because they not only focus on all the collected data from the participants, but they also focus on the essential parts of the collected data, in relation to the aims and objectives of the study. When themes are thus assessed and refined, one notes an improvement in the structure of the themes and in descriptions of the focus of each theme (Braun & Clarke, 2006).

Reporting the Findings

The themes were sorted, and the findings of the analysed data were ready to be documented. This was a concise account of the findings from the participants. However, the report did not only provide information about the data collected from the study participants; it also showed the various options they needed to consider to be free from pregnancy-related complications. This was an essential part of the study because it defined what the participants considered to be care in pregnancy thereby enriching the study with more information than was needed to meet the aim and objectives of the study (Braun & Clarke, 2006).

It has been argued that thematic analysis should be regarded as a tool, rather than a method, for data analysis. However, describing thematic analysis as a method is useful because it can be applied in various qualitative research, irrespective of the methodology, for providing detailed information about the themes emanating from the collected data (Nowell et al., 2017). It was applied in this research along with a software package to aid the retrieval of clear and logical results.

In this research, NVivo 12 was used because it involves the formation of themes using codes, a predominant resource of the thematic method of data analysis. The NVivo software package was also used because it is widely popular when compared to others and there is adequate training at the University of Salford to facilitate easy learning and understanding. It is also believed to save time because it reduces the time and stress involved in the analysis of collected data when compared with the manual method of data analysis, since manual data analysis involves a high risk of stress should the researcher lose any part of the paper-based data while coding. With the use of the NVivo software, such a stressful scenario can be minimised because data can be easily retrieved from the sources. The structure of the node can also be changed in both methods of data analysis, but when using the manual approach, the researcher may have to spend a long period of time in doing so. The use of the NVivo software thereby saves times by reducing the duration of data analysis.

NVivo software program was used for coding and indexing the interview transcripts, along with some elements of data analysis, because it is flexible (Cope, 2014). This was done

through de-contextualisation and re-contextualisation. De-contextualisation involves the selection of the main themes from the data, where the emerging themes were noted and compared with others as they appeared. Similar themes were then grouped and analysed through thematic analysis.

Table 6.1: List of final codes that emerged from the collected data in alphabetical order

A–B	C–D	E–F	G–H	I–K	L–M	N–O	P–R	S–T	U–Z
Advice	Cassava	Eat	Garri	In-laws	Late night	Native medicine	Palm wine	Safe delivery	Upper teeth
Afternoon	Caesarean section	Eat anything hard	Giving alms	Information	Leaves	Nurse	Pap	Safety	Vegetables
Against	Care	Eba	God	Jesus	Loss of a baby	Neighbours	Pap water	Safety pin	Vegetable oil
Alcohol	Catfish	Egg	Groundnut oil		Lying down	Occasionally	Parent	Sanctify	Vigil
Amala	Christian	Elders	Guardian		Malaria herbs	Okra	People	Seven -up	Vitamins
Anointing oil	Church	Elder sister	Hospital		Malt drink	Oranges	Pins	Sideways	Walk-in
Antenatal care	Clinic regularly	Elderly people	Husband		Midnight		Power	Sister	Walking around
Avoid	Complications	Exercise	Herbalist		Midwife		Powder form	Sister-in-law	Wall
Banana	Concoction	Evening	Herbs		Milk		Prayer	Sitting down	Water
Bath	Death	Evil spirits	Herbal mixture		Milo		Pregnancy	Sleep	Yam
Beans	Delivery	Facing up	Herbal product		Miscarriage		Prescription	Sleeping position	
Belief	Depression	First pregnancy	Holy water		Monthly		Previous pregnancy	Sleep properly	
Belief in oneself	Disclose	Force	Home		Mosque		Protection	Small baby	
Belief in prayer	Divine favour	Face down	Honey		Mother		Psalm	Snail	
	Doctor		Hope		Mothers-in-law		Reading psalm in	Snail in my food	
	Doorstep								

Bending Bible Big baby Bushmeat		Family member Family taboo Fasting Father Fear of the unknown Financial issue Fish Friends Fruits	Hospitals Hot Hot sunny day Hot sunny afternoon		My people My previous experience		water Red meat Register Regular Religion Rest Rice Rub on the stomach Routine	Snail in my soup Soft drinks Special bath Squatting Stages of pregnancy Stomach Sun Supernatural Taboo Tea Traditional things TBA Trees	

6.14 Quality in Qualitative Research

The value of research depends largely on the credibility of the results of the study. Irrespective of the aim of the study, the method of data collection, or the method of analysis of the collected data, all scientific enquiry wants is results that are justifiable. Reliability and validity are mostly used by quantitative researchers to increase the credibility of the findings of the study. Although this study is ethnographic research, it is still important to address the issue of credibility.

Credibility involves addressing the level of trustworthiness of the collected data. This is similar for different studies irrespective of ontological or epistemological positions (Green, 2000, cited in Denzin, 2018; Nowell et al., 2017). The credibility of this research is like the validity employed in other quantitative studies, but it is different in terms of the method used to ensure credibility because it is not based on any form of statistical interpretation (Noble & Smith, 2015). To increase the credibility of this study, I documented and reflected on all the individual biases that might affect the results of the study (Noble & Smith, 2015), therefore other than eliminating all my impacts, I tried to comprehend the impact on the study (Noble & Smith, 2015).

There was also an extended involvement in the study area to enable the interpretation of the participants' experiences from their respective points of view – an approach which allows the emergence of innovative ideas that may be assessed for further understanding of the research. All the processes employed for the collection of data from the study participants were also accurately documented for transparency (Noble & Smith, 2015).

The data collected from the participants was verified in form and context for accuracy. This involved using multiple sources in collecting the qualitative data. For this research, data were collected through semi-structured interviews, observations, and field notes at various times of the day depending on the time of arrival of the patient attending the clinic. This was extended to weekends to observe what happened when women attended clinic days on Saturdays and Sundays. Although this was done initially due to the location of the maternity service provider within the community, it was beneficial

subsequently because the collection of data from different study sites within the chosen study area was used to assess the consistency in the collected data (Noble & Smith, 2015).

Furthermore, in order to ensure a higher level of trustworthiness, the collected data were also cross-checked by two members of the antenatal department team of the PHC with knowledge and expertise in issues related to women seeking care during pregnancy. This was carried towards the end of the fourth year of my PhD, when I travelled to my home country for my mother's funeral. It was a challenging time for me, but I thought it was necessary to share my findings with some of the participants and therefore visited the PHC where data were collected and the other clinics used for the research – herbalist, spiritualist clinic and TBA clinics.

I was given a very warm welcome and was asked questions regarding the progress of my research. I explained to them the outcome of my visit to their clinic and what I did with everything they had sheared with me during my previous visit. Some expressed surprise and happiness upon learning that the findings of my research would be relevant to the body of knowledge on this subject.

I asked the practitioners if they could confirm that the data, I had collected was an accurate representation of the form of care they provide to women seeking care. They all confirmed to me that it was exactly what they practised, and they also reinforced the belief that protection from evil spirits was an important part of pregnancy care that could not be ignored. We also talked about some of the challenges women experience while seeking care at their clinic, most of which have been described using the SEM.

6.15 Reflexivity

Reflexivity is described as a continuous process that shows the relationship between the research and the researcher (Attia & Edge, 2017). Although not all researchers discuss the significance of reflexivity in their research, it will be discussed as part of this study due to the direct or indirect impact on the results of the study (Fontana, 2004). In this study it is important to include information about reflexivity due to the background knowledge of the researcher about the community where the study was carried out. Reflexivity will therefore be discussed to control the quality of the research (Berger, 2015).

The information about reflexivity is also important for increasing individual knowledge about the impact of the interest of the researcher on the different steps involved in the research process (Primeau, 2003). Reflexive practice varies from one individual to the other because it does not involve employing a particular approach or technique, rather it is a state of mind used by individuals to learn from the various activities they engage in as practitioners (Downling, 2006; Parahoo, 2006). Thus, each individual behaviour is the result of the person's ethical values. When employed by researchers, reflexivity allows them to learn from their personal experience which they may not be able to communicate to others. Therefore, they can ask questions and challenge some cultural myths or questions related to human action (Downling, 2006). Due to the significance, it is important as a researcher to reflect on the process employed in this research in order to increase the credibility of the study.

With the study area being my homeland, access was considerable easier for me, but I was conscious of the likely impact this might have on the collected data. This is because participants may have provided specific answers to questions in the belief that they were helping me. However, it was made clear to the participants that there were no right or wrong answers but rather the focus of the study was to explore the different beliefs and practices that may influence their health seeking behaviour during pregnancy. The purpose of the research was also clearly explained to the participants, and it was stated that the researcher was not approaching them as an indigene of Ota but rather as a student conducting research as part of the requirement to complete their study.

In other to reduce the level of bias, as a researcher, I clearly stated the approach to be employed in the study. I also ensured that throughout my stay in the field diaries were kept, as this form of record keeping has been identified as mitigating against factors such as previous knowledge or personal beliefs that could possibly influence the data collected. My familiarity as an indigene of the study area increased the level of connection with the study participants. Although this was a benefit for the study, it was also a challenge due to the difficulty in separating personal experience from the experience of the study participants. To minimise the effect on the collected data, I ensured that prior to collecting the data, possible challenges that may arise while in the field were identified and documented, enabling me to view the collected data from a more general perspective (Dowling, 2006).

While in the field conducting the research, I also employed a reflexive approach in order to provide detailed description of the impact of cultural factors on women's health seeking behaviour during pregnancy (Jootun & McGhee, 2006). Data were collected through semi-structured interviews and observation in order to provide precise account of the situation in the field. A researcher's understanding of the impact of reflexivity on all the different parts of the study increases the need to employ the approach (Bradbury-Jones, 2007; Berger, 2015). Self-reflection was, therefore, employed during the data collection stage to identify questions that I may have attempted to avoid due to sensitivity. To minimise my familiarity affecting the study, this approach was also employed during other stages of the study (analysis and findings).

As a nurse–midwife and as provider of emergency first-aid service in the area, I was already aware of some of the challenges of pregnant women in the study area. It was, thus, slightly challenging to assume the role of a stranger in a familiar environment, but I was also fully aware of the need to focus on the study. I used the interview guide (Appendix 6) to detach from the role of a nurse–midwife or a provider of emergency first-aid service to a researcher. Switching roles was challenging, but with the interview guide's open-ended questions related to the research I was able to focus solely on the research. Open-ended questions provide information for subsequent questions, thus allowing a researcher to follow the participant's story.

During the analysis stage, self-reflection was employed because it alerted me to unconscious editing of the data stemming from sensitivity to some of the findings. Employing self-reflection during the analysis stage thereby allowed me to engage completely with the collected data and provide a full account of the analysis of the collected data (Berger, 2015). While in the field, I ensured that the focus remained only on pregnant women – when information about other areas related to maternal healthcare services emerged, I transcribed the collected data in order to prevent other information from affecting the quality of the collected data. This method provides other information that could be useful for future research (Jootun et al., 2009).

My presence and regular attendance at the various centres where the study was carried out increased the sense of trust and working relationships that led to the retrieval of accurate information from both pregnant women and the healthcare providers. Nevertheless, it was important to discuss my impact on the research, as individual values can affect the quality of the research findings. This aspect was included in my write-up in order to show that as a researcher I was telling the story exactly the way it was said.

It is important to note that not all the information from the participants could be fully understood by an outsider, but with the researcher being an insider with a good grasp of the environment, I was availed an opportunity to provide a nuanced understanding, and therefore an accurate interpretation, of the information that was shared with me (Jootun & McGhee, 2006). As a researcher, one concurs that while in the field it is challenging not to influence or be influenced by study participants regardless of the level of objectivity employed. Furthermore, the opinion that results of qualitative research cannot be totally objective is a valid one. Although subjectivity is sometimes viewed as problematic, in this research it was used positively. This is because when developing the themes that would aid the understanding of the beliefs and practices that may influence the healthcare seeking behaviour of women during pregnancy, my personal understanding of the impact of culture provided a theoretical framework that was used as a guide in this research. I was therefore able to provide unique ways of understanding the research findings.

Reflexivity in research is mostly ignored because it is subjective, but it was added to this study because a reflexive account is believed to increase the rigour of the study (Jootun

et al., 2009). Moreover, reflexivity has been described as an approach that is more than the subjective part of the study, because it provides more information about other areas of the study (Jootun & McGhee, 2006; Lamb & Huttlinger, 1989). Although it is difficult to apply validity and reliability to qualitative research studies, the subjectivity of qualitative research is important for generating comprehensive information about the cultural beliefs and practices that influence the health seeking behaviour of women during pregnancy. Reflexivity was therefore employed to separate the researcher from the research – when it was impossible to separate the researcher from the research, I had to ensure a central point was reached, in order to limit the impact of total objectivity of the researcher on the research. It is therefore important to state clearly that the researcher cannot be detached totally from the research because they both can influence each other. This is explicitly included in this research in order to show how subjectivity can benefit the research.

One area that elicits subjectivity is a researcher's background knowledge and experience. As a nurse–midwife, with experience in maternal and child health, I was knowledgeable about what constitutes positive health seeking behaviour to help prevent complications in pregnancy and promote a safe childbirth where mother and child are alive. I was conscious of my positions both as nurse–midwife and as researcher. As a researcher, I acknowledged the likely impact my background knowledge of the subject area might have on the study. On the other hand, I understood the need to consciously step back and reflect on all the parts of the research activities in the field (Attia & Edge, 2017).

6.16 Summary

This chapter presented the information about the study site and the rationale for choosing the study area. There was also a succinct description of the method employed in the selection of study participants from the study area. Chapter 6 also discussed semi-structured interviews and observation as methods of data collection, a summary of the codes that emerged from the collected data was presented in Table 6.1. The next chapter will describe the findings of the study.

Chapter 7: Findings

7.1 Introduction

This chapter presents an overview of the findings from the study after analysing the data collected from the study participants. There is also a description of the central theme, core themes and sub-themes that appear from the collected data. The central theme that appeared after the analysis of the data collected from the study participants will be called Supernatural Power of Caring. This will be described first, and it will be followed with information about the main themes from the central theme as listed below (Figure 7.1): Fear of the Unknown, Divine Favour, Herbal Mixture, Snail in the Soup, My Previous Pregnancy Experience, and My People. I will also show the relationship between the central theme and the main themes from the study participants.

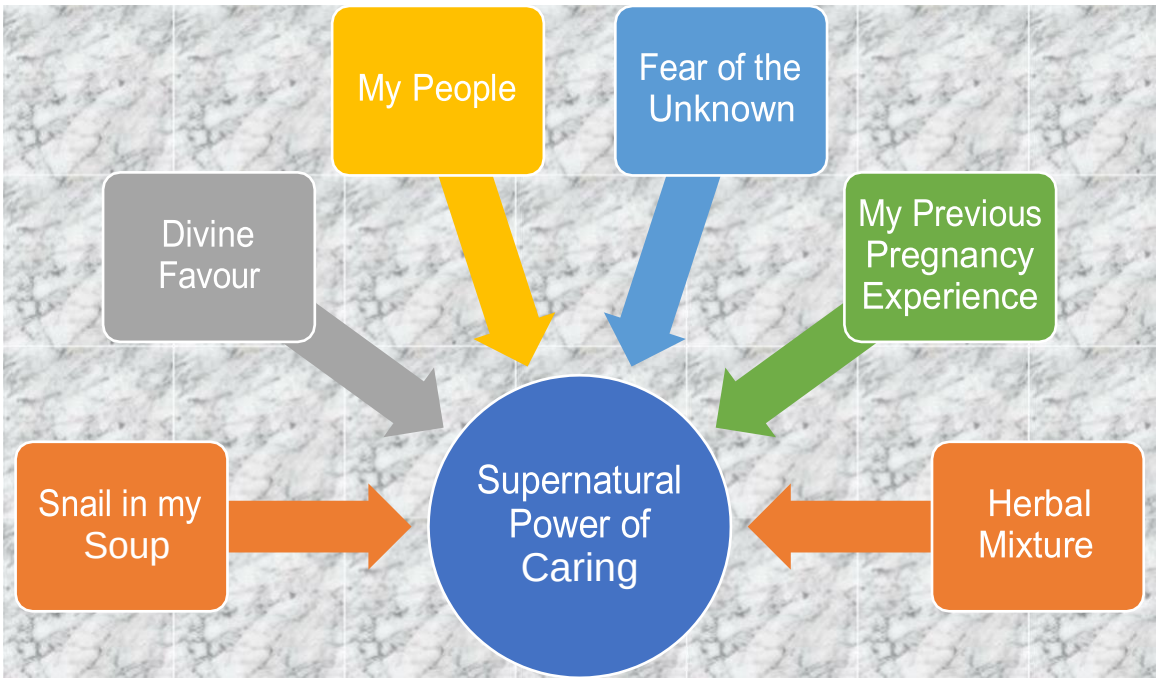


Figure 7.1: Themes from the study participants

7.2 Demographics of The Study Participants

The study was conducted in four different clinics in Ota, a community located in the south-western part of Nigeria. They include Sango PHC, TBA clinics, spiritualist clinics and herbalist clinics. A total of 28 participants took part in the study: 2 nurse–midwives, 2 TBAs, 2 herbalists, 2 spiritualists and 20 pregnant women. Below are the demographics of pregnant women who participated in the study, followed by those of the maternity service providers.

7.2.1 Demographics of the Pregnant Women

Age

In this study a total of 20 pregnant women were selected purposively to participate in the study from Sango PHC, as well from spiritualist, herbalist and TBA clinics. The women were aged between 21 and 45 years old, with the youngest 22 years of age and the oldest 41 years of age. Maternal age is considered as part of the demographics in this study due to its impact on the outcome of the pregnancy, but also for whether it influences health seeking behaviour.

Marital Status

A total of 18 out of the 20 pregnant women selected to participate in the study were married and living with their partners; 2 were neither married nor living with their partners. The result of previous research studies on maternal healthcare services considered marital status as a factor which is not directly linked with a negative pregnancy outcome, but it affects the rate of utilisation of ANC because women who are single are less likely to seek ANC. The disparity with women who are married is due to support from husbands and other relatives (Alenoghena et al., 2015; Rashid & Antai, 2014; Simkhada et al., 2008).

Conversely, a survey conducted among 2,199 participants showed that married women are less likely to seek care from skilled healthcare personnel because they cannot afford the cost of healthcare services (Fagbamigbe & Idemudia, 2015). Authors have also advocated marital status as a factor to be considered when aiming to improving healthcare services of women within the reproductive age group (Auger et al., 2008) because it

sometimes limits the level of psychological support available to women, thus exposing them to more risk which may negatively affect the pregnancy (Bird et al., 2000; Shah at al., 2011). Marital status remains a compounding factor due to its impact on the rate of utilisation of ANC. However, the research findings remain inconclusive due to the contextual variation in the socio-economic factors affecting the utilisation of maternity care. Therefore, it is also important to assess whether marital status influences health seeking behaviour which is within the scope of the study.

Occupation

None of the pregnant women selected to participate in the study were contracted employees; they did not earn a salary from an established employer. They were mostly businesspeople who engaged in small-scale, independent trading to support their families. Three of the pregnant women did not have an occupation outside the home. Although the selected group of participants who engaged in small-scale enterprises used the return on their investment to support their families, they nevertheless depended on their partner for all the financial costs associated with their health, because the husband as the head of the family was the primary provider for the entire household. Therefore, the financial capability of a husband determines where a woman might seek care during pregnancy (Yaya et al., 2019), and this will be considered in this study.

The type of work women engage in during pregnancy has been classified as one of the factors that may affect pregnancy outcome (Ahmed & Jaakkola, 2007). Although this varies across all organisations due to the difference in the working environment, previous research findings have shown that physical, chemical, and psychosocial factors associated with the workplace may affect obstetric outcome (Burdorf et al., 2006). Occupational stress because of physical workload within the engineering sector has been classified as a contributory factor that may increase the risk of a negative birth outcome among women working within the engineering sector (Ahmed & Jaakkola, 2007). Therefore, it is important to consider non-work-related causes of obstetric complications because occupation-related issues may only be relevant during a particular stage of the pregnancy (Burdorf et al., 2006).

Number of Pregnancies

All the pregnant women selected to participate in this study had previous childbirth experience. Although there was a disparity in the number of previous pregnancies of the participants, they have all had experience of healthcare seeking during pregnancy. Most of the participants have previous experience of care seeking during their past pregnancies. A total of 11 of the 20 pregnant women had experienced healthcare seeking during two previous pregnancies. Six of the pregnant women had only experience healthcare seeking during pregnancy once, with three having experienced healthcare experience in more than two different pregnancies. Although there is no universal definition of the right age or most suitable parity for pregnancy, research has shown that advanced maternal age and parity may increase the risk of pregnancy-related complications (Shechter-Maor, 2020). It is, therefore, important to consider whether the previous number of childbirth experiences influenced health seeking behaviour.

***Table 7.2a*: Background characteristics of all the pregnant women participating in the study**

Total Number of Pregnancies (including the present pregnancy)	Age	Level of Formal Education	Occupation	Marital Status
3	38	None	trader (sells different types of pepper)	married
2	34	None	trader (sells fruit)	married
2	26	None	trader (sells bread)	married
4	41	None	trader (sells local drink called *agbo* by hawking around the community)	married
3	32	None	trader (sells drinks and water)	married
3	31	None	trader (sells fish around the main road)	married
2	28	None	trader (sells pepper)	married
3	29	None	trader (sells fruit and vegetables)	single
3	26	None	trader (sells used cloth called *okrika*)	married
2	28	None	trader (sell sachet water known locally as pure water)	married
3	28	None	no occupation	single
4	37	None	trader (sells fish)	married
3	28	None	trader (sells groceries locally called provision)	married
3	30	None	trader (sells local black soap)	married
3	29	None	trader (sells vegetables)	married
2	26	None	trader (hawks sachet water known locally as pure water)	married
2	22	None	trader (sells wood)	married
3	36	None	trader (sells cooked food in front of her house)	married
4	30	None	trader (sells different types of fish)	married

	3	32	none	trader (sells cloth)	married

The demographic characteristics of women in Ado-Odo/Ota are not available, but the demographic characteristics of the participants selected for this study can be compared with the overall characteristics of women within the reproductive age group in Nigeria as documented in the 2018 Nigeria Demographic Health Survey. The survey shows that the average number of children per woman in the south-western part of Nigeria (the region where the study setting is geographically located) is 3.9. Although this varies across the six different states within the region, when compared with the demographic characteristics of women in the north of the country it is still low because the average number of children per woman in north-western Nigeria is 6.6 (NDHS, 2018). The survey also shows that the wealthier a woman is, the fewer children she has (NDHS, 2018).

In Nigeria, 75% of women have their first child before the age of 25 (NDHS, 2018). Although the prevalence of teenage pregnancy has also been reported to be high among women with no formal education (Onwubuari & Kasso, 2019), the rate varies across the different geopolitical zones due to religious, economic, and cultural factors (Onwubuari & Kasso, 2019). After the first pregnancy, it has been reported that the average child spacing is two years and eight months – a figure that is less than the required number of months that may be effective in minimising child mortality rate (Oni & Samuel, 2016). Research has also shown that it may be difficult for women who have experienced childbirth, or women with fewer children, to practice child spacing (Kopp et al., 2018).

Although child spacing is unarguably an effective way to reduce infant mortality and to improve obstetric outcome, it is not the major contributor to child and maternal deaths in low-resource nations, due to the impact of other medical and non-medical causes of maternal mortality. Therefore, the promotion of interventions such as family planning for child spacing cannot be ignored since it is part of an evidenced-based approach to improving obstetric outcome (Kopp et al., 2018). Thus, the various cultural factors associated with child spacing are mentioned in this study in order to ensure the suggested intervention will be acceptable. However, in this study the focus is not to identify the factors affecting the use of family planning or child spacing among the women within the reproductive age group, but to explore the cultural factors affecting women's choices regarding where to seek ANC during pregnancy.

Level of Education

Findings from previous studies show that educated women and women with a secondary school leaving certificate, or those who completed high school, are more likely to seek care from qualified healthcare workers during pregnancy or deliver in the presence of skilled healthcare personnel such as a registered nurse or midwife than women with little or no education (Khatri & Karkee, 2018; Okedo-Alex et al., 2019). In this study none of the women were educated; although this is not the focus of this research, it would be considered as part of the demographic factors due to the documented impact of education on women's healthcare.

7.2.2 Demographics of the Maternity Service Providers

- All the maternity service providers included in the study had more than ten years of experience.
- Two female nurse–midwives were registered with the Nursing and Midwifery Council of Nigeria.
- Six unskilled maternity service providers had no formal training but the knowledge that was bequeathed to them.
- The unskilled maternity service providers in this research consisted of two males and four females.
- All the maternity service providers worked full time, except for the nurse–midwives who worked shifts based on their rota in the PHC. In this setting, the nurse–midwife is a government employee and a permanent member of staff.
- The unskilled healthcare personnel (TBAs, spiritualists and herbalists) who were selected outside the hospital setting mostly worked from home, and therefore were available to offer their services whenever required.

Table 7.2b: Background characteristics of all the maternal healthcare providers that participated in the study

Occupation	Sex	Years of Experience
TBA	Male	32
TBA	Female	37
Spiritualist	Female	40
Spiritualist	Female	30
Herbalist	Female	25
Herbalist	Male	40
Nurse	Female	11
Nurse	Female	12

7.3 Observation of ANC at the PHC

This section of the thesis will focus on the contextual description of the study setting and this will be followed with the themes which arose from the observation of the various providers of maternal healthcare services selected for the study. This includes inferences from the participants at the primary healthcare facility, TBA clinic, spiritualist clinic and herbalist clinic.

Arrival at the healthcare facility

Most of the pregnant women arrive at the healthcare facility on public transport, they get off the bus, and then walk down to the clinic. On their way to the clinic, they buy food and snacks from the traders around the clinic building. On entering the building, they walk through the postnatal department to the antenatal department. On arrival at the antenatal department, they register with a member of staff who is a community healthcare officer. The registration involves entering their details into a record book and checking their weight. After registration, each woman is given a small card that has been numbered; the card indicates the order in which she arrived at the clinic.

When it is time to be attended to in the palpation room, the women are called into the room according to the number on the card they are holding. This is to ensure there is a form of orderliness in the clinic. However, the number on the card is only relevant for that session's visit and it becomes irrelevant at the end of each clinic visit. When they have completed the session with the community health support officer, they will then go and sit down on a brown bench which is permanently stationed in the room for the prenatal clinic. This process continues until a sufficient number of women have arrived in the clinic.

Theme 1 – starting the clinic session with prayer

The staff on duty at the antenatal clinic commence the daily activities for the clinic with a prayer session. The staff presiding over the clinic for the day will select two pregnant women within the clinic to pray; this usually includes one Christian and one Muslim, and sometimes the staff will ask if there is anyone willing to offer a prayer session before commencing with the daily activities of the clinic. (Field note from PHC)

On one occasion during my observation, the sister-in-charge at the antenatal department talked to the group of women attending the clinic about the importance of believing in God. This included trusting God for a positive pregnancy outcome.

> The antenatal clinic is conducted in an open area, with each pregnant woman sitting close to each other on the bench in the clinic. While in the general clinic room the staff do not discuss issues that are directly tailored to each person attending the clinic rather the discussion is generalised towards all pregnant women seeking care at the centre (Field note from PHC).

Theme 2 - lyrics of the song

When the two women selected to pray in the clinic have completed the activity, the staff presiding over the clinic encourage everyone to stand up and start singing. They have different songs which they also dance to. The lyrics of the song are formed from some of the things that are important for a safe childbirth. Some of the song lyrics are words of encouragement, assuring women to be optimistic about the outcome of the pregnancy.

I will be the mother of my child
I will be the mother of my child
May death not come my way
May death not come my way
So that I will be able to take care of my child
(Song 1)

Make me deliver safely my Lord
Make me deliver safely my Lord
Make me deliver safely my Lord
On the day of my delivery
May water not exceed the required amount needed
May blood not exceed the required amount needed
May it not be below the amount required
Make me deliver safely my Lord
(Song 2)

The journey of nine months
My divine helper
Help me
So that it won't turn into something that will be discarded in the bush
(Song 3)

Taking care of a child is stressful
Taking care of a child is stressful
Taking care of a child is stressful but it is the child that will buy me a house
(Song 4)

The baby in my womb
When he is due to be delivered
He should not be positioned abnormally
He should not stress me
(Song 5)

My head, my shoulder, my knee, my toes
My head, my shoulder, my knee, my toes
Everything belongs to you my Lord
(Song 6)

There is a reason why I took the care of my baby so serious
There is a reason why did I took the care of my baby so serious
I am the one that gave birth to my child and
I will be the one that will reap the fruit of my labour
I will be the one that will reap the fruit of my labour
(Song 7)

The women usually sing between five and ten songs, depending on the staff leading the clinic for the day. This is then followed with a talk on any aspect of ANC; it could be health education on balanced diet, the importance of exercise in pregnancy, or the importance of cleanliness in pregnancy. The staff encourage women seeking care at the clinic to ask questions, either from the topic discussed or any other issue they would like to have clarified.

Theme three: the waiting room

The waiting room is where you will find all the pregnant woman immediately after the health education session in the antenatal department. After the general clinic session with the nurses, midwives and community health support officers in the antenatal department, the pregnant women move in groups to the waiting room for the next session.

The waiting room is another section of the antenatal department with lots of brown benches where women sit while waiting to be called into the palpation room. The waiting room is a spacious room zoned into two sections, without a room divider. To the right is the actual waiting room where women wait until they are called into the palpation room; on the left is a postnatal area were women who have just delivered their baby are transferred to. Therefore, while waiting to be called into the palpation room, pregnant women have the opportunity to see women who had just had their child.

> Chit chat: Looking over, while waiting to be called into the palpation room, the women talk to each other about what has just been discussed in the clinic. On some occasions they argue with each other and even give their own opinion about some of the issues that were raised during the health education section in the antenatal clinic (Field note from PHC).

The palpation room

The palpation room is a smaller space than the waiting room. It is the room where the woman's abdomen is palpated to check the height of the fundus, to determine the position of the baby and to listen to the foetal heartbeat. At the entrance of the room there are three chairs. Once the chairs are empty, the nurse–midwife goes out of the palpation room to call three pregnant women into the room. On entry into the room, they are directed to sit on the chair and then the nurse will collect their clinic card. The card is a small cardboard paper which is used to record all the information for the clinic visit; this includes

weight, outcome of urinalysis, gestational age and any other information related to the patient attending the clinic for each day. The staff start by first recording the date and then they will wait to record the result of the assessment. Once this is done, the next pregnant woman is directed to lie down on the padded table for assessment.

Follow-up

While in the waiting room, the staff on duty conduct an assessment before carrying out the palpation. The assessment involves asking questions about what has happened since the last visit. If there is no issue to be addressed, the woman is palpated, and a date is given for the next appointment. If there is a concern, the woman is booked for an appointment with the doctor on call. On some occasions when the pregnant woman comes to the appointment with a test result that was requested during previous appointment, the nurse checks the result and then books the pregnant woman for an appointment with the doctor (Field note from PHC).

Doctor's consultation room

The doctor's consultation is a small room with a chair and a table. On the table are some forms that are meant to be used for patient. When patients go for appointment in the consultation room, they come back to the nurses to inform them about what they have been told by the doctors.

Need for assurance

Some of the patients come back to the nurses or any of the antenatal department staff to ask them more questions about what the doctor discussed with them. This is sometimes for clarification or reassurance about the information from the medical doctor (Field note from PHC).

End of the visit

The pregnant woman's clinic activity ends with either a visit to the laboratory or in some cases they go home.

The joyful sigh

Going home is a joyful time for most of the women after the clinic. After the clinic, some of the pregnant women buy food to eat from the vendors outside the clinic building. While some women are in a haste to leave the premises before noon, sometimes, when it is raining, they wait within the clinic building until the rain stops before going home (Field note from PHC).

Inferences from the interactions are prayers, chit chat, leaving before noon and the assurance available in this centre.

7.4 Observation of ANC Outside the PHC

7.4.1 Observation of Care at the Herbalist Clinic

It is a large building with a shop close to the entrance. The shop is owned by the wife of the herbalist. She sells different items that are required for the form of service her husband provides. These range from local pots used for cooking and eating concoctions to different leaves used for medicinal purposes.

Most pregnant women walked down to the clinic, while some women arrived at the clinic by motorcycle – being the primary means of transportation in the area. None of the pregnant women arrived at the clinic by car. On arrival at the clinic building, they are welcomed first by the wife of the herbalist. On some occasions, a few of the women have a chat with the wife of the herbalist, before going inside for their appointment. After the brief chat with the wife of the herbalist, the pregnant women walk inside to meet the herbalist. Once they are inside the premises, they walk down to the main building to join other people that are waiting to see the herbalist.

Chatting with the wife

> While in the compound of the herbalist, I noticed that most of the pregnant women have a cordial relationship with the wife of the herbalist. They spent a lot of time with her chatting about so many things, ranging from issues in the community to the products they will be buying when they are done with their appointment (Field note from the herbalist clinic).

The waiting room

In the herbalist clinic, the waiting room is not a room, but it is a designated area within the premises where women wait until it is their turn to see the herbalist. It is an open place were pregnant women chat with other pregnant women and the support staff working with the herbalist.

Chat with the support staff

> While in the waiting room, pregnant women talk to the support staff about what they have been asked to bring for the next appointment. In some cases, this could be what they will use to collect the local soup that is to be eaten as part of their food. This will be prepared for them to take home after the appointment. It could also be what they will use to preserve what will be given to them.

I also noticed that the support staff working with the herbalist make the best use of the time the women spent in the waiting room by asking them about their preference for the special soup, if needed after having a meeting with the herbalist. However, when women have been informed during their last visit that they are due to take the local soup, they will inform the support staff about it while in the waiting room. The support staff will then gather all the ingredients that are required for the soup, in preparation for cooking while she is going into the herbalist office for her appointment. This is done in order to ensure it is hot and ready after her appointment. (Field note from the herbalist clinic)

Consultation with the herbalist

The herbalist consults with each pregnant woman on an individual basis. After sitting on the bench provided in front of the consultation room for some minutes, the pregnant woman is notified by the support staff working with the herbalist that it is her turn. She will stand up, take her belongings, and then go inside the consultation room for her appointment. When in the consultation room, the pregnant woman discusses all her problems with the herbalist. This may include changes she noticed since the last appointment; it may be in form of an improvement or deterioration in the health of the woman seeking care.

End of the visit

The visit ends with the collection of the required herbs, local soup or concoction to be taken home.

Inferences from the visit to the herbalist clinic are chit chat, support staff, local soup, and concoction.

7.4.2 Observation of Care at the Spiritualist Clinic

Arrival at the healthcare facility

The spiritualist clinic setting is different from another clinic setting because it is in an enclosed area that has a gate for entry and exit from the premises. Most pregnant women walk down to the clinic, while few of them arrive by motorcycle. Once they alight from the motorcycle, which is locally called *okada*, they open the gate to come inside the premises. At the gate, they exchange greetings with the security officer who is locally called the

gateman.

The compound

On several occasions, it was observed that most of the women arrive at the spiritualist clinic at any time. It is not operated based on a specific clinic time; everyone comes in at any time and they leave when they are done with the activity for the day (Field note from the spiritualist clinic).

The waiting room

The small space in front of the clinic building is the waiting room in the spiritualist clinic. It has a small bench which is used for sitting down on arrival at the clinic. They do not book or collect any form of card as they come in, but they will just communicate with each other and then take turns to see the spiritualist according to their time of arrival.

Chit chat

While in the waiting room, women seeking care engage in a chit chat with the security, the support staff and with each other. While pregnant women wait for their appointment, they join other women sitting outside the main building for clinic activity. While sitting, they chat with each other about issues in the society and other related healthcare issues.

While the pregnant women are in the waiting room, they chat with the support staff working with the spiritualist. They pray together and then reassure each other with the word of God (Field note from the spiritualist clinic).

Consultation with the spiritualist

The consultation with the spiritualist takes place informally in the office of the spiritualist. The office is a small room with chairs, table and lots of materials that may be needed to support the form of care provided. This includes varied quantities of olive oil, anointing oil, bibles, candles, and bottles that may be used for dispensing some oil for use by the woman seeking care.

Prayer session

The spiritualist holds group prayer sessions with everyone in the clinic and there is opportunity for individual prayer session with each woman attending the clinic or as requested. It was observed that the essence of the prayer is to join the faith of the pregnant woman with the faith of the spiritualist for a successful childbirth delivery. The prayer specifically focuses on the baby, the mother, and anyone who may be an enemy

trying to attack the mother or baby (Field note from the spiritualist clinic).

End of the visit

The visit to the clinic ends with the collection of the special oil that has been blessed by the spiritualist.

The inferences from the spiritualist clinic are untimeliness, no booking, chit chat, prayer, olive oil, anointing oil, bible, candles, and bottles.

7.4.3 Observation of Care at the TBA Clinic

Arrival at the clinic

Some pregnant women walk to the clinic, while some arrive at the clinic by motorcycle. The clinic is located at the extreme end of a large compound, so when women come in for their clinic appointment, they will have to walk through other buildings located within the premises before getting to the clinic building. While walking through the compound, they exchange greetings with people living within the compound. On arrival at the clinic building, they greet everyone; these are other pregnant women who had arrived before them and the support staff working with the TBA.

The greeting

On arrival at the TBA clinic, pregnant women exchanged greetings with other women in the clinic and the support staff working in the clinic. The support staff asked them if there was anything they would like to discuss; this was maybe in relation to what was discussed during their last appointment or an update that needs to be discussed with the support staff. On one occasion, one of the pregnant women told the support staff that she discussed a family preference with her husband, after her previous visit to the clinic – in relation to the consumption of either fish or snails in pregnancy. It was agreed that she should inform the staff when next she visited the clinic that her preference was fish soup and that snail soup was the preference of the family. The family's choice is considered when making local soup in this clinic due to cultural differences among the different women attending the clinic (Field note from the TBA clinic).

Sometimes when the pregnant women arrive at the TBA clinic, they meet the TBA at the entrance of the clinic. On one occasion the TBA talked to the group of women at the entrance about the importance of seeking care from the local provider of maternity service. He said part of the treatment some of the women would be getting will involve preserving the pregnancy, to prevent any form of miscarriage, either during the early or late stage of the pregnancy. He talked about how they would hang the pregnancy and would only bring it down when the woman was due to deliver (Field note from the TBA clinic).

Description of the term 'hanging the pregnancy'

Hanging the pregnancy is a term that was widely used by the TBA. It does not involve physical hanging of pregnancy because pregnancy itself is not an object or entity that can be hanged. Rather, the term refers to the protection and preservation of pregnancy in order to prevent a woman from experiencing miscarriage.

The process involves hanging a pregnancy culturally on a tree (Figure 7.4a). The TBA puts some herbs together, makes some incantations on it and then labels it in a unique way. Each one is put together in a leaf and then a bag is used for its protection over a prolonged period, until when it is needed. When everything is ready, each bag is hung on a tree within the compound of the TBA. The tree is used for women with fertility issues, women trying to conceive and women who have experienced miscarriage.

Figure 7.4a: Tree for hanging pregnancy

Interviews with TBAs

"Women come here because they want me to help them from experiencing miscarriage. When I tell them about what is involved, they will tell me to go ahead. Most people that come here trust us because if they do not trust what we do, they will not come here. I always try to do my best to make them happy but at the same time I always tell them to follow my instruction; if I ask them to do something, they should do it. If they do not do it and any terrible thing happens, I will tell them the cause of the problem and most of them will start to beg me that they are sorry. That when they got home, the taste of what I gave them to use was not nice to them, they will then throw it away into the bin. Due to my experience, I sometimes encourage people to use everything I have for them in my presence, but there are things that they must take home to use at a particular time of the day" (Interview with the TBA).

"Women come here because they believe we have supernatural powers. Let me tell you something, not all pregnancy-related issues need to be taken to the hospital; there are

some issues we need to use our inner eye to see. Inner eye means it can't be seen or understood by just an ordinary person that doesn't have power to communicate with the ancestors. Do you know that some women still experience problems in pregnancy, despite going to the hospital? This is because the hospital people cannot see or understand why the woman is having the problem; they will just be treating her for other things and the problem will still be there" (Interview with the TBA).

The waiting room

The waiting room is the small room before the consultation room. Pregnant women sit in the waiting room with either their friend or any of their family members that accompanied them to the clinic appointment to see the TBA. While in the waiting room, they have a pre-appointment discussion with the support worker at the clinic. This is done to ensure everything is right before she goes inside the consultation room for her appointment. They make enquiries about her preference: what she would like to include in the local soup that will be prepared for her.

On one occasion while in the clinic with the TBA, he talked to the women attending the clinic on the day about how to have a successful childbirth – where mother and child will be alive. He said it was important they follow all the instructions that will be given to them, and on any occasion when they need help, it is important they contact him quickly before things start getting worse. He talked about some of the things they needed to avoid throughout the pregnancy period; this includes low salt intake, less use of vegetable oil, not cooking with potash, and to avoid taking chocolate drink because it makes baby big (Field note from the TBA).

Consultation with the TBA (local herbs)

The consultation with the TBA is the last phase of the clinic. The pregnant woman is asked about what she can use to improve her health and well-being during pregnancy. The woman is welcomed by the TBA into the clinic. Once she is inside the room, she will be asked to sit down to talk about the purpose of the visit. This may be the changes she noticed since she started taking the local herbs given to her after the previous visit. The clinic ends with what she will be given to improve her health; this could be another soup, local herbs or medicines in the powdered form that will be used with water or pap. When she is required

to take local herbs home for consumption, this will be prepared together by the support staff and handed over to the pregnant woman. The herbs may be different leaves put together to be cooked with water in a local pot on the stove at home.

The centre also has already prepared herbs which have been mixed and stored in a bottle. Sometimes they give the woman both the fresh herbs and the powdered form; it all depends on the need of each pregnant woman. The leaves they usually use for the herb preparation are referred to as fresh because they are harvested from the small farm within their compound. On certain occasions when all the leaves from their farm have been exhausted, they go to the local market to get the leaves. They also made some herbal mixture with leaves and stick-like herbs.

Figure 7.4b: Herbs and related products used for women seeking healthcare at the TBA clinic

Consultation with the TBA (local soup)

The pregnant woman is also given special type of soup to be consumed for the protection of the baby *in utero* and for a safe childbirth. The soup is prepared by the support staff as directed by the TBA in the centre. It involves cooking different things together with either snails or fish. They usually prepare it in a local clay pot which is black in colour. They start the cooking by washing all the different items to be cooked, the shell of the snail is removed and then the snail is washed. If they intend to use fish for the special soup, the fish is washed and kept in a bowl. After washing all the ingredients with clean water, they are transferred into the black pot. The black pot is also a special type of pot because it is not made with aluminium or steel but is made with clay locally. All the content is then cooked for about 20–30 minutes until it is ready. When it is ready to be eaten, it is not transferred to another pot or plate, but it is eaten directly from the local black pot. It is prepared and eaten within the premises of the TBA and on some occasions it is taken home to be consumed at a specific time of the day.

Figure 7.4c: Snails used in the preparation of special soup

Figure 7.4d: Catfish used in the preparation of special soup

Figure 7.4e: Local clay pot used for the preparation of special soup

Figure 7.4f: Calabash used for the consumption of herbs, herbal mixture and special soup

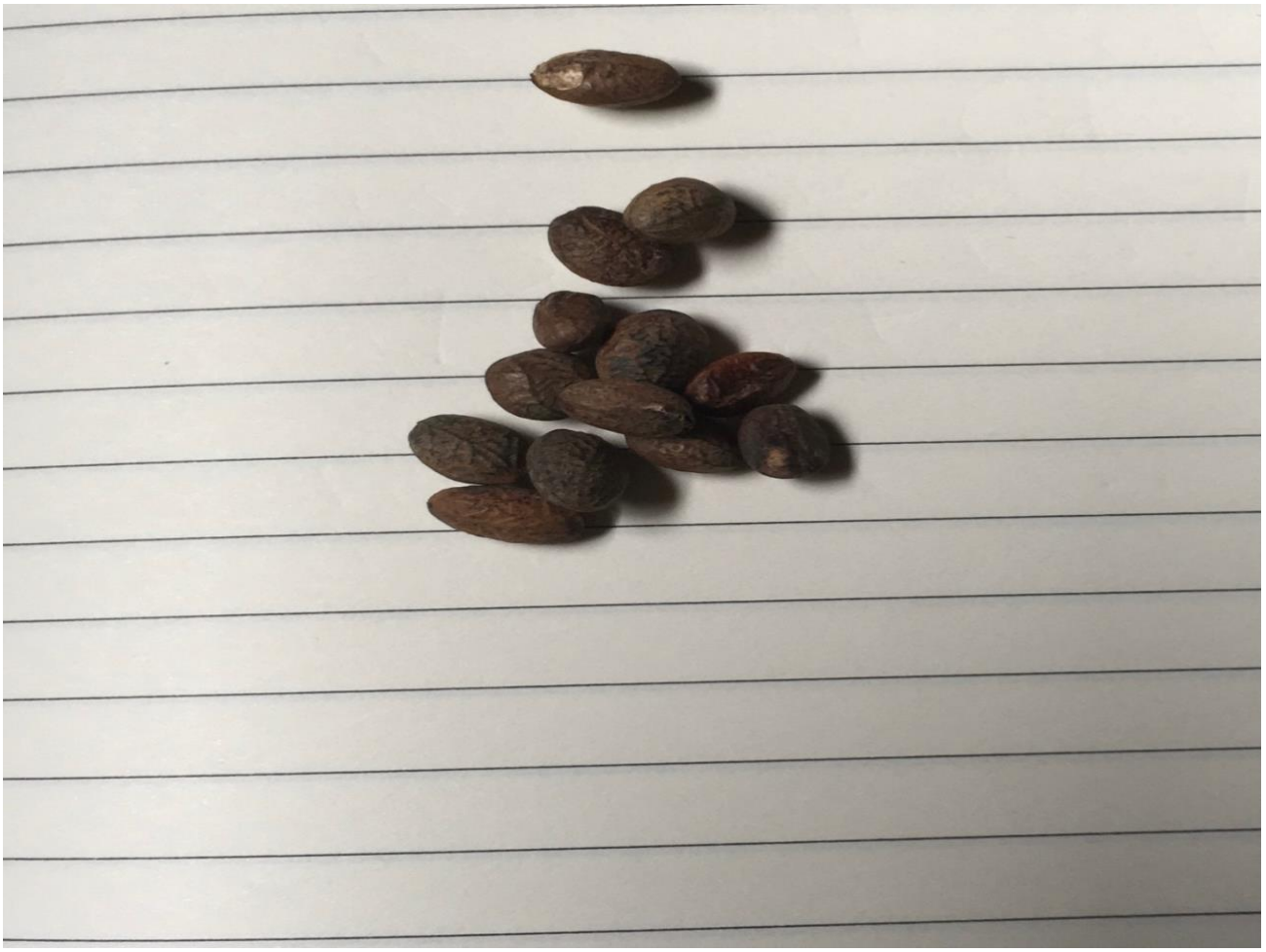


Figure 7.4g: Some herbs used for the preparation of herbal mixture

End of the visit

The pregnant woman leaves the office of the TBA to meet with the support staff working in the clinic to collect what has been recommended for her.

On one occasion the pregnant woman ended her clinic visit by leaving the TBA office to discuss her treatment options with the support staff, she talked about the type of fish that could be use as part of the ingredients for her local soup. She said snail can also be used, if necessary, but she prefers big snail with much meat to make her full after consuming the soup (Field note from the TBA clinic).

Inferences from the TBA clinic are hanging the pregnancy, fish, snail, fish soup, snail soup, clay pot, local herbs, and powdered medicines.

7.4.4 Summary of Observation Data

The observation of the three different clinics outside the PHCs showed how the experience of each person seeking care varied, and that a description of the activities involved in the care had been provided by the local maternal healthcare providers in a community.

7.4.5 Introduction to Interview Data

A total of 28 interviews was conducted with selected participants across different centres in Ota. Some of the interviews were conducted in a room (within the PHC) while some were conducted under a tree or in a room in the compound of the other maternal healthcare providers working in the different centres outside the PHCs.

7.4.6 Factors Affecting the Health Seeking Behaviour of Pregnant Women in Ota

The aim of this study was to explore the health seeking behaviour of pregnant women in Ota. Health seeking behaviour being part of health behaviour is not the same for everyone around the world; it depends on cognitive, non-cognitive and contextual factors associated with healthcare. Due to the complex nature of health seeking behaviour, it is important to identify a range of factors that may affect individual behaviour. Therefore, this research was conducted using an ethnographic approach. Data were collected through semi-structured interviews and observations.

With the supernatural power of caring as the central theme, the distinct factors pregnant women consider before seeking care in Ota can be further themed into fear of the unknown; divine favour; herbal mixture; snail in my soup, my previous pregnancy experience; and my people.

The supernatural power of caring is applied as the central theme in this study because it is part of the belief that is common to all the selected participants in this study. An example of the central theme was observed when the TBA, aiming to restore hope of the woman seeking care, told them they would use some form of hidden power to protect the

pregnancy from any form of harm. Belief in protection from evil spirits is an important part of maternity care that cannot be ignored. This is because the provider of maternity services ascribes some pregnancy-related problems to evil spirits. Thus, during consultation with the pregnant woman, they tell her about the importance of clients using some resources they will be providing for protection. It was also observed that the providers emphasise the need to comply with all the advice they are giving. This includes using the products they are giving correctly at the right time. During one of my visits to the herbalist clinic, I asked the herbalist about the form of service available in his clinic. Below is the response:

> "There are so many things involve in this service we provide. One must be careful because we cannot see the actual people involved in some of the problems affecting the women that come here. But what we do is to protect them from everything, just to prevent them from being harmed. We also remind them to do everything we asked them to do. This may be taking some things home to use" (Interview at the herbalist clinic).

During another visit I observed that when the TBA provides maternity service to the pregnant women seeking care, they encourage them to believe what they are being given to use will work very well for them. For instance:

> "This thing is what our ancestors use to take care of their pregnant wife and other women who may need such service. If you do not believe in it, it may not work for you so I will encourage you to put your mind at rest" (Observation at the TBA clinic).

I also observed that all the different local maternity service providers that took part in this study talked about a unique form of power that is part of the service they provide. They believe it exists and it can be used for maternity care. This is the supernatural power they believe can be used to protect the mother and baby. It also forms part of the hidden content of the special soup, consumed by women during pregnancy (Observation at the herbalist clinic, TBA clinic and spiritualist clinic).

Thus, the excerpts from the participants' stories and my own observations at various centres in the study area show that all the providers of local maternity services believe in the existence of a form of supernatural power. The herbalist, for example, provides care with the belief the Almighty will support him to make the herbs work perfectly for the individual seeking care, while the spiritualist believes that reading psalms in water, praying to God and using anointing oil can help protect the mother and the baby during pregnancy

and on the day of childbirth. The TBA uses his unseen power to advise the woman about the right thing to do for a positive childbirth experience – some of which may entail consuming a special soup whose content is based on the belief of the woman seeking care.

The pregnant woman seeking care also believes in all the different resources that will be used during her care. Thus, her beliefs partly guide her regarding what to do or what to avoid during pregnancy. For instance, some of the women that participated in this study did not support the use of herbs. Instead, they believed that they could be protected from evil spirits and related issues affecting the normal development of the pregnancy or delivery on the day of childbirth by using anointing oil given to them from the church. There is also a selected group of participants who believe that the solution to any issues related to pregnancy is a visit to the herbalist – where they can be provided with resources that can be used for bathing, to restore their health back to normal. The different choices women in Ota make regarding the choice of where to seek care is all centred around their unique belief about a particular power that cannot be categorically defined but can only be described through the expression of people.

Table 7.4: Six themes that emerged from the interviews and observations

	Themes	Sub-themes	Quotes
1	Fear of the unknown	Evil spirits Protection Pin	Fear of losing the pregnancy Protection from bad spirits Hot sunny afternoon Nights
2	Divine favour	Church Mosque	Anointing oil Fasting Prayer Vigil Reading psalms in water Giving alms God Holy Water
3	Herbal mixture	Herbs Visit to the herbalist Trees	Prevention of miscarriages Protection from evil spirits
4	Snail in my soup	Catfish Snail Egg Groundnut oil	Healthy baby Eat anything hard
5	My previous pregnancy experience	Miscarriages Emergency Safety experience	Protection of the present pregnancy Experience is never forgotten Relationships forged
6	My people	Mother-in-law Friends Neighbour Elders Mothers Husbands Sisters	Advice on where to seek care Existing relationship with the care provider

7.4.6.1 Fear of the Unknown

Women within the study area had numerous beliefs about the different spirits that exist. This is based on the information that was passed down to them from past generations and other people, most often with experience of pregnancy and childbirth such as their mothers, grandmothers, mothers-in-law, neighbours, sisters, and aunts. Due to the fear of giving birth to *Abiku*, women engaged in different practices they believed will protect them from evil spirits. The beliefs of the pregnant women about spirits determined what time of the day they could go out. This is a major belief for most of the respondents in this study who maintained that if they did not comply, they may give birth to *Abiku*. The concept of *Abiku* was described by the TBA as follows:

> "*Abiku* is when a pregnant woman give birth to a child, but the child did not stay. Lots of women experience this because they do not listen to us. Some women may experience *Abiku* several times during their reproductive years. While some may experience it for a long time and after two or three pregnancies the child may stay back" (TBA).

Abiku is a major theme in this study because it affects pregnant women directly. Women attended ANC but were always in a hurry to get back home before midday. It is believed that the sun reaches its peak between 12pm and 1pm, and thus pregnant mothers are encouraged not to go out during this time of the day. Both categories of participants included in this study (providers of maternity services and pregnant women) were conscious of the belief and how it impacted on their behaviour, as seen in the following interviews:

> "All of us in this department know the style all these women you are seeing try to use when they are talking to us. We can't force them, but we can only tell them some things are good for their health and it is important to use them or follow what we tell them. But there are some things you can't force them to stop. For example, telling them not to go home when they are thinking of rushing to do everything so that they can leave early. If we don't allow them to do what they like, and any bad thing happens to them or the baby they are carrying, they will say is the nurse working in that hospital" (Interview with the nurse at the PHC).

> "We understand that women that visits this clinic, do lots of things. For instance, some of the women that receive care here also visits other people in the community that care for women during pregnancy because they don't want to give birth to Abiku".

(Interview with the nurse at the PHC)

"When women come here for care, part of what we tell them is that they should follow everything we tell them to do. This includes not going out around certain time of the day, just to protect them from all those things that are walking around. Those things walking around are sometimes bad and, because they are pregnant, it is better for them to

protect themselves. They can't even see them with their normal eyes; it is only people like us that can see it through the supernatural power that we have" (Interview with the TBA outside the PHC).

Many of the respondents, as seen in the following excerpts, had beliefs centered around spirits, thus it is necessary for them to use a range of resources or change their lifestyle for protection from these evil spirits. These beliefs were often passed down to them from previous generations and in cultural terms are considered an essential part of protection for the mother and baby during pregnancy:

"Another thing that they usually tell pregnant women is not to walk around in the afternoon or at night. Because it is around that time spirits walk around, and if you as pregnant woman meet them on the way, you will not recognise them, but you may feel a form of sensation in your body. To tell you evil spirts are around you, they can even change the baby in your stomach and turn it into another thing, and that is why you see some pregnant women giving birth to a baby with incomplete fingers or babies that are not looking right. In fact, they can even disappear into your tummy, and that is why everyone does tell us as pregnant mothers not to walk around in the afternoon or in the middle of the night" (Interview with a 29-year-old pregnant woman at the herbalist clinic).

"What I do to protect myself from evil spirits is to always use a safety pin in the morning when am leaving home. I can tell you that once I get pregnant, I go out with a safety pin every day. Check the tip of my cloth now and you will find it there. I bought so many pins and I can never be short of one for a day. It may look funny to you, but I know you too will have seen someone that does this too, even if you come from abroad, that does not mean you didn't hear about this before travelling. It is even not just safety pins, there are other items too. You know that before our mothers put the pin at the tip of their wrapper, but because things have changed now and most pregnant women now wear gowns, so what they do is to attach the pin on the other side of their cloth close to the tummy area, to serve as a protection to the baby." (Interview with a 34-year-old pregnant woman atthe PHC).

Inferences

Fear of unknown is a salient theme for this research; this involves engaging in actions that will aid the protection of the mother and baby, since the outcome of pregnancy remains hidden and unpredictable. Thus, it evidently influences women's behaviour when seeking care. Most of the pregnant women pay heed to the information

that has been passed down to them from others, when making healthcare choices. Due to the fear of evil spirits and other unseen supernatural phenomena, some women were often in a hurry to leave the clinic before midday.

This fear, which influenced their behaviour when seeking care, meant that women attended a clinic close to their home to avoid travelling far for ANC. The information passed down from past generations, also extended to the best place a pregnant woman should sit when indoors. In order to preserve culture, women go to the places that seem to safeguard cultural priorities and cultural advice such as the use of a safety pin and sitting on a doorstep.

> "I remember one thing I usually do when I am pregnant is to avoid sitting down at the entrance of the door. They said if you sit at the doorstep when spirits are walking around, they may catch sight of you quickly and then they may attack you or the baby in your stomach" (Interview with a 41-year-old pregnant woman at the PHC).

7.4.6.2 Divine Favour

The belief in favour from God has a significant impact on some aspects of human life and thus determines social interaction among groups of people. People of the same faith tend to interact together, and they interact with people from other faiths because of the associated benefit (Yesufu, 2016). However, there is a conflict between religion and healthcare as individuals tend to bring religion into healthcare by engaging in a form of combination therapy, where they use both indigenous forms of care (for example, traditional healthcare and the use of herbs) with modern forms of care (for example, attending ANC and delivering in the presence of a skilled birth attendant).

If the care given to pregnant women leads to a safe outcome where mother and child survive, they show appreciation with expressions such as 'God really did it' (Observation of a 25-year-old pregnant woman at the spiritualist clinic).

At times, due to their experience during a previous pregnancy, women make plans to combine different forms of care to have a safe childbirth. These decisions were made consistently regardless of their religion or the place where data was collected e.g herbalist clinic or spiritualist clinic

> "During pregnancy they advise us to have a strong belief in God because he is the only

one that can do it. The God that created the pregnancy will protect it. I come here because I believe it is better to come to a safer place" (Interview with a 36-year-old pregnant woman at the spiritualist clinic).

"Any time I am afraid or being informed about anything regarding the pregnancy especially when it is bad, I read psalm inside water" (Field note at the PHC).

"Aside from coming to the hospital, I also go to church for prayer. Normally, we go to church with olive oil and bottled water, and this is prayed upon for special protection" (Interview with a 26-year-old pregnant woman at the PHC).

"Me, I am a Muslim and the only thing I do is to pray – the Muslim prayer" (Interview with a 26-year-old pregnant woman at the PHC).

"Apart from using herbs, as a Christian I also go to church for prayer. I use the anointing oil given to me. I always use the anointing oil to rub my tummy and occasionally I drink it when I am feeling somehow. Immediately after using it I am always relieved of any pain or strange feeling I may be having" (Interview with a 31-year-old-pregnant woman at the TBA clinic).

Inferences

The implication of divine favour is that people believe in the existence of a form of unique power, which can only be bestowed on them through prayers. This power therefore forms part of the factors to be considered in this research because it is part of the basis for the beliefs of the majority of the pregnant women. Due to the strength of the belief associated with divine favour in individual religions, pregnant women combine the resources obtained from churches or mosques with the medicines they are prescribed elsewhere. They therefore engage in a form of care that combines both traditional forms of care with modern forms of care. This is a major theme for this research because the study participants use prayer and other resources such as holy water and oliveoil along with the care they receive from the primary provider of care.

7.4.6.3 Herbal Mixture

The use of herbs and roots is a customary practice during pregnancy for safe childbirth. The decision to use a herbal mixture is based on each woman's personal preference and beliefs. Most families support the use of herbs because they believe they can be used safely with allopathic treatment to improve the health of pregnant women (Fakeye et al., 2009). During my interaction with the respondents, they explained (below) why they used herbs and the source of the herbs they used. These vary for each participant, with some pregnant women receiving herbs directly from their care provider, while some receiving herbs directly from close relatives or members of their community.

> "I take herbs very well. I take some once a day while I take some monthly. Most of the herbs they give me I do take them with pap [a semi-liquid food made from a blend of maize mixed with water]" (Interview with a 37-year-old pregnant woman at the herbalist clinic).

> "I use herbs, but I don't just take herbs from anybody; I only use herbs given to me by my mother-in-law. I used to drink all the herbs she prepares for me and sometimes she even tells me to use part of it to bathe in the morning and at night. (Interview with 34-year-old pregnant woman at the PHC).

> "Most of the advice people give me is centred around attending antenatal clinic very well and to always make sure I buy all the medicine that was prescribed for me, but when a problem arises – I know you are a Yoruba lady and you understand what I am saying – when complications arise, we no longer have time; we have to quickly combine the treatment with local medicine, so when we go there, they do give us some things to take. This medicine is made from herbs and trees. I used them regularly and I have noticed some changes" (Interview with a 38-year-old pregnant woman at the PHC clinic).

> "As an herbalist with more than 20 years' experience, I specialise in the care of both women trying to conceive and those that are pregnant. There are lots of things we advise pregnant women on, before commencing treatment. This is because if they follow all our advice, then there is a high probability that the mother will give birth to a healthy baby. But if not, then the mother may experience some complications because of non- adherence to the advice given to them. This includes not using ako koun [potash] for anything; if used for cooking or any medicinal purpose it can lead to miscarriage. The pregnant woman is also advised not to consume vegetable oil; this is because the excessive consumption of vegetable oil can cause fibroids. We also have some leaves that we use in making concoction; these are special leaves, and they are usually given to pregnant women before childbirth" (Interview with the herbalist).

Some of the participants were aware of the possible side effects of consuming different herbs

during pregnancy. They were also aware that skilled healthcare professionals do not support the use of herbs, as evidenced in the following excerpts.

> Even sometimes when I am going to clinic, I take them before leaving home. But do you know one thing, when we go for clinic in the general hospital, the staff do tell us not to visit the local providers of maternity services but really before the advent of modern medicine, that is the way our ancestors cared for pregnant women. We are Yoruba's. We need to hold on to our belief. We should therefore use it since it is part of our belief. We should not ignore anything during pregnancy, you know it is risky and it is about life or death" (Interview with a 38-year-old pregnant woman at the PHC).

> "Me, I do not use herbs, but I know very well that people use herbs for safe delivery, but do you know that nurses are against the use of herbs?" (Field note at the PHC).

> As a registered nurse, I cannot support the use of herbs because of its side effects. This is because some herbal mixtures do not have an actual dosage, they are only used based on the individual discretion, so it's difficult for us as nurses, to support the use of herbs because we know it has lots of side effects. So, during the health talk we tell them not to use anything that may affect the baby. (Interview with the midwife at the PHC)

Inferences

The main implication of the use of herbal mixtures is that; they are consumed due to the belief associated with its use during pregnancy. Thus, it is used at different times of the day for its health benefit. Herbal mixtures are prepared with the use of herbs and other resources provided by the maternity service provider or other people as illustrated in this study for the safety of the mother and baby. However, the skilled health practitioners such as nurses and midwives within the PHC, do not support the use of herbs due to their side effects. Furthermore, pregnant women seeking care from skilled health practitioners do not disclose their use of herbal mixtures as they are aware of this dissapproval.

7.4.6.4. Snail in my Soup

The consumption of a special type of soup is another practice that is common among the participants in this study. It is important to note that the use of herbs and roots also encompasses eating certain types of soup that are specially prepared. These are freshly prepared for each pregnant woman and the content of the soup is based on the belief or the tradition of the pregnant woman. Irrespective of the type of care provider, the advice given is similar. This advice can be based on the tradition of the woman herself, or the tradition of the family she is married into, but the general belief of the woman is to consume food that does not affect her adversely, as described below.

"I take herbs very well and this sometimes includes eating certain types of soup. This soup I am talking about is always prepared fresh and when it is ready, we are asked to eat it before going home, even sometimes they tell me to take it home and then eat it in the night before going to bed or as my last meal for the day. Even sometimes they give me

certain types of mixture, I do not know how to describe it, but that mixture is something that is already prepared. When they give it to me, they will only tell me to mix it with pap, because it is already prepared in powder form" (Interview with a 28-year-old pregnant woman at the herbalist clinic).

"I am always being reminded about the special bath that they do in my husband's family. This special bath is done around the ninth month and after the bath I will be given something to eat; this is a form of special soup that is prepared by my mother-in-law" (Interview with a 37-year-old pregnant woman at the herbalist clinic).

Do you know that apart from the medicine they give us in the hospital there are things we use to take care of ourselves? These things are not part of what they give us from the hospital, but they are given to us elsewhere. Some people get it from there herbalist but as for me, it is from the TBA I go to. When he gives me the soup, he will tell me to eat it before leaving his compound. The soup is special because before they prepare it, they will ask me if I like to eat snail. Me, I like to eat snail so I will tell them to prepare it with snail and when it is given to me, I will finish everything. It is not an easy thing to eat oooooo! But because I want everything to be fine, I must eat it" (Interview with a 38-year-old pregnant woman at the PHC).

"When people come here there are very certain things, we tell them before commencing any form of treatment. I do tell all the pregnant women to listen to me and that they should follow all my instruction. If they do not follow my instruction, I will know because when anything happens, especially if it a terrible thing, I will know why it happens. Let me give you an example: when I give women soup to take home to eat, some women do not eat it, and when you ask them why they did not eat it, they will tell you it is because of the smell, some will even tell you the look alone can make someone to vomit. That is why I now changed my method, so when people get to that stage when they will need to eat the special soup, I tell them to come here and eat it. It is better they eat it in front of me, so I will know they eat it, but some people will tell you they would like to take it home. There is nothing I can do. I will only tell them to be sure to eat it and not throw it

into the bin because if any dreadful thing happens it will be their fault" (Interview with the herbalist).

Inferences

Some special soups are prepared with tilapia fish (locally called catfish), while some are prepared with snails. The soup is prepared by the care provider for the pregnant woman to eat either before leaving the premises or to be taken home to be consumed at a stipulated time. This research therefore shows that the care a woman receives is centred

around the patient's beliefs. These beliefs are partly a product of the community as an external environment to the pregnant woman. This research also shows that health seeking behaviour is not just based on the intention or attitude of the pregnant woman, but that it is a combination of a range of factors that determine choice of where to seek care during pregnancy.

7.4.6.5 My Previous Pregnancy Experience

Previous pregnancy experience with skilled birth attendants or local providers of maternity service determines the choice of where some women choose to receive care during pregnancy. The experience of women shapes their health seeking behaviour during pregnancy by determining their choice of where to receive ANC. Their perception about the choice of care is influenced to an extent by previous experiences. This is evidenced from a study conducted in Kenya, which indicated that the previous experience of a pregnant woman contributed to the low attendance at antenatal clinic by shaping the pregnant women's health seeking behaviour in the present pregnancy (Onyeajamet et al., 2018).

A study conducted among pregnant women attending ANC in a tertiary hospital in Nigeria shows a high preference for vaginal birth; the women associated delivery through caesarean section as a form of failure or disappointment, while others rejected a caesarean section because they feared dying (Ashimi et al., 2013; Jeremiah et al., 2014). Women with a previous history of caesarean section therefore seek healthcare elsewhere because they do not want to deliver their baby through caesarean section. This was narrated by one of the respondents as the reason for choosing to seek care from an herbalist during pregnancy.

> "I didn't have any experience during my last pregnancy, I only went to the hospital and then the baby was delivered through caesarean section, so now I want to try all the things that will not make me to deliver through caesarean section again, and that is why you see me here" (Interview with a 28-year-old pregnant woman at the herbalist clinic).

> This is my third pregnancy, but I lost the second pregnancy when it was around three months. Due to my last experience, I do everything I am being advised to do in order to have a safe delivery" (Interview with a 38-year-old pregnant woman at the PHC). Thus, justifying that woman will do everything that will help prevent the reoccurrence of certain problems during pregnancy. This may include changing where they receive care, or they may increase the number of centres where they receive care during pregnancy.

Inferences

The previous experience of the pregnant woman is also categorized as part of the factors that determine where a woman seek care during pregnancy. In this case it involves receiving care from a primary healthcare centre and a traditional birth attendant clinic or it may be a combination of a healthcare centre with a spiritualist clinic. Thus, it can be concluded that previous experience of the pregnant woman, play a significant role when making choices about where to seek care.

7.4.6.6 My People

One of the main themes common among the pregnant women that participated in this study is the issue of people within the community who can influence women's decisions. In this study, all the identified people were women; they included mothers, mothers-in-law, sisters, sisters-in-law, and neighbours. Some of the people identified were educated while some were not. This is considered in this study because in Nigeria education is a tool widely used for the social stratification of the members of the society. It creates a form of social class among individuals in the community, thereby creating a type of strata. Education can, therefore, be classified as a predisposing factor that influences the choice of where a woman seeks care during pregnancy. Individuals with a higher level of education are therefore highly influential and can influence the health seeking behaviour of women during pregnancy (Ololube, 2012; Ololube et al, 2015).

> "As this is my second pregnancy, my mother reminded me about various things I need to start doing again. This includes eating vegetables and not eating snail or okro. She also said I should be using all the things they give me; this includes things like herbs and concoction" (Interview with a 28-year-old pregnant woman at the TBA clinic).

> "My mother does bring herbs for me to use; she was the one that actually brought me to this place. Aside from that, there are other things I use to take care of myself; this is different ooo! because I got it from church" (Field note at the herbalist clinic).

"We are aware that there are people at home that tells the pregnant women what to do, some of whom are not related to the individual. We just encourage the pregnant women visiting our clinic to ask question during the health talk or if they are shy, they can come and meet us after the clinic to clarify any information or anything that has to do with their health" (Interview with a nurse at the PHC)

Uneducated family members are included in this theme because the level of education affects a woman's health seeking behaviour. Irrespective of the level of education of the family member, the members of the family and other community members of the community are still accorded much respect due to their age, previous experience, and the form of advice they give. They, therefore, have a significant impact on women's decisions during pregnancy, as narrated in the exchange below.

"My mother told me to first visit Baba [herbalist] before going to any other place. This is because my dad is Baba's friend. Every member of our family visits Baba once they become pregnant. I only chose not to visit Baba during my last pregnancy because it is not necessary. I thought going to the general hospital is the main thing that is needed during pregnancy, but when the pregnancy came down, I was sad and decided that if I ever get pregnant again, I will listen to everything that I am being told to do. Now that I am pregnant again, I have been reminded about Baba again and I immediately decided I am going to go to Baba's place" (Interview with a 37- year-old pregnant woman at the herbalist clinic).

The respondent was further asked if money was a factor in making that decision. This is due to the existing relationship with the herbalist (Baba being a family friend) the cost of the service might have been cheaper. I was made aware that she spends a lot coming to the clinic and, to do so, she must take *okada* from her house to Baba's place and, furthermore, every time she comes to the clinic there is always something to buy: all of this is an additional expense. Notwithstanding, the participant went on to say she was not concerned with the cost of services

"All I want is to have a safe childbirth. This is because the loss of my previous pregnancy is due to the negligence of not attending Baba's clinic."

Simkhada et al. (2010) and Upadhyay et al. (2014) identified mothers-in-law as the significant other individual that may influence a woman's health seeking behaviour during pregnancy. Similarly, in another study conducted in Nepal in 2014, family members were believed to have had an influence on pregnant women's healthcare seeking behaviour (Upadhyay et al., 2014). This research, therefore, suggests that a woman's choice of where to receive ANC during pregnancy is the outcome of the health seeking behaviour with other external factors within the environment.

While conducting an interview in one of the rooms at the herbalist clinic, I noticed the impact of the significant others in relation to other factors within the environment. As documented in the following field note:

> Mrs A was incredibly happy talking to me about her pregnancy and the previous experience she has had about care in pregnancy. While chatting with her she stressed that if she has her way, she will be going to the hospital to receive care because the baby she is carrying is precious to her. Although she is happy with the form of care they provide at the herbalist clinic, she stressed that she also wants to go to the hospital to receive care, but she cannot just go to the hospital because her mother-in-law believes so much in the care they are receiving here, and she will say going to the hospital is just a waste of money. I tried to understand why she cannot be supported by her husband to go to the hospital, since she has a husband. I also thought why she cannot convince the mother-in-law to support her decision to go to the hospital. She explained to me that she would have gone to the hospital without the knowledge of her mother-law, but she cannot afford the pay for healthcare services in the hospital. I can see from her expression that she is willing to receive care from skilled healthcare personnel, but affordability of the cost of health and the influence of significant others hinder her from going to the hospital. Listening to her story, it shows the level of impact the mother-in-law can have on a pregnant daughter-in-law (Interview with 29- year-old pregnant woman at the herbalist clinic).

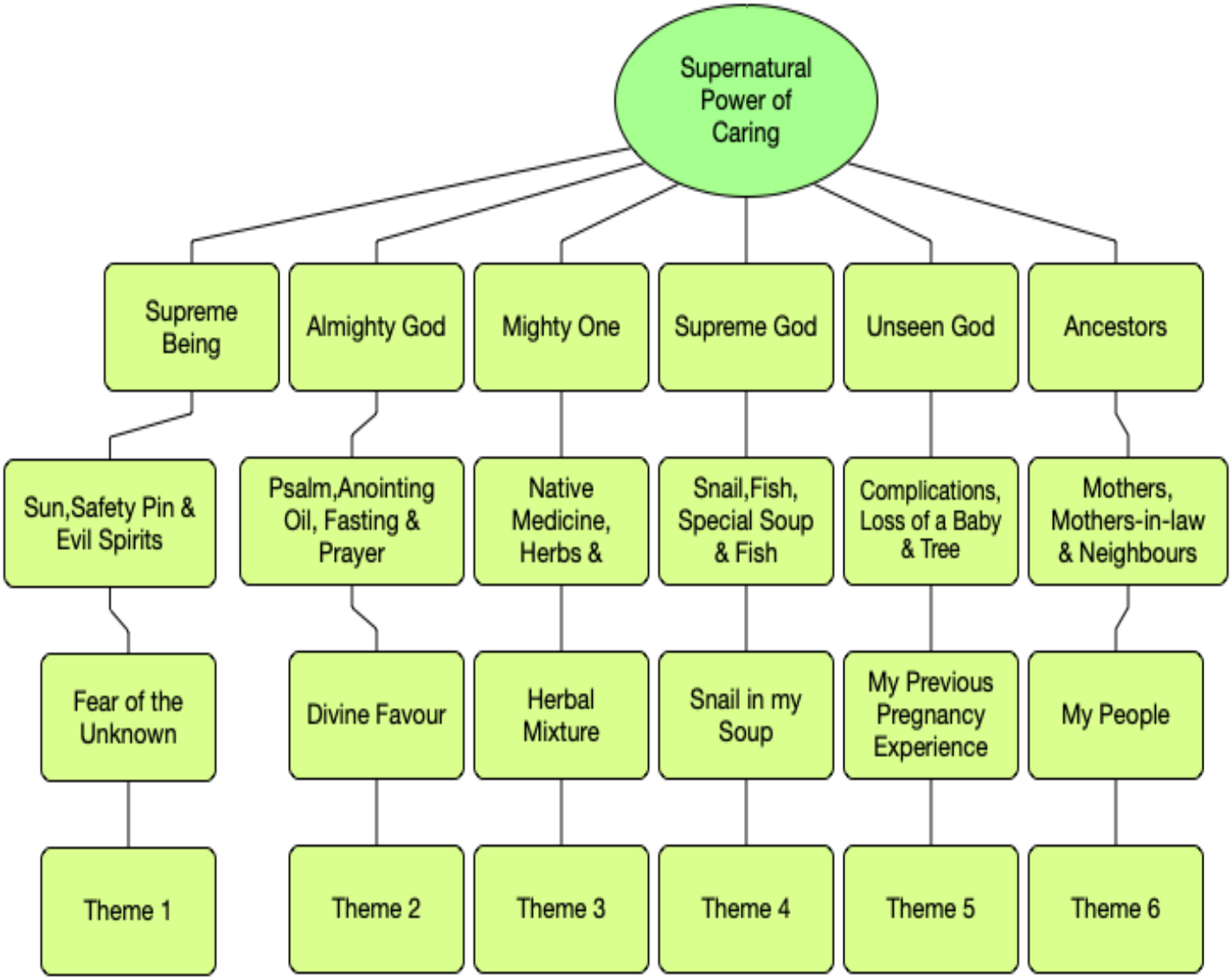


Figure 7.4h: Relationship between the central theme and the final themes generated from the code

7.5 Summary

The pregnant women in this study believed they could be protected with supernatural power. This is a unique form of power used in the care of pregnant women. It involved using spiritual power, making incantations, and having a strong belief in divine favour. This theme reiterated across all the different forms of care provided by the local providers included in this study. However, there was a slight variation in terms of the resources that are used in providing care. An herbalist, for example, made an incantation on the herbs and herbal mixture to be consumed by pregnant women, while a spiritualist made water and oil holy by praying on it. All the different actions of the various providers of maternity services were carried out in the pursuit of favour from the Supreme Being. A strong belief in the existence of a form of supernatural power is part of what pregnant women considered before making the decision to patronise a particular provider of maternity service.

Due to the need to protect both the mother and baby from evil spirits, some pregnant women sought care from the primary healthcare along with TBA clinic, while some of the participants made choices based on their previous experience; thus, their behaviour was due to the need to meet some individual needs. An example of this is seeking care where a pregnancy can be 'hung', to prevent women from experiencing miscarriage. Therefore, the various choices of the participant regarding where to seek care during pregnancy depended on numerous factors as identified in the study area. All the aforementioned factors did not only determine where to seek care, but also determined pregnant women's food choices, their sleeping patterns, and their behaviour within the community.

The findings also showed that some groups of people play a key role in women's decisions when seeking healthcare during pregnancy. This may be because of their position within the community, their profession, or their status within the family. Although the pregnant woman is the centre of care, due to fear and belief about pregnancy it is challenging for some women to go against the advice of the key people within the community. The next chapter will focus on the discussion of the findings using the SEM.

Chapter 8: Discussion of Findings

This chapter will focus on the discussion of findings in relation to the central theme of the supernatural power of caring, and the main themes which are as follows: fear of the unknown, divine favour, herbal mixture, snail in the soup, my previous experience of pregnancy, and my people. A rationale for using the SEM to frame the discussion will be provided as well as an explanation of its alignment with the research philosophy and how it adds to the research value.

8.1 Contributions of this Thesis to Knowledge

8.1.1 What Is Known

Women need to seek care from maternal healthcare services providers during pregnancy. The utilisation of the services of skilled healthcare personnel during pregnancy is the documented approach for a positive pregnancy outcome. This includes completing the required number of visits as stated in the healthcare policy. However, there has been a low utilisation of ANC in certain parts of the world, particularly among women who belong to a lower socio-economic class. Low utilisation of ANC has been attributed to level of finance, level of education, geographical location, cost of healthcare, age, delay in seeking care, government policy, and sociocultural factors.

Globally, poor maternal health outcome has been the result of direct or indirect causes of complications during pregnancy. The numerous factors directly contributing to poor maternal health outcome are obstetric haemorrhage, obstructed labour, and sepsis. The indirect factors contributing to poor maternal health outcome are poverty, cost of healthcare, lack of education, geographical location, delay in seeking care, and cultural factors. The impact of the indirect factors is significant due to its effect on the rate of utilisation of maternity care services during pregnancy.

In Africa, all the indirect factors affect the utilisation of ANC during pregnancy along with specific cultural factors peculiar to the region, which include the need to bury the placenta after childbirth, the consumption of herbs for protection of the mother and baby during pregnancy, and the performance of rituals to prevent complications. It is also believed that pregnant woman could be affected by the evil eye and that unsettled dispute with members of the family may delay delivery of the baby. Similarly, the consumption of yellow fruit during pregnancy is believed to be the cause of jaundice in babies.

In Nigeria, beliefs and practices are passed down from bygone generations – a concept shared in other parts of Africa with varied interpretations depending on location and tradition. In some parts of Nigeria, it is believed that pregnancy is a natural process, and a woman need only seek care from a TBA because of the protection afforded to both the

mother and the baby. Elsewhere in Nigeria, it is believed that when a woman disobeys significant members of the family, the woman may be cursed.

Although some previous studies conducted in Nigeria classified indigenous practices and religious beliefs as part of the factors affecting the healthcare choices of women during pregnancy, none were conducted explicitly to classify the diverse cultural factors that may affect the utilisation of maternal healthcare services. They focused only on naming all the factors associated with maternity as indigenous factors or cultural factors. In addition, previous studies on the factors affecting women's healthcare choices focused on the identification of taboos associated with illness in pregnancy or identifying the cause of the complications and not on the beliefs and practices associated with the health seeking behaviour of women during pregnancy. Therefore, this study was carried out with the aim of exploring the beliefs and practices that may influence the health seeking behaviour of women during pregnancy in Ota.

8.1.2 What this study will add

The review of the literature in chapter 4 shows that beliefs, practices, health seeking behaviour, and ANC are the four core elements associated with women's healthcare choices. Each study included in the review focused on one or more core elements; however, none of the studies focused on the impact of all the four core elements on women's healthcare choices. Therefore, this study contributes to the literature by focusing on all the core elements associated with women's healthcare choices during pregnancy. This study also contributes to the literature by identifying the beliefs and practices associated with women's healthcare choices during pregnancy. This is crucial because part of the evidence-based approach to improving maternity care is to provide a contextual form of care. There is a tendency to accept that the availability of a contextual form of care in healthcare centres is going to affect people's views about the utilisation of the service of skilled healthcare personnel, hence contributing to the overall maternal healthcare index of the area. These beliefs and practices can be expressed within one overarching theme, the supernatural power of caring: the unique contribution of this research.

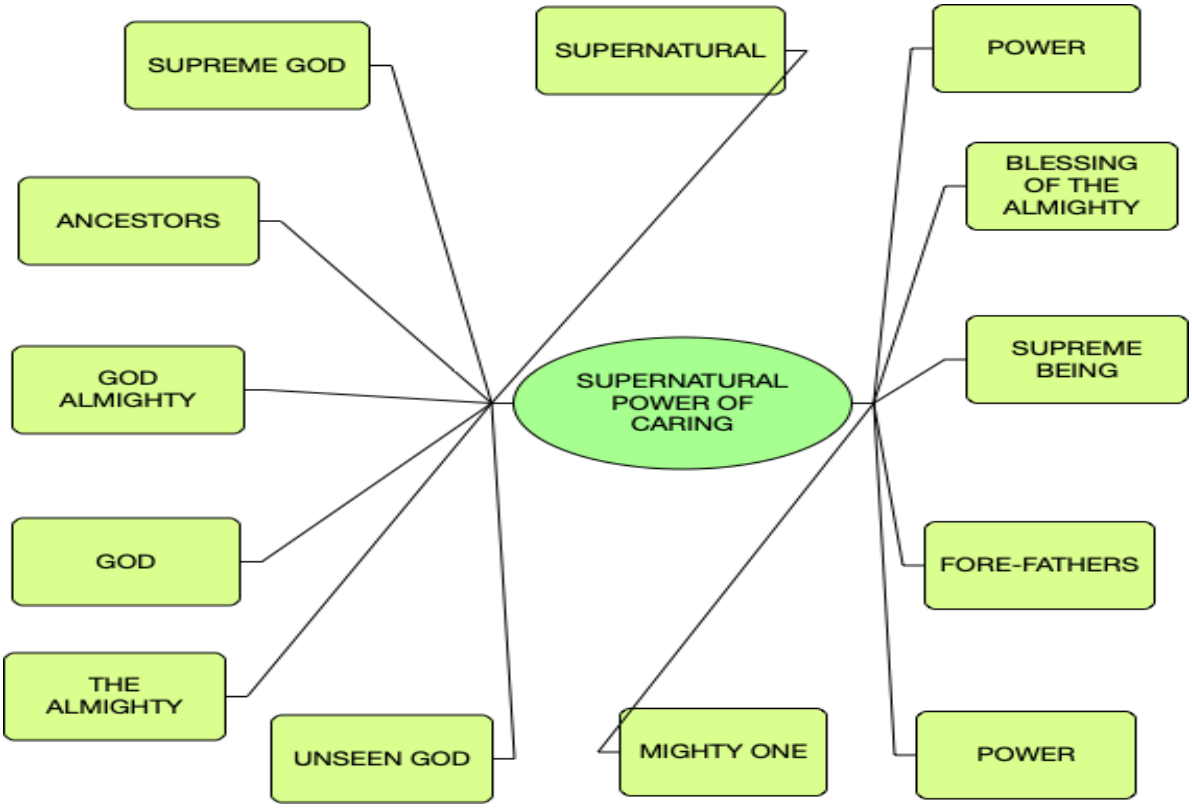


Figure 8.1a: Supernatural Power of Caring

Due to a fear of the unknown outcome of pregnancy, women try to do everything that will make them have a positive childbirth outcome. This includes following the steps of past generations by considering both the visible and non-visible component of maternity care as identified from the participants' stories. The visible part includes going to the healthcare centre and consuming herbs or soup made with snails, while the non-visible component includes engaging in practices that will protect the baby and mother from evil spirits or seeking for divine favour to prevent complications in pregnancy. The supernatural power of caring on women's healthcare choices during pregnancy are significant because the maternity service provider uses it along with incantations, rituals, and

other practices such as, praying, holy water, anointing oil, and hanging of pregnancy, to protect the mother and the baby.

However, this is slightly different for the pregnant women whose use of supernatural power is based solely on her personal belief or any practices or resources that will protect her during pregnancy. The supernatural power of caring involves using a form of invisible power along with other resources to protect the mother and baby from harm. This involves protection from evil spirits, since it is believed that they may harm the baby. It was also identified from the findings of this study that women with previous miscarriage experience will want to do everything to protect the pregnancy. This includes hanging the pregnancy on a tree or the consumption of herbs for the prevention of miscarriage. Here is another contribution of this study: none of the previous studies identified the hanging of pregnancy with supernatural power as an act which may affect healthcare choices. Thus, the central theme; supernatural power of caring that emerge from the collected data, can be used for the provision of contextual form of care through the availability of a form of maternity service that align with the belief of each pregnant women seeking care. This may include having a healthcare centre that offers a form of service that is based on supernatural power around the primary healthcare center or regulating the service of the various providers of such maternity care within the area.

Care during pregnancy is considered incomplete without the use of indigenous healthcare services. Thus, from the findings of this study, one's understanding of ANC should extend beyond seeking care from skilled healthcare personnel, or completing the required number of visits, as documented in the antenatal healthcare policy. ANC is a complex process that involves appealing to the supernatural for a safe childbirth as well as seeking care from skilled healthcare personnel for safe childbirth and positive childbirth experience. Therefore, by highlighting the significance of a biomedical system of care alongside indigenous practices which are represented by the supernatural power of caring such as the hanging of pregnancy or consumption of special soup for the protection of the mother and baby, one gains a closer understanding of holistic forms of care.

8.2 Overview of My Research Findings

The central theme in this study is the supernatural power of caring. This is the overarching theme for all the themes in this study because the outcome of the pregnant woman's behaviour or the local maternal healthcare service provider's action is based on the belief that a form of supernatural power exists. This power is being used for protection from any form of harm, including evil spirits, that could affect the mother or the baby during pregnancy and on the day of childbirth. Thus, it is believed that in order to prevent pregnancy-related complications, a pregnant woman needs to ensure she engages in practices that will ward off evil spirits or any form of harm to her or her baby. This is the unique finding in this study as it dominates the responses of both the pregnant women and maternity service provider regarding how they seek and deliver care during pregnancy.

The protection of the mother and baby was important to the participants in this study due to a fear of the unknown, which is another theme in this study that affects the health seeking behaviour of women during pregnancy. Due to a fear of the unknown outcome of pregnancy, women sought to do everything within their capacity to ensure they are protected from evil spirits during pregnancy or childbirth. This included attaching a safety pin to their clothes, having a special bath around the fourth month of the pregnancy (using elements prepared according to family tradition) and avoiding any activity that was considered a taboo according to family traditions. Thus, they sought care where they could be provided with services that they believed would aid safe childbirth.

It is also obvious from the findings that due to the fear of the unknown outcome of pregnancy, and other needs associated with their belief, women sought care from more than one clinic. For instance, some of the women that took part in this study who sought care from the PHC combined the care they received from skilled healthcare personnel with other forms of care available at the clinics of unskilled maternity service providers such as herbalists, spiritualists, or TBAs. The participants in this study made their choice from the maternal healthcare service providers available within their area. Some sought care with traditional practitioners in the community because they provided a form of care unavailable elsewhere.

Hence, they sought care from a local maternity service provider for a form of care that met their cultural norms.

Seeking divine favour from the Supreme Being is also another theme in this study. This is unique from other themes because it shows how the behaviour of an individual seeking care is influenced by her own belief. In this study, pregnant women sought care where they could be supported with prayer for safe childbirth. When they visited local providers of maternity services, the items given to them for the protection of mother and unborn child were olive oil, anointing oil, and water. The maternity service provider prayed on such items to render them holy and ready for use by the woman seeking care.

Herbal mixture is another theme generated from the experiences of the participants in this study. It involved the use of herbs obtained fresh from the compound where the local maternity service provider was situated or bought from the community market. On some occasions dried plant-based herbs and roots were used in the preparation of the mixture, which was consumed for the protection of the mother and baby.

Another theme from the participants' stories is termed as snail in the soup. This special form of soup was prepared by the local maternity service provider for the pregnant women which, in addition to the eponymous ingredient, had contents based on the preference of the individual. Accepting or consuming such soup reflected the belief of the individual, the family tradition that was transferred to them, and the practice that was common in the area. All these are factors which a pregnant woman considered before making her choice regarding where to seek care.

The previous experience of the woman seeking care also affected her health seeking behaviour. This is another theme emerging from the desire to have a positive childbirth experience and a safe childbirth where mother and child are alive and healthy. This was borne out by some of the participants trying to change their care provider because they did not have a desired outcome from the PHC. Thus, they tried to use other healthcare centres, such as clinics of spiritualists, herbalists, or TBAs, which provided traditional forms of care for pregnant women. They were selected to protect the pregnancy as the form of service provided was not available at the PHCs and were, hence, considered as a need that must be met to have a safe childbirth.

The identified needs of the woman seeking care are based on the belief of the individual, common practices in the area, and other members of the community. These

groups of people are categorised in this study as people. People are the last theme generated from the findings of this study. In this study, the term ‘people’ refers to the members of the community that may influence the health choices of pregnant women. Some of these individuals are related to the woman seeking care, others are members of the community where the women seeking care reside.

8.3 Interpretation of Study Findings

The first objective of this research was to identify the beliefs and practices influencing health seeking behaviour of women during pregnancy in Ota. The findings of this study shows that there are practices that are considered as norms during pregnancy in this part of Nigeria. Women engage in the practices to protect the mother and baby from harm and pregnancy-related complications. Likewise, they also belief in the existence of a form of supernatural power; a unique form of power which when combine with practices that align with the belief of the woman, is considered to aid safe childbirth and prevention of pregnancy related complications.

Due to the belief attached to indigenous practices, women use such practices for guidance when choosing where to seek care. They tend to choose clinics that can provide resources that will protect them from what are considered to be the adverse consequences of their unwitting contact with the unseen world. Women engage in these practices because of their personal beliefs despite documented negative repercussions associated with some local practices (Shewamene et al., 2017).

The findings of this study also show that women seek care from alternative service providers because of their trust in this system of care. Trust is held to be an essential element of maternity care: lack of trust is part of the evidence-based barriers that affect the utilisation of maternal healthcare services in sub-Saharan Africa (Kyei-Nimakoh et al., 2017). Research has shown that the institutions in the modern system of healthcare in Nigeria do not make provision for all the factors within the environment that may affect the behaviour of the individual seeking care (Welcome, 2011). This lack of inclusion relates to the non-integration of the traditional system of care into the Western system of care, contrary to the recommendation for contextual care, as directed by WHO (Isola, 2013). This has an implication for maternal health outcomes because it is believed that Western forms of healthcare cannot proffer solutions to all healthcare issues during pregnancy, and, as such, it is important that a woman seek other forms of care for protection and general well-being for herself and the baby (Isola, 2013).

Therefore, it is important that all maternity service providers enquire about the beliefs and practices of women seeking care in their practice. This should extend beyond

asking question about their culture for the patients' health notes. It should include asking women about the practices that are important to them during pregnancy. In addition,

maternity service providers need to undergo training on the importance of respecting a patient's belief regarding maternity care. I believe these measures will increase service providers' understanding of how the environment has affected the pregnant woman as an individual seeking care – thereby providing skilled healthcare personnel an opportunity to advise a pregnant woman based on her belief. When maternity service providers are aware of an individual's beliefs and practices, there is also an opportunity to provide a comprehensive care that will meet all her needs. This is especially important as comprehensive person-centred care is part of the approach that has been recommended as a way forward for improving maternity care in low-resource nations, where there is low utilisation of the services of skilled healthcare personnel for issues related to pregnancy or childbirth (Izugbara & Wekesah, 2018).

The findings of this research also show that a range of people, as described in the previous chapter, influence women's choices regarding where to seek care. Previous research has considered the people within the community who may influence healthcare choices an essential element of ANC that needs to be understood by policy makers to develop interventions that will be contextually appropriate (Akeju et al., 2016; Ganle et al., 2015; Simkhada et al., 2010).

To meet the aim and objectives of this study, an ethnographic approach was used to explore the cultural beliefs and practices that may influence the health seeking behaviour of pregnant women. Data were collected through semi-structured interviews and observations with a focus on exploring the practices common to a group of women. Employing this approach provided an in-depth understanding about the various practice's women engage themselves to have a safe childbirth. It also facilitated a critical understanding of the sources of information that influence the health seeking behaviour of pregnant women.

The WHO recommends the use of an evidence-based ANC approach that will provide a positive childbirth experience. This involves having one contact with skilled healthcare personnel during the first trimester, two contacts during the second trimester and five contacts during the third trimester. Having a minimum of eight contacts with a skilled healthcare personnel during pregnancy is recommended for increasing the likelihood of a positive pregnancy outcome (WHO, 2016).

The guideline used in the development of the WHO recommendation prioritises its implementation in low-resource settings. This was developed from the systematic review of evidence from high-, middle- and low-income countries, with the aim of providing more information about the needs of women during pregnancy. The findings of the systematic review show that the main need of women during pregnancy is a positive childbirth experience (Downe et al., 2016; WHO, 2016). According to WHO (2016c) positive childbirth experience involves "maintaining physical and socio-cultural normality". Thus, the beliefs and practices of the pregnant women considered in this study will be a valuable resource for a positive childbirth experience.

Furthermore, the WHO guideline also recommends healthcare stakeholders to ensure that the implementation of the suggested approach is appropriate for their setting (WHO, 2016c). Since the overall aim is to proffer solutions to some of the issues associated with the delivery and utilisation of ANC, due to its complex nature. In addition, in order to ensure the objective of each contact with a skilled healthcare personnel is achieved, WHO recommends the availability of trained and certified healthcare personnel in rural settings (WHO, 2018d). However, this may be challenging in some parts of Nigeria, due to the inequality in the distribution of healthcare resources: the number of healthcare centres in rural communities is low and there is shortage of staff and other resources required for the provision of healthcare services (Ariyo et al., 2017; Nwakeze & Ngianga-Bakwin, 2011)

The availability of a functioning healthcare centre, however, does not directly lead to its utilisation because the choice of a woman regarding where to seek care is also affected by some intrapersonal factors, as illustrated in the SEM (Munguambe et al., 2016). For instance, research has shown that there is a shortage of healthcare staff in rural healthcare settings due to lack of infrastructure and poor renumeration (Ozodiegwu & Doctor, 2017). Most pregnant women within the study region do not seek care from skilled healthcare personnel due to unaffordability of the cost of healthcare services (Onasoga et al., 2012). However, this research shows that women do seek care from unskilled healthcare personnel due to their personal beliefs. Therefore, it is important that healthcare stakeholders consider a biomedical model of care alongside traditional practices such as the consumption of special soup made with snails for protection from evil spirits during pregnancy. These

findings are in line with studies from other African countries; for example, a study conducted in Ghana showed that herbs and herbal products are used regularly by local maternity service providers due to the belief that such products can protect the woman from evil spirits and proffer solutions to any underlying health issue that may compromise safe delivery (Aziato & Omenyo, 2018). Similarly, another study conducted in three communities in Ethiopia among diverse groups of women showed that the healthcare centre is regarded as an unsuitable place because it does not allow the woman seeking care to perform the rituals that are necessary for safe childbirth, nor to use some local resources that are necessary for the protection of the new baby immediately after childbirth – some pregnancy-related complications are believed to be caused by evil spirits (Ababor et al., 2019). This study therefore focuses on the practices that are considered by participants to be part of the essential care required for safe childbirth.

8.4 Health Seeking Behaviour and the Construct of the SEM

The SEM was applied in this study because it has been used in previous research to identify factors affecting healthcare services (Ezenwaka et al., 2020; Nicolson et al., 2019; Shahabuddin et al., 2017; Uchendu et al., 2020). According to the SEM it is maintained that an individual's behaviour is the result of the interaction between all the factors within the environment, thereby suggesting that the behaviour a woman exhibits during pregnancy is the outcome of the impact of the intrapersonal-level factors, interpersonal-level factors, organisational-level factors, community-level factors and public policy. The interaction between the different constructs within the SEM is reciprocal because the individual exhibiting the behaviour tends to influence the social environment and, likewise, the environment can also influence the individual (Salihu et al., 2015). The various levels of the SEM are used to explore the study findings and will aid in the identification of what level of the social environment needs to be targeted to increase the rate of utilisation of the services of skilled healthcare personnel. The five constructs in the SEM are intrapersonal-level factors, interpersonal-level factors, organisational-level factors, community-level factors, and public policy.

Intrapersonal-level factors

These factors are described as the characteristics of an individual that can influence behaviour (Adu et al., 2018). They encompass knowledge, attitudes, beliefs, and perceptions of individuals seeking care (Ngomane & Mulaudzi, 2012; Salihu et al., 2015). The findings from this study show that pregnant women in Ota attach importance to indigenous beliefs and practices that will help protect pregnancy, prevent complications, and aid positive childbirth experience. These beliefs and practices include using a safety pin for protection from evil spirits, not going out at midday or at night, using olive oil and holy water for protection of the mother, and consuming special soup for protection from any form of harm. In addition, individual-level factors in this study also include making choices regarding the content of the special soup consumed by the pregnant woman for protection. The woman's behaviour is based on her belief, which includes making choices about the content of the soup. There are two options that the pregnant woman must choose from: when her belief supports the consumption of snails, the soup is made with snail and some other

herbal product: when her belief does not support the consumption of snails, the soup is made with fish and additional herbal products as required.

The identified reasons why women seek care from local healthcare providers include a belief that Western medicine cannot offer a solution to all health issues affecting women during pregnancy (White, 2015). Thus, some of the participants in this study use local healthcare services along with Western forms of healthcare, which involves seeking care from skilled healthcare personnel.

The contextual description of care in pregnancy also affects the choices of women during pregnancy; for instance, the participants in this study believe that the care a woman receives during pregnancy should involve protection from evil spirits. Due to this, some women seek care from traditional maternity service providers despite the availability of Western system of care. This has been related to the reliance on the system of care that was passed from past generations. According to Helms and Cook (1999), indigenous systems of care involve using the helpful beliefs and practices that originate within a culture or society and are designed to treat the inhabitants of the community. In addition, among the individual-level factors is the belief of the participants in relation to divine favour and snail in the soup. This is because the health belief of a pregnant woman is based on societal norms and values – a feature which is central to an individual's background (Rego et al., 2020).

All the themes from the findings of the study can be discussed in relation to the intrapersonal-level factors since each construct illustrates how the elements of the external social environment influence healthcare choices. For instance, the identified local practices have been described as the result of the interaction of the individual (pregnant woman) on the environment. This is a practice that women adopt to have a safe childbirth where mother and child are alive. This is consistent with the findings on the beliefs and practices of pregnant women in Uganda (Atuyambe et al., 2009), in Zambia (M'soka et al., 2015), in Ghana (Farnes et al., 2011), and in Malawi (Roberts et al., 2016). Reliance on the indigenous system of care is a common practice in Africa despite the availability of Western systems of healthcare. Furthermore, in Africa, seeking healthcare during pregnancy is not only for the well-being of the pregnant woman but is also described in relation to both the living and the

ancestors. Therefore, pregnant women engage in behaviours that meet the cultural beliefs and practices of their society, since their behaviour is the result of interaction with their external environment. This is upheld to ensure they follow the tradition that has been passed to them and engage in practices to ensure their practice will aid a positive childbirth experience where mother and child are alive (White, 2015).

The intrapersonal-level factors are the identified needs of the women in this study. They are a pregnancy free of complications, pregnancy protected from evil spirits, and a safe childbirth where both mother and child are alive. To meet these needs, study participants use different care providers during their pregnancy. When an individual combine's conventional medicine with ethnomedicine or any form of complementary medicine, it is referred to as medical pluralism (Munguambe et al., 2016). This is a practice that is contextually common globally and in Africa, it provides a woman with the opportunity to receive a holistic form of care that meets her needs (Farnes et al., 2011; Munguambe et al., 2016). In this study, complete care for the pregnant woman involves patronising diverse types of maternity service providers to have a positive childbirth experience. In addition, the choice of where to seek care depends on the belief of the woman about the aetiology of the illness in pregnancy. Thus, when the cause of an illness in pregnancy is termed as spiritual, women will seek care from a spiritualist, and if it is attributed to evil forces, they may seek care from herbalist or TBA. This is clear from participants' narratives about seeking help through divine favour, using olive oil, and eating snail soup for protection. Therefore, the belief of an individual about where to receive care is an important part of healthcare because it guides behaviour. This implies that the factors associated with the individual are essential in the improvement of maternity care and the realisation of a positive childbirth experience.

Interpersonal-level factors

At the interpersonal level of the SEM, the external factors that influence individual behaviour are the significant others within and outside a pregnant woman's household (Adu & Oudshoorn, 2020; Golden & Earp, 2012). In this study, the identified significant others are described under the theme of people. They include mothers-in-law, sisters, and other women within the community. The participants in this study verbalised that there were

certain members of the family or community who played a significant role regarding decision-making during pregnancy. Below, is an example.

> While chatting with her, she stressed that if she has her way, she will be going to the hospital to receive care because the baby she is carrying is precious to her. Although she is happy with the form of care they provide at the herbalist clinic, she stressed that she also wants to go to the hospital to receive care, but she cannot just go to the hospital because her mother-in-law believes so much in the care they are receiving here, and she will say going to the hospital is just a waste of money (Interview with a 29- year-old pregnant woman at the herbalist clinic).

Those related to the individual are the mother-in-law or sister-in-law. While the other women who influence healthcare choices but are not related to the pregnant women seeking care are the elderly women within the community. These groups of people advise pregnant women on where to seek care and the various practices they might engage in to aid positive childbirth experience, as narrated below by two pregnant women.

> "My mother told me to first visit Baba [herbalist] before going to any other place. This is because my dad is Baba's friend. Every member of our family visits Baba once they become pregnant. I only chose not to visit Baba during my last pregnancy because it is not necessary. I thought going to the general hospital is the main thing that is needed during pregnancy, but when the pregnancy came down, I was sad and decided that if I ever get pregnant again, I will listen to everything that I am being told to do. Now that I am pregnant again, I have been reminded about Baba again and I immediately decided I am going to go to Baba's place" (Interview with a 37- year-old pregnant woman at the herbalist clinic).

> "I use herbs, but I do not just take herbs from anybody, I only use herbs given to me by my mother-in-law. I used to drink all the herbs she prepares for me and sometimes she even tells me to use part of it to bathe in the morning and at night" (Interview with 34-year-old pregnant woman at the PHC).

The above examples are consistent with findings from earlier studies which illustrate how the extended family members impact on women's choices about where to seek care (Akeju et al., 2016; Brighton et al., 2013; Ganle et al., 2015; Roro et al., 2014). Likewise, research has shown that due to the patriarchal nature of Nigerian society, women have limited power to make decisions about their health (Ononokpono & Odimegwu, 2014). Thus, men are categorised as the head of the family and the main decision makers, while women are described as the possession of the men (Akeju et al., 2016).

In this study, however, patriarchy did not appear as an influence on the health seeking behaviour of women during pregnancy even though men controlling women's choices regarding where to seek care during pregnancy is part of the cultural milieu within most African societies. While the patriarchal structure of the society gives women limited ability to make decisions about their care during pregnancy, where women reside also affects the choice of where to seek care (Adamu & Salihu, 2002). The impact of location is shown in a qualitative study conducted in six different communities in Ghana (Ganle et al., 2015). The study focused on how intra-familial decision-making affects the use of healthcare during pregnancy. The findings reported that women in urban area have a different health seeking behaviour compared to women in rural areas, because they do not totally depend on their husband for healthcare needs (Ganle et al., 2015). Thus, this group of individuals (husbands) shared the authority to make decisions about where to receive prenatal care with the pregnant woman.

Organisational-level factors

Organisational-level factors focus on the impact of social institution such as healthcare facilities and healthcare workers on individual healthcare choices (Olaniyan et al., 2021). The findings of this study shows that herbalist clinics, spiritualist clinics and TBA clinics are some of the commonly used organisations for maternal healthcare services within the area. While the herbalist seeks for protection from evil spirits using special soups whose composition is based on the belief of the woman seeking care, the spiritualist seeks for divine favour from the Supreme Being using prayer, olive oil and holy water for protection, and the TBA uses herbal mixtures for the protection of the woman and the prevention of pregnancy-related complications.

The alternative providers listed in this study are the preferred choice of selected participants because they provide resources that can be used to protect the mother and baby based on her personal beliefs. Such a unique role differentiates the local provider from other maternity service providers in the area because the resources they use in the care of pregnant women are different from what is used by other local maternity service providers that participated in the study. Furthermore, the findings of this study show that pregnant women seek care from the clinics of these local maternity service providers because they provide a form of service that meets their needs during pregnancy. The identified needs of the pregnant women in this study are prevention of miscarriage, protection from evil spirits, protection of the baby *in utero*, and a safe delivery.

All the identified needs are being met in the different organisations (TBA clinic, spiritualist clinic and the herbalist clinic) within the study area. Although a woman's preferred choice of organisation for maternity care varies, the main goal of seeking care is to have a have a safe childbirth where pregnancy is hung to prevent miscarriage and the baby and mother are protected from evil spirits through the consumption of herbal mixtures and supernatural powers.

In this study, the participants visited the TBA clinic, herbalist clinic and spiritualist clinic as organisations that provided care for pregnant women because of their belief in such form of maternity care, whereas the findings of earlier research shows that women seek care from the TBA clinic because they are the primary providers of maternity service and the

first point of contact for most women (Aziato & Omenyo, 2018). Likewise, there is also a high preference for such maternity service providers because they speak the local dialect and understand the beliefs and practices common in the area (Aziato & Omenyo, 2018; Choguya, 2015). However, some authors have argued that TBAs are the first point of contact for some women due to their geographical location (where they reside); a situational report included in a study conducted among residents of a community in Zimbabwe shows that women patronised a local maternity service provider clinic because it was the only form of service available in the area (Choguya, 2015). Thus, the scarcity of a functioning healthcare organisations, either private or public, affects the healthcare seeking behaviour of women during pregnancy. In Nigeria, this is more prevalent in rural areas due to inequality in the distribution of healthcare services. This further affects the use of maternal healthcare services because living in a rural community located in a developing nation means living in a community with reduced infrastructure when compared to urban areas (Okoli et al., 2020).

In addition, the environment where a healthcare centre providing maternity service is located also controls the practices women engage in during pregnancy. The finding of this study, for instance, show that part of the practices common in the study area is that pregnant women should not go out at night or at noon when the sun is at its zenith. It was observed that women tried to leave the clinic early to avoid being outside in the midday sun when they had been advised to stay indoors. This behaviour is the outcome of the environment where the clinic is located and the time the clinic is open. Thus, when the utilisation of the services of skilled healthcare personnel does not support the indigenous practices common in an area, it will reduce the rate of attendance at antenatal clinic, thereby affecting the choice of where to seek care and the health seeking behaviour of women within the area (Ngwenya et al., 2020).

Community-level factors

At the community level, beliefs, values, norms, and practices are the range of factors associated with healthcare choices (Farnes et al., 2011; Ngomane & Malaudzi, 2012). The consumption of herbal concoctions during pregnancy is classified in this study as the community-level factor affecting the health seeking behaviour of women during pregnancy. It involves the use of herbs, herbal products, and the consumption of snail soup during

pregnancy. All the said items are classified as traditional medicine based on the description of the “practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises applied singularly or in combination to treat, diagnose and prevent illness or maintain well-being” (Fokunang et al., 2011, p. 284). Using this definition of traditional medicine to identify community-level factors, it should be noted that the focus of this study only considers the factors that affect the choices of women during pregnancy.

The findings of this study show that pregnant women consume herbal products during pregnancy. This is consistent with the findings of other studies which show that the use of herbs during pregnancy is a widespread practice in Africa, especially in rural communities where there is reduced or low access to the healthcare centres offering Western forms of care (Aziato & Omenyo, 2018; Farnes et al., 2011; Romeo-Daza, 2002; Shewameme et al., 2017). This is because good health, a positive childbirth experience, and safe delivery within an African context involves engaging in practices such as the use of herbs and other related products during pregnancy, in order to prevent any misfortune which may be the result of disobeying the ancestors (White, 2015). Thus, what is considered suitable behaviour in pregnancy is to live by the beliefs and practices of the community where one lives.

Part of the widespread practice among the selected participants in the study was to visit two or more clinics for pregnancy care – a visit to a PHC and spiritualist clinic, or a visit to the herbalist clinic and a spiritualist clinic. Women who visited the spiritualist, sought care from a TBA and the PHC. This supports the findings of authors who suggested that seeking care in pregnancy is in two phases. The first is to find the physical cause of complications or illness in pregnancy, and this may involve going to the PHC or TBA for care in pregnancy. The second phase involves consulting the unseen world, spirits, or deities to name the cause of the illness (Olupona, 2004; White, 2015).

Public policy

The public policy of the SEM focuses on policy that guides both the individual seeking care and the provider of maternity services within an area. Most government policies focus more on the provider of the maternity service, with little consideration for the

woman seeking care (Stephenson et al., 2006). Thus, in order to improve maternity services authors have suggested providing a form of care that considers the law of the society and the norms of the community where people live (Doctor et al., 2018). Likewise, the available form of ANC should not only rely on scientific evidence while leaving out the non-scientific evidence which may make maternity care contextually appropriate. This aligns with this study's findings which demonstrated that women used maternity services that is accorded with their beliefs such as protection from evil spirits and aiding positive childbirth with no complications.

The best approach to improving maternity care and enhancing positive childbirth experience is to acknowledge a biomedical model of care alongside indigenous practices in antenatal healthcare policy. Although this study focuses only on exploring the beliefs and practices that affect the health seeking behaviour of women during pregnancy, the policy governing the practice in the area cannot be ignored – the current antenatal healthcare policy does not have well-defined guidelines regarding the operation of local maternity service providers within the area (FMH, 2016).

The findings of this study show that there are certain practices that are considered to be an important part of maternity care; these cannot be ignored. All the different practices women engage in have an implication on the healthcare institution, the provider of maternity care and the policy makers. In summary, the findings of this study show that the health seeking behaviour of a pregnant woman is the result of various interrelated factors within her environment. The application of the SEM to the findings of this study shows that the behaviour the participants exhibit is the result of the various forces within the environment.Thus, to protect the woman seeking care, she needs to be considered as an intrapersonal- factor as depicted in the model.

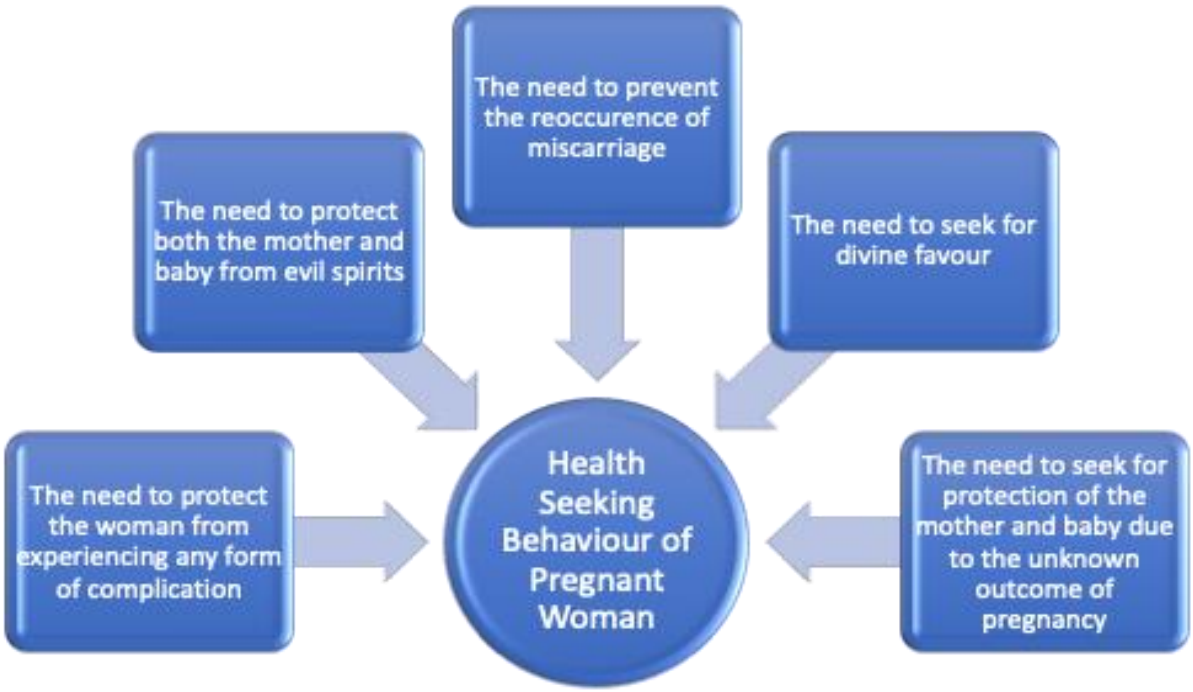


Figure 8.3a: Factors affecting the healthcare seeking behaviour of pregnant women in Ota

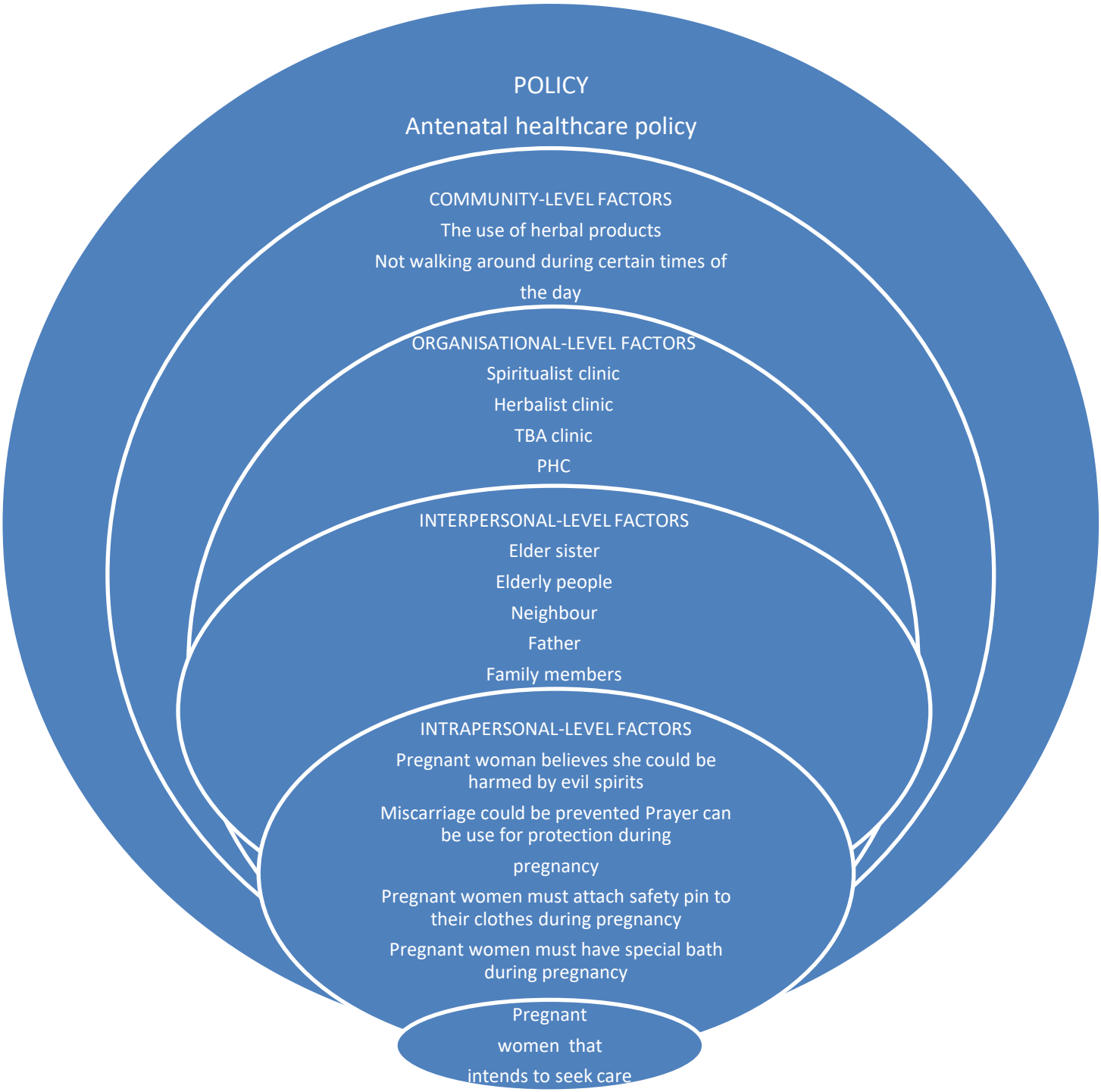

POLICY
Antenatal healthcare policy
COMMUNITY-LEVEL FACTORS
The use of herbal products
Not walking around during certain times of the day
ORGANISATIONAL-LEVEL FACTORS
Spiritualist clinic
Herbalist clinic
TBA clinic
PHC
INTERPERSONAL-LEVEL FACTORS
Elder sister
Elderly people
Neighbour
Father
Family members
INTRAPERSONAL-LEVEL FACTORS
Pregnant woman believes she could be harmed by evil spirits
Miscarriage could be prevented Prayer can be use for protection during pregnancy
Pregnant women must attach safety pin to their clothes during pregnancy
Pregnant women must have special bath during pregnancy
Pregnant women that intends to seek care

Figure 8.3b: Beliefs and practices associated with the health seeking behaviour of women during pregnancy in Ota based on the SEM (Adapted from the findings of this study and information from Shahabuddin et al., 2017)

8.5 Meeting the Objectives of the Study

The first objective of this research was to identify the cultural beliefs and practices influencing the healthcare choices of women during pregnancy in Ota. This is an important part of this research because after listening to the stories of the selected group of women that participated in this study, it is evident that there are some cultural practices that are considered an essential part of maternity care. These include seeking divine favour with anointed oil or holy water and not going out during certain times of the day for a complete protection of the pregnancy and a safe childbirth. Although this affected participants' choices of where to seek care, it could also have been the result of their low levels of education as evidenced in the demographic characteristics of the participants in this study. This finding reflects previous research which shows that the utilisation of indigenous forms of healthcare during pregnancy can be the result of the low levels of education of some women. It is a practice that is more prevalent in rural areas than urban areas, due to inequality in the distribution of healthcare resources (Shewame et al., 2017). Thus, it is crucial that the indigenous beliefs of the woman seeking care are considered an essential element of an individual that must be given priority when amending or developing healthcare policy.

The second objective of the study was to explore what is considered to be care in pregnancy. The findings of this study show that Western systems of care are not the only forms of care needed in pregnancy; other needs, such as the non-biomedical part of care, are also important parts of women's care. This is evident from the participants' behaviour; the majority considered visiting more than one clinic in order to meet their needs. Some participants, for example, believed that it was important to visit the spiritualist clinic as well as the PHC during pregnancy, while others only sought care from the spiritualist clinic without going to the PHC (these women comprise the group of participants in this study that considered spiritualist care as the form of care needed for a positive childbirth experience). Some participants opted to seek care from herbalists because they needed to identify the cause of a problem in pregnancy (these women are the selected group of women who opted for a TBA to provide the service and resources needed for successful childbirth, where mother and child remained alive and healthy). Thus, the different choices

of where to seek care are based on each woman's personal belief in what is needed for a positive childbirth. One of the identified resources needed for positive childbirth was the use of anointing oil, or what is considered special oil, from the spiritualist. Another practice common among the participants was the consumption of soup made with snails for protection of the foetus *in utero* and a safe childbirth. These practices are not based on, nor justified by, scientific evidence to aid positive maternal healthcare outcome.

The third objective of the study was to identify who influences the choice of where women seek care during pregnancy. The findings of this study show that the individuals who influence the healthcare choices of women in a remote community like Ota are people around them, some of whom are close family members. There are also members of the identified people who are not family members but can still influence the decision of where care should be sought. These people are classified as significant others that can influence the choice of where a woman seeks care, due to the culture of respecting others, and especially older women with previous experience of childbirth (Ganle et al., 2015; Magadani et al., 2015; Simkhada et al., 2010). The spouse, partner or husband is also categorised as part of the significant others influencing the choice of where a woman seeks care, due to the patriarchal nature of the community to which the participants of this study belong.

Several other factors, not investigated directly in this study, are also likely to have influenced women's choices of care. An example is where participants' low incomes were insufficient to take care of their hospital bills, they depended on their partner for financial support to meet the cost of ANC. The cost of maternity service is an essential element that cannot be ignored because unaffordability is also part of the identified factors that limit the utilisation of ANC services during pregnancy. In addition, the low levels of formal education of the participants affected the behaviour of women seeking care: more education could have provided them with more opportunities and information about seeking care in pregnancy. Thus, there may have been a difference in their healthcare seeking behaviour if they had been educated and earning a good salary. Geographical location also played a significant role in affecting choices of care: where participants lived limited their access to the services of skilled healthcare personnel. The inequality in the distribution of healthcare centres leaves rural areas underdeveloped, with women left to make decisions based on

what is available within the area. Thus, the health seeking behaviour of a woman is affected by the resources at her disposal.

Previous pregnancy experience of the women seeking care affects their healthcare choices in the present pregnancy. Considering some of the experience of the women that participated in this study, a positive experience reinforces a particular behaviour, while a negative experience has the tendency to change an individual's behaviour. Experience of miscarriage, for example, affected some participants' decisions to seek what they regarded as a comprehensive form of care that would ensure positive childbirth experience and that both mother and child were alive and healthy. This form of care during pregnancy is described as medical pluralism because it involves seeking care from both the local maternity service provider and skilled healthcare personnel working in a healthcare centre.

Lastly, this study also explored the role of the different indigenous maternal healthcare providers in the community. Despite living in the same area, there were variation in participants' healthcare choices due to personal beliefs and practices. The role of some of the selected practitioners went beyond taking care of the present pregnancy; it involved taking care of the other needs of the woman seeking care. Some healthcare providers selected in this study offered services and advice that would help prevent issues that may affect the child or mother later in life. There were also practitioners who helped maintain a balance between the physical world and the other world, described as the unseen world. A maternity service is thus selected by women because of the form of care they provide.

This study found that a range of indigenous practices affected women's health seeking behaviour in relation to maternity care. All these stemmed from a desire to have a healthy pregnancy and childbirth and the participants' belief that a supernatural being would help them to achieve this. The beliefs differed between women and resulted in them seeking care from different providers according to their individual beliefs. Some visited multiple providers including the PHC. Women were also heavily influenced by others around them; female family members provided guidance and knowledge about family traditions and directed them towards practitioners. Some women had to balance this influence alongside their own desire to seek care from the PHC. This study has provided several novel contributions to knowledge through the identification of the various beliefs and practices

associated with health seeking behaviour. Unless and until the power of such beliefs and practices (special soup and hanging of pregnancy) are acknowledged along with bio-medical model of antenatal care in low resource economy with poor rate of attendance at antenatal

8.6 Strengths and Limitations of the Study

The strength of this study is that it is the first to identify the beliefs and practices that may affect the health seeking behaviour of women during pregnancy in Africa, thus providing an in-depth knowledge about what pregnant women consider and which factors affect their healthcare choices over where to seek care in Ota.

The findings of this study also present an overview of the complexity of seeking ANC by using the SEM to illustrate how the varied factors within the external environment of the individual affect healthcare choices, thus providing a new dimension to the understanding of the choices of women during pregnancy. These will be relevant in other settings, especially other towns, villages, or communities throughout Africa – although it is to be accepted that certain beliefs and practices are peculiar to some settings due to lifestyle differences.

The identification of the beliefs and practices associated with healthcare choices provide an in-depth understanding of some of the factor's women consider before seeking care. It also describes some of the factors contributing to low attendance among pregnant women in low-resource economies, thus prompting the delivery of resources that could be used to improve the existing form of maternity care.

Despite the contribution of this study to the body of knowledge on maternity care, there are still some associated limitations. Firstly, the study was carried out in only one community located in a rural area in Nigeria. Hence, the study only captured stories of pregnant women in a rural setting, leaving out the experiences of other pregnant women in urban areas or other rural areas. The inclusion of women from other areas would have provided another overview of the varied factors associated with health seeking behaviour.

Secondly, data were collected from research participants through semi-structured interviews and observations. Focus group discussion was not used because the traditional maternity service providers were not happy to share their business strategies and closely guarded knowledge in the presence of their peers. Thus, no data were collected through focus group discussion. While not a severe limitation, this method of data collection would have provided group opinion about individuals that share similar beliefs, which could

subsequently have provided additional resources to be used as part of the evidence by healthcare stakeholders in Nigeria.

In addition, the client participants in this study were restricted to pregnant women with previous childbirth experience. Including other women with or without previous childbirth experience would have been an advantage, but this study was not able to capture the opinion of other women within the reproductive age group. Furthermore, the findings may be somewhat challenging when the focus is on people who do not share similar beliefs. With Nigeria being a country that is highly populated and consisting of people with different ethnic backgrounds, not all will share common values. Thus, applying the findings to other settings may not be feasible, but future research studies can focus on identifying the beliefs and practices of other ethnic groups in Nigeria.

Using an ethnographic approach in this study provided an in-depth understanding of the beliefs and practices associated with women's healthcare choices. I was able to understand some of the factor's women considered before seeking care. I was also able to understand the role of each maternity service provider in the community and their mode of operation regarding pregnancy. However, there were still some things that remained undisclosed due to their importance to the maternity service providers. I was not privy to how supernatural power prevented complications during pregnancy. An example of this is where the process of hanging pregnancy was described, I was permitted to document the herbs and components used in the process, but the mode of operation remained a secret known only to the maternity service provider. Similarly, I was not able to monitor participants' pregnancies and, therefore, while the herbalist claimed to have imparted the knowledge and resources to prevent complications during pregnancy or on the day of childbirth, I was not in a position to verify any such claims. Taking on a role to monitor pregnancies would have provided more information about the effectiveness of the herbs given to women during pregnancy. I would therefore recommend further studies on the effectiveness of the herbs given to women during pregnancy.

8.7 Recommendations for Future Studies in Relation to Policy

The healthcare stakeholders in FRN are amending the healthcare policy and developing new strategies for the improvement of the health and well-being of the citizens of the country. However, the impact of the contribution of the different healthcare stakeholders is still unnoticed due to the widespread poor maternal healthcare outcomes within the region. Thus, it is important that policy makers and healthcare stakeholders amend policies based on the needs of the individuals seeking care. This may include encouraging the implementation of local measures such that clinics are planned to accommodate the preference of most women in the area; for example, being mindful of the beliefs of women who are encouraged not to go out during certain times of the day to enhance protection against evil spirits.

A recommendation of this study is to advise policymakers to work at the local government level. Policymakers currently monitor all the activities of the various maternity centres within their respective jurisdictions: skilled maternity service providers within each region are regulated by the NMCN and their activities are managed by the Ministry of Health at the local government level. This study would recommend that the Ministry of Health develops strategies to ascertain the total number of non-skilled maternity service providers within each area. This would provide a comprehensive record of all the maternity service providers in the community. Documenting non-skilled maternity service providers is important for the improvement of maternity service because it will be a vital resource for planning within the region.

It is also crucial that the role of the different maternity service providers is clearly stated in the federal government maternal healthcare policy to allow a clear definition of the expected role of each practitioner, particularly all the undocumented service providers in Nigeria. This includes the roles of TBAs, spiritualists, herbalists and other service providers as depicted in Figure 2.4.

8.8 Recommendations for Future Studies in Relation to Practice

Trust is one of the factors that made people refer their friends and family members to a particular provider of maternity service in the area. This may be due to their own experience with the service provider. Thus, it is important that maternity service is developed such that members of the community trust the practice and they can refer others to patronise the same service. In addition, when talking to the women attending the PHC, care should be taken not to abuse or judge clients who may also visit a local maternity service provider. Rather, the practice should involve listening to women and the reasons they give for visiting a clinic of the local maternity service provider despite attending the clinic of the skilled healthcare personnel. In a similar vein, traditional healthcare workers need to be encouraged to work with skilled healthcare personnel within the community, to improve their own practice. Traditional healthcare workers need to be trained in what to do when there is no progress during childbirth and when it is necessary to refer to skilled healthcare personnel: a delay in transferring a woman with obstructed labour or postpartum haemorrhage may lead to death. Thus, it is important that traditional healthcare workers are provided with basic information about signs and symptoms associated with complications during pregnancy or the presenting signs of complications during or after childbirth. All maternal healthcare providers should also ask pregnant women about the various practices that are important to them. When a pregnant woman comes to the clinic for booking, ANC staff should ask her about the practices considered important to her during pregnancy, on the day of childbirth, and after pregnancy. All the recommendations can be applied to practice through various processes. This may involve working with non-governmental organisation that are already carrying out various activities with the service provider and the members of the community. It will also involve liaising with the appropriate regulatory body at the local level and the staff of the ministry of health at the local government. This will start with a discussion with the head of the department of the ministry of health at the Ado-Odo/Ota local government, with a focus on improving maternity service through the training of both skilled, and unskilled maternity service within the community. The skilled maternity service provider will be trained on the significance of discussing the cultural needs of

women seeking care within their practice. While the non-skilled maternity service provider will be trained on when to initiate transfer or referral to the hospital. They will also be trained on other related skills based on the identified needs of members of the community as documented in the findings chapter.

8.9 Recommendations in Relation to Future Research

Due to the overall impact of women's healthcare behaviour about maternity care, it is important that future studies focus on other stakeholders such as Pentecostal and non-Pentecostal churches that provide maternity care services. This is important due to the present healthcare situation in the country: Nigeria has yet to achieve part of the target SDG and it is still one of top ten countries with the highest rate of maternal death globally. Likewise, it would also be relevant that future research studies focus on the impact of supernatural powers on the rate of utilization of maternal healthcare services.

With maternal mortality and morbidity being very high within the region, more research studies need to be carried out among women resident in both rural and urban areas. This is of high significance because of the disparity in the distribution of healthcare resources. Nigeria being a country with various religions, it is also important that future studies focus on exploring the impact of supernatural powers on the maternal healthcare choices of Christians, Muslims, and traditional worshippers within the region. The impact of spiritualism on women healthcare choices during pregnancy also needs to be explored.

The findings of this study shows that people who are mostly women have a significant influence on the maternal healthcare choices of pregnant women during pregnancy. Thus, it is paramount that future studies focus on exploring the categories of people with the highest influence on women's choices during pregnancy. The research can also explore how the economic state of the country affects women choices during pregnancy. Likewise, future studies could also focus on the impact of religious leaders or community heads on women healthcare choices during pregnancy.

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8.10 Summary

In Nigeria, healthcare policies are changed from time to time but with insignificant impact on the overall maternal health index of the country. Thus, due to the disparity in the healthcare institutions in urban and rural locations, it is important that policies are amended to accommodate the factors affecting maternity care. Since it has been documented that woman in remote areas are the group of people with the least chances of utilising the service of skilled healthcare personnel (WHO, 2021), part of the suggested approach to improving maternity care is the integration of the findings of studies conducted in the field into the maternal healthcare policies of Nigeria (WHO, 2021). The findings of this study have shown that a clinic which is based on indigenous practices is the clinic of choice for some pregnant women. This resonates with previous findings from other studies which classify sociocultural factors as part of the factors that affect women's choices regarding where to seek care (Akeju et al., 2016; Ganle et el., 2015). Consequently, it is important to contextualise healthcare if the aim is to bring about improvement in maternity care and to provide more opportunities for future development.

The stories of the participants in this study show that healthcare seeking behaviour is complex in nature. Hence, it may be challenging to implement change, but research has shown that it can be improved upon by establishing a model that can integrate the indigenous system of health with the Western system of healthcare. This is crucial because the existing healthcare policy in Nigeria focuses more on the Western system of healthcare with little information about the indigenous system of care. Healthcare policy in Nigeria may have a clear structure regarding the role of the Ministry of Health about the diverse types of healthcare institutions in the country, but it fails to consider the mode of operation of indigenous healthcare practitioners who are clearly valued and used by the participants.

The traditional system of healthcare is still in use in Africa because it is believed that before the advent of the Western system of healthcare, our ancestors relied on the traditional system of healthcare for the care of a woman during pregnancy (Abdullahi, 2011; Isola, 2013; James et al., 2018), signifying that it is an acceptable system of care especially among women in rural communities (Shewameme et al., 2017). Given the importance of the

traditional system of care, the institution cannot be ignored if there is a problem with the maternity care because according to the Alma Ata declaration (1978) the best approach to attaining an improvement in the health outcome of people living in any community is to ensure the existing system of care is socially acceptable. However, this is not the situation in Nigeria; this study clearly shows that women hide information about the alternative care they receive from the skilled healthcare personnel working in healthcare centres. Therefore, there is a need to ensure that the service available in the community is socially and culturally acceptable to the members of the community. It is also important that the available form of healthcare service is safe to use by women during pregnancy or on the day of childbirth. Using a service should not be the cause of complication during pregnancy or on the day of childbirth.

In Nigeria, it is a common believe that the Western system of care available in a hospital cannot be used to proffer solutions to all healthcare issues during pregnancy. This is because skilled healthcare personnel working in healthcare centres will only focus on the medical aspect of the issue (leaving out the traditional part), while the indigenous healthcare system tries to maintain a balance between the visible and the non-visible, unforeseen, world (Shewamene et al., 2017). The next chapter will focus on the implication of the findings for skilled healthcare workers, healthcare institutions and policy makers.

Chapter 9: Conclusion of the Study

9.1 Introduction

This chapter presents the conclusions of my study which aimed to explore the beliefs and practices that may influence the health seeking behaviour of women in Ota, Nigeria. This study was undertaken by using an ethnographic approach to identify the specific beliefs influencing pregnancy in Ota; to explore what is considered as care in pregnancy; to identify who influences the choice of where to seek care during pregnancy; to gain an understanding of the indigenous practices influencing pregnancy; and to explore the role of TBAs, spiritualists and herbalists in the community.

There were 28 participants in this research: 20 pregnant women and 8 maternity service providers were selected purposively to take part in the study. Data were collected through semi-structured interviews and observations. The findings of the study allowed me to understand the different indigenous practices that women engage in during pregnancy, why they engage in these practices, who provides the practices, and how these integrate with the conventional form of ANC. The findings further enabled me to understand what is considered as care during pregnancy among women in the selected community. Thus, the use of supernatural power for the prevention of harm to the unborn child and mother is part of the unique contribution to the body of knowledge.

9.2. Implications of the Study for Skilled Healthcare Personnel

The findings of the study show that local practices should be considered alongside a biomedical model of ANC. However, it is also important that non-skilled healthcare personnel are knowledgeable about the negative consequence associated with excessive consumption of herbal mixture without a documented prescription that is based on research evidence.

9.3 Implications of the Study on Healthcare Institutions

It can be deduced from the result of the study that strategies to improve maternal health outcomes should not only focus on the establishment of more healthcare institutions, but that there should be the creation of institutions which are locally acceptable to the members of the community. Furthermore, healthcare institutions should focus beyond the medical needs of the individual seeking care. The institution should make provision for all other factors which may influence the choice of where to seek care. Such factors as highlighted in this study are the beliefs and practices associated with the Ota community and the people within the environment which have the tendency to impact on the choices of women during pregnancy.

9.4 Implications of the Study on Healthcare Policy Makers

Considering the rate of utilisation of indigenous healthcare, regardless of the availability of a healthcare centre, it is important than the healthcare stakeholders make provision for local beliefs and practices. This is because the formal healthcare setting is believed to take care of only some of the needs of women, leaving aside other needs. In trying to meet their needs, some women visit other clinics for care. Thus, it is paramount that policy makers are aware of the needs of the individual seeking care. This is because the participants seeking care in this study are an integral part of the healthcare system; therefore, policy makers should endeavour to include them as part of the policy team.

9.5 Conclusion

Maternal healthcare seeking behaviour is an important part of maternity care and is affected by numerous factors within the environment. The literature identified various themes which may affect the utilisation of the services of skilled healthcare personnel by women during pregnancy. It also enumerated the overall impact of the level of utilisation of ANC on maternal health outcomes. The rate of maternal mortality following childbirth in low-resource economies was also explained. A qualitative approach was employed to explore the participants' experiences regarding what to consider when making decisions about where to seek care during pregnancy. This provided a comprehensive description of the beliefs and practices women consider before choosing where to seek care.

This study also provided a contextual description of the meaning of care in pregnancy – a description which is different from the global definition of antenatal care in pregnancy. The experience of the participants also shows that partners are not the only people influencing women's choices regarding where to seek care: several factors which are inter related from the environment of the individual all play a crucial role. Although socio-economic factors such as low levels of financial capability may hinder women from seeking care from skilled healthcare personnel, indigenous beliefs and practices remain part of the unrecognized factors that women consider before deciding where to seek care. Thus, it is important that policies are amended based on the identified needs of pregnant women who are, after all, at the centre of maternity care.

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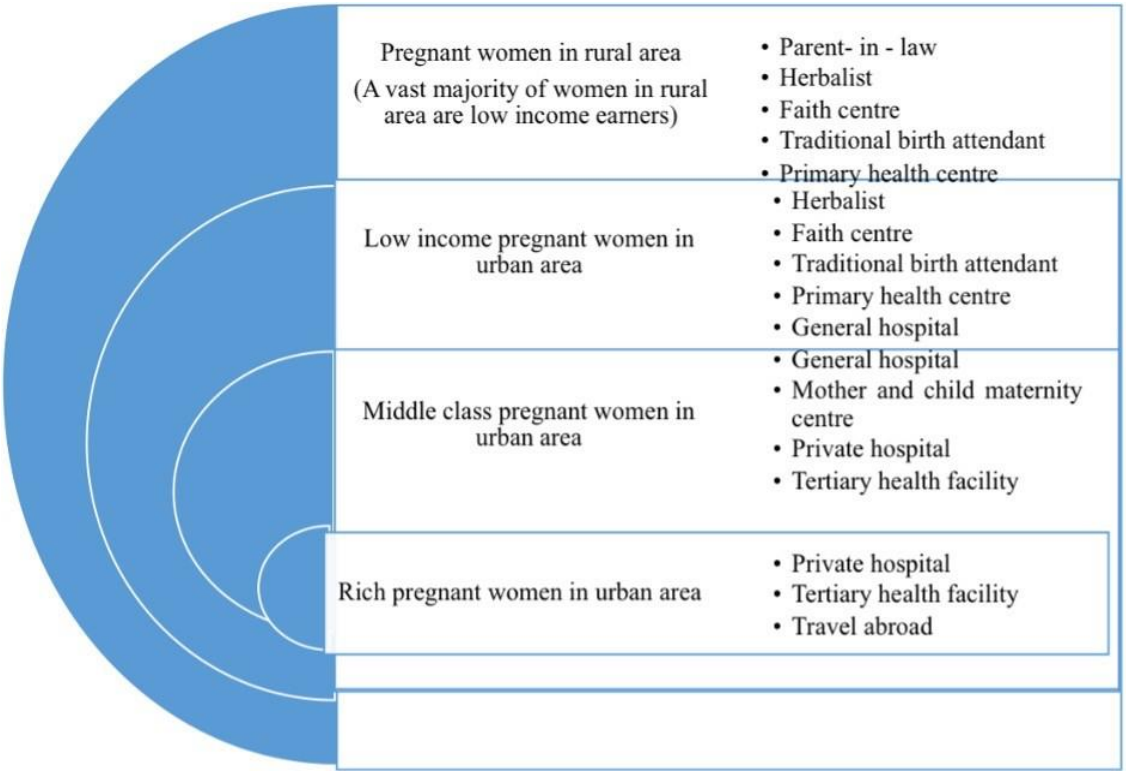
Appendices

Appendix 1: Relationship between the level of income, the geographical location of a woman and the available healthcare services



Appendix 2: Work plan

Activity	Dates
Obtaining Ethical clearance from the University of Salford and the State Ministry of Health Ogun State, Nigeria	01/10/2017- 31/03/2018
Data Collection	01/07/2018- 30/10/2018
Data Analysis	01/11/2018-30/03/2019
Completion of Literature review	01/04/2019-31/10/2019
Completion of Research Methodology	01/10/2019-31/12/2020
Presentation of Findings	01/01/2021-31/05/2021
Submission of draft copy of the PhD Thesis	01/06/2021-31/08/2021
Completion and submission of final PhD thesis	01/09/2021-31/09/2021

Appendix 3: Record of trainings

Date	Title
02/05/2017	Induction
20/09/2017	Ethics Approval Training
23/10/2017	0pen access week
01/11/2017	Methods fair
02/11/2017	Full care meetings
03/11/2017	Structuring your thesis
06/11/2017	Welcome to PGR in the School of health and society
07/11/2017	Doing a literature review
08/11/2017	What is a PhD?
14/11/2017	Systematic searching workshop
18/01/2018	Care Seminar: Academic writing in the contemporary University Workplace
05/04/2018	Writing for publication session 1
19/04/2018	Writing for publication session 2
26/04/2018	Preparation for interim assessment
25/10/2018	Strategies for Managing your literature and reading effectively
25/10/2018	You have your data- what to do with it
26/10/2018	Experimental and Research Design planning and Methodologies
22/11/2018	Introduction to NVivo
28/11/2018	Qualitative research and NVivo
15/01/2019	Introduction to NVivo

04/05/2020	Turbocharge your writing
18/05/2020	Wikipedia-a-thon
21/05/2020	Thesis and Beyond Researcher Development Day- Whilst doing your PhD
28/05/2020	Data Collection using NVivo & SPSS
15/07/2020	Reflexivity in Qualitative Research
21/07/2020	Writing & Thriving, Writing as Narrative: Structuring your chapter or thesis
12/08/2020	Developing your Researcher Identity - ORCID
24/08/2020	Reflexing our Muscles- analysing examples of reflexivity
05/05/2021	PGR Inter-disciplinary Research Seminar Series
12/05/2021	Ethnography
19/05/2021	USIR Training (Library)
21/05/2021	Researcher Development Conference: Preparing for your IA, IE & Viva
24/05/2021	Academics Talking: Bridging the gap between commercial and academic research
26/05/2021	Three Minute Thesis Information Session
07/05/2021	Research Storytelling Workshop
08/05/2021	Getting to the end of your PGR Journey

Appendix 4: Research supervision record

Number	Date
1	25/05/2017
2	19/06/2017
3	19/07/2017
4	08/08/2017
5	20/09/2017
6	17/10/2017
7	29/11/2017
8	13/12/2017
9	18/01/2018
10	07/02/2018
11	14/03/2018
12	09/04/2018
13	17/05/2018
14	14/06/2018
15	30/07/2018
16	09/08/2018
17	10/09/2018
18	23/10/2018
19	14/11/2018
20	13/12/2018

21	21/01/2019
22	28/01/2019
23	25/02/2019
24	11/03/2019
25	03/04/2019
26	07/05/2019
27	12/02/2020
28	03/04/2020
29	24/04/2020
30	06/05/2020
31	17/06/2020
32	20/07/2020
33	14/08/2020
34	14/09/2020
35	16/09/2020
36	12/10/2020
37	06/11/2020
38	07/12/2020
39	15/01/2021
40	19/02/2021
41	22/02/2021
42	22/03/2021
43	07/06/2021

44	26/07/2021
45	12/08/2021
46	02/09/2021

I have also been communicating with my supervisor and my co–supervisors in between the meeting dates.

Appendix 5: Interview guide for pregnant women

Title of the Study: Cultural Beliefs and Practices influencing the Health Seeking Behaviour of Women during Pregnancy in Ota, Southwest Nigeria

Name of Researcher: (.....)

1.1 Introduction:

The researcher will welcome the participants and introduce herself. The purpose of our meeting today is to discuss the various cultural practices we engage in during pregnancy. I am here to carry out this study as part of the requirement for the award of Doctor of Philosophy in Nursing from the School of health and Society, University of Salford. We will need your contribution for the improvement of antenatal care services in the area. We will also be having similar discussion with other pregnant women and maternity service provider in the area.

Rules guiding the interview:

The rules guiding the interview will be explained and there will be time to ask questions and make clarifications about any part of the study.

(A) Permission to use a digital audio recorder:

This object am holding is called a recorder. We will be using it to record the interview, because we do not want to miss any information discussed during the interview, but that will be with your approval. So many important things will be discussed, and we will not be able to write down everything as we are talking. Names will not be included in our report; all information will be strictly confidential.

(B) Confidentiality

All information obtained during the study will be strictly confidential; no name will be included in the report. After the study, no individual will be able to link any information to any individual, everything will be anonymised.

(C) Illegal act

While conducting the interview, if we discover or retrieve any information that may be harmful to you or others within the community, we will have to report to the appropriate regulatory body.

(D) Role of the researcher

The role of the researcher is to moderate the interview but you as the research participant will be doing the talking.

(E) Answer to our question

In this interview, everything is right, because the information from this discussion is crucial to our research study.

1.2 Demographic Information

Age…

Level of Education: ……

Number of Children…

1.3 Pregnancy

a) Previous history of pregnancy?
b) What do you consider as care in pregnancy?
c) Can you give examples of what you consider as care during pregnancy?
d) Tell me about what is expected of women during pregnancy?
e) What form of care instruction do pregnant women follow?
f) Is there any known reason why women must follow the instruction?
g) Does any of the instruction affect them from going to the hospital?

1.4 Beliefs, Practices and Pregnancy

Intrapersonal level factors

a) Can you tell me about the various beliefs surrounding pregnancy?
b) Can you tell me about the various cultural practices' women are expected to do during pregnancy?

c) Tell me about what pregnant women are supposed to do, what they are supposed to eat and where they are to receive care during pregnancy?
d) Are you aware of any beliefs or practices associated with pregnancy?
e) Can you give examples of any cultural practices associated with pregnancy?
f) To understand what they consider as care in pregnancy

Interpersonal level factors

(a) Who recommend the various practices women engage in during pregnancy to them?
(b) Have you got anyone around that can guide you on where to seek care during pregnancy?
(c) Who recommended this clinic to you?
(d) Have you got any friend or family member that has used this clinic in the past?

Organisational level factors

a) Where did you deliver the last child, you had?
b) How did you get to know about where to receive care during your last and present pregnancy?
c) Where did you receive antenatal healthcare services during your last pregnancy? Is there any reason why you want to change, or did you use the same clinic during your last pregnancy?
d) When do you think is right to visit the clinic for antenatal care?
e) Can you tell me about the previous antenatal healthcare service you have received?
f) Where is your preferred choice of antenatal healthcare?
g) Is there any reason why you must seek care from the centre?
h) Can you tell me about the available antenatal healthcare services within this area?

Community level factors

a) Tell me about the cultural practice's women engage in during pregnancy?
b) What are the various norms women are expected to practice when pregnant in this area?
c) What are the norms and practices common in this area?
d) Where do women seek care during pregnancy in this area?

e) Any reason why they choose a particular clinic

Policy

a) Is the government providing any free service for pregnant women within this community?
b) Is there anybody in this community advising people to go the hospital to seek care during pregnancy

Appendix 6: Interview guide for the maternity service provider

Title of the Study: Cultural Beliefs and Practices influencing the Health Seeking Behaviour of Women during Pregnancy in Ota, Southwest Nigeria

Name of Researcher: (.....)

1.1 Introduction:

The researcher will welcome the participants and introduce herself. The purpose of our meeting today is to discuss the various cultural practices we engage in during pregnancy. I am here to carry out this study as part of the requirement for the award of Doctor of Philosophy in Nursing from the School of health and Society, University of Salford. We will need your contribution for the improvement of antenatal care services in the area. We will also be having similar discussion with pregnant women and other maternity service provider in the area.

RULES GUIDING THE INTERVIEW:

The rules guiding the interview will be explained and there will be time to ask questions and make clarifications about any part of the study.

(A) Permission to use a digital audio recorder:

This object am holding is called a recorder. We will be using it to record the interview, because we do not want to miss any information discussed during the interview, but that will be with your approval. So many important things will be discussed, and we will not be able to write down everything as we are talking. Names will not be included in our report; all information will be strictly confidential.

(B) Confidentiality

All information obtained during the study will be strictly confidential; no name will be included in the report. After the study, no individual will be able to link any information to any individual, everything will be anonymised.

(C) Illegal act

While conducting the interview, if we discover or retrieve any information that may be harmful to you or others within the community, we will have to report to the appropriate regulatory body.

(D) Role of the researcher

The role of the researcher is to moderate the interview but you as the research participant will be doing the talking.

(E) Answer to our question

In this interview, everything is right, because the information from this discussion is crucial to our research study.

1.2 Demographic Information

Age…

Level of Education: ……

Number of Children…

1.3 Pregnancy

(a) What do you consider as care in pregnancy

(b) Can you give examples of what you consider as care during pregnancy

(c) Tell me about what is expected of women during pregnancy

1.3 Norms and Pregnancy

(1.3 Pregnancy

h) History taking from women attending the clinic during pregnancy?
i) What do you consider as the appropriate care in pregnancy?
j) Can you give examples of what you consider as care during pregnancy?
k) Tell me about what is expected of women during pregnancy?
l) What form of care instruction do pregnant women follow?
m) Is there any known reason why women must follow the instruction?
n) Does any of the instruction affect them from going to the hospital?

1.4 Beliefs, Practices and Pregnancy

Intrapersonal level factors

a) Can you tell me about the various beliefs surrounding pregnancy?
b) Can you tell me about what is expected of women during pregnancy?
c) Tell me about what pregnant women are supposed to do, what they are supposed to eat and where they are to receive care during pregnancy?
d) Are you aware of any beliefs or practices associated with pregnancy?
e) Can you give examples of any cultural practices associated with pregnancy?
f) What do you think women should consider as care in pregnancy?

Interpersonal level factors

a) Who recommend the various practices women engage in during pregnancy to them?
b) Who advise women to attend a particular clinic?
c) Have you got anyone around that can guide you on where to seek care during pregnancy?
d) Who recommended this clinic to you?
e) Have you got any friend or family member that has used this clinic in the past?

Organisational level factors

a) What advice do you offer women that comes to receive care in your clinic?
b) Do you enquire about what other things women do to protect themselves during pregnancy?
c) When do you think is right to visit the clinic for antenatal care?
d) What is your preferred choice of important practices during pregnancy?
e) Is there any reason why you must seek care from this centre?
f) Can you tell me about the available antenatal healthcare services within this area?

Community level factors

a) Tell me about the cultural practice's women engage in during pregnancy?
b) What are the various things women are expected to practice when pregnant in this area?
c) What are the norms and practices common in this area?

d) Where do women seek care during pregnancy in this area?
e) Any reason why they choose a particular clinic?

Policy

a) Is the government providing any free service for pregnant women within this community?
b) Is there anybody in this community advising people to go the hospital to seek care during pregnancy

Appendix 7: Participants information sheet for maternity service provider

Study Title: Cultural Beliefs and Practices influencing the Health Seeking Behaviour of Women during Pregnancy in Ota, Southwest Nigeria

Invitation

I am inviting you to take part in this study because you are providing maternal healthcare services. The information we obtain from you and others that are participating in the study, will provide more information about the beliefs and practices influencing pregnancy.

Aim of the Study

To explore the cultural beliefs and practices of women in Ota, south-west Nigeria, that may influence their health seeking behaviour during pregnancy, particularly in relation to ANC.

Do I have to take part?

It is up to you to decide if you will be taking part in this study or not. If you decide to take part in this research study, you will have to give consent, and this will be recorded, but you are free to withdraw from this study at any time.

What will happen to me if I take part in the research?

If you decide to take part in this research study, I will get InTouch with you to provide more information about the study. I will need to fix a date and time for the session. During the session, information about the various cultural practices surrounding pregnancy will be asked. I will also ask you about the general health seeking behaviour of women during pregnancy in the community. I will also inform you that all the sessions will be audio-recorded.

Expenses and Payments?

Financial incentives will not be provided to the study participants, but a call card voucher of 1000 Naira (2 pound) will be given as compensation for their time.

What are the possible disadvantages and risks of taking part?

No risk is associated with this study, but you will be asked about the service you provide to pregnant women. You do not have to answer the entire question, if you are uncomfortable with any question, the interview will be stopped if you want to.

What are the possible benefits of taking part? I may not be able to provide any form of help to you directly but the information I obtain from you will be used to improve maternal healthcare both nationally and locally within the local government area.

What if there is a problem?

If you have any form of concern with this research, whether during or after the research has been concluded, you can speak to me through the contact details below.

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Will my taking part in the study be kept confidential?

Your taking part in the study and the information you provide will be strictly confidential. If any information leaves the university, your name and address will be removed. Information will be collected through interview and focus group discussion. Individual data obtained through interviews will be anonymous and given a code, only the researcher knows that. A master list-identifying participant to the research codes will be held on a password-protected computer, accessed only by the researcher. Hard paper will be stored in a locked cabinet accessed only by the researcher. Electronic data will be stored on a password-protected computer known only by the researcher. The participants also need to be aware that if they reveal any information related to criminal activity or something that is harmful to self or to others; the researcher will have to share that information with the appropriate authorities. All information obtained during the study will be kept for a minimum of 3 years after which it will be destroyed.

What will happen if I do not carry on with the study?

You are free to withdraw from the study at any time, all information obtained will be deleted and erased. You can contact the researcher one month after the data has been collected.

What will happen to the results of the research study?

The outcome of the study will serve as a guide to the policy makers. It will also form the basis for future research in this area. Parts of the study will also be published in journal articles.

Who is organising or sponsoring the research?

This has been sponsored by the University of Salford, after a review from the ethical committee of the University.

Further information and contact details

Principal Investigator:xxxxxxxxxxxxxxx

Telephone number: xxxxxxxxxxxxxxxxx

Address: xxxxxxxxxxxxxxxxxxxxxxxxxxx

Email Address:xxxxxxxxx

Appendix 8: Participants information sheet for pregnant women

Study Title: Cultural Beliefs and Practices influencing the Health Seeking Behaviour of Women during Pregnancy in Ota, Southwest Nigeria

Invitation

I am inviting you to take part in this study because you are pregnant. The information we obtain from you and others that are participating in the study, will provide more information about the beliefs and practices influencing pregnancy.

Aim of the Study

To explore the cultural beliefs and practices that may influence the health seeking behaviour of women in Ota, Southwest Nigeria, during pregnancy, especially in relation to ANC.

Do I have to take part?

It is up to you to decide if you will be taking part in this study or not. If you decide to take part in this research study, you will have to give consent, and this will be recorded, but you are free to withdraw from this study at any time.

What will happen to me if I take part in the research?

If you decide to take part in this research study, I will get InTouch with you to provide more information about the study. I will need to fix a date and time for the session. During the session, information about the various traditional practice surrounding pregnancy will be asked. I will also ask you about the general health seeking behaviour of women during pregnancy in the community. I will also inform you that all the sessions will be audio-recorded.

Expenses and Payments?

Financial incentives will not be provided to the study participants, but a call card voucher of 1000 Naira (2 pound) will be given as compensation for their time.

What are the possible disadvantages and risks of taking part?

No risk is associated with this study, but you will be asked about your pregnancy experience. You do not have to answer the entire question, if you are uncomfortable with any question, the interview will be stopped if you want to.

What are the possible benefits of taking part?

I may not be able to provide any form of help to you directly but the information I obtain from you will be used to improve maternal healthcare both nationally and locally within the local government area.

What if there is a problem?

If you have any form of concern with this research, whether during or after the research has been concluded, you can speak to me through the contact details below.
xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

However, if any issue arises while conducting the research, the study participants will be referred to the community midwife for appropriate support. If further assistance is needed after the study, the study participant will be referred to the general hospital within the local government area.

Will my taking part in the study be kept confidential?

Your taking part in the study and the information you provide will be strictly confidential. If any information leaves the university, your name and address will be removed. Information will be collected through interview and focus group discussion. Individual data obtained through interviews will be anonymous and given a code, only the researcher knows that. A master list-identifying participant to the research codes will be held on a password-protected computer, accessed only by the researcher. Hard paper will be stored in a locked cabinet accessed only by the researcher. Electronic data will be stored on a password-protected computer known only by the researcher. The participants also need to be aware that if they reveal any information related to criminal activity or something that is harmful to self or to others; the researcher will have to share that information with the appropriate authorities. All information obtained during the study will be kept for a minimum of 3 years after which it will be destroyed.

What will happen if I do not carry on with the study?

You are free to withdraw from the study at any time, all information obtained will be deleted and erased. You can contact the researcher one month after the data has been collected.

What will happen to the results of the research study?

The outcome of the study will serve as a guide to the policy makers. It will also form the basis for future research in this area. Parts of the study will also be published in journal articles.

Who is organising or sponsoring the research?

This has been sponsored by the University of Salford, after a review from the ethical committee of the University.

Further information and contact details

Principal Investigator:xxxxxxxxxxxxxxx

Telephone number: xxxxxxxxxxxxxxxxx

Address: xxxxxxxxxxxxxxxxxxxxxxxxxxx

Email address:xxxxxxxxxxxxxxxxxxxxxxx

Appendix 9: Request for permission to carry out research in Ado-Odo/Ota

The Executive Chairman

Ado-Odo/Ota Local Government Area

Ota

Ogun State

Nigeria.

16th July 2018

Dear Sir/Madam,

REQUEST FOR PERMISSION TO CONDUCT RESEARCH STUDY IN ADO-ODO/OTA

I am a PhD student from the school of Health and Society, University of Salford, UK. As part of the requirement to complete my study titled "Impact of cultural beliefs and practices on the antenatal health seeking behaviour of women in Ota". I will need to seek the views of maternal health care providers and women above the age of 18 years who had child/children in the last five years, to take part in the study.

I will abide by the rules and regulations of the health centre and will also ensure that the research does not disrupt the work of the maternal healthcare providers and women within the antenatal department.

Data collected during the research will be kept strictly confidential for 3 years after the graduate award is made.

Please any further enquiry or information request may be sent to me

Adedoyin Adeosun: a.adeosun@edu.salford.ac.uk(Doctoral candidate)

Yours faithfully

Adedoyin Adeosun

xxxxxxxxxxxx

a.adeosun@edu.salford.ac.uk

PhD Student

School of Health and Society

University of Salford

Manchester

United Kingdom

Appendix 10: Approval letter from University of Salford

Research, Enterprise and Engagement
Ethical Approval Panel

Doctoral & Research Support
Research and Knowledge Exchange,
Room 827, Maxwell Building,
University of Salford,
Manchester
M5 4WT

T +44(0)161 295 2280

www.salford.ac.uk

25 September 2018

Dear Adedoyin,

RE: ETHICS APPLICATION–HSR1718-092 – 'Impact of cultural beliefs and practices on the antenatal health seeking behaviour of women in Ota.'

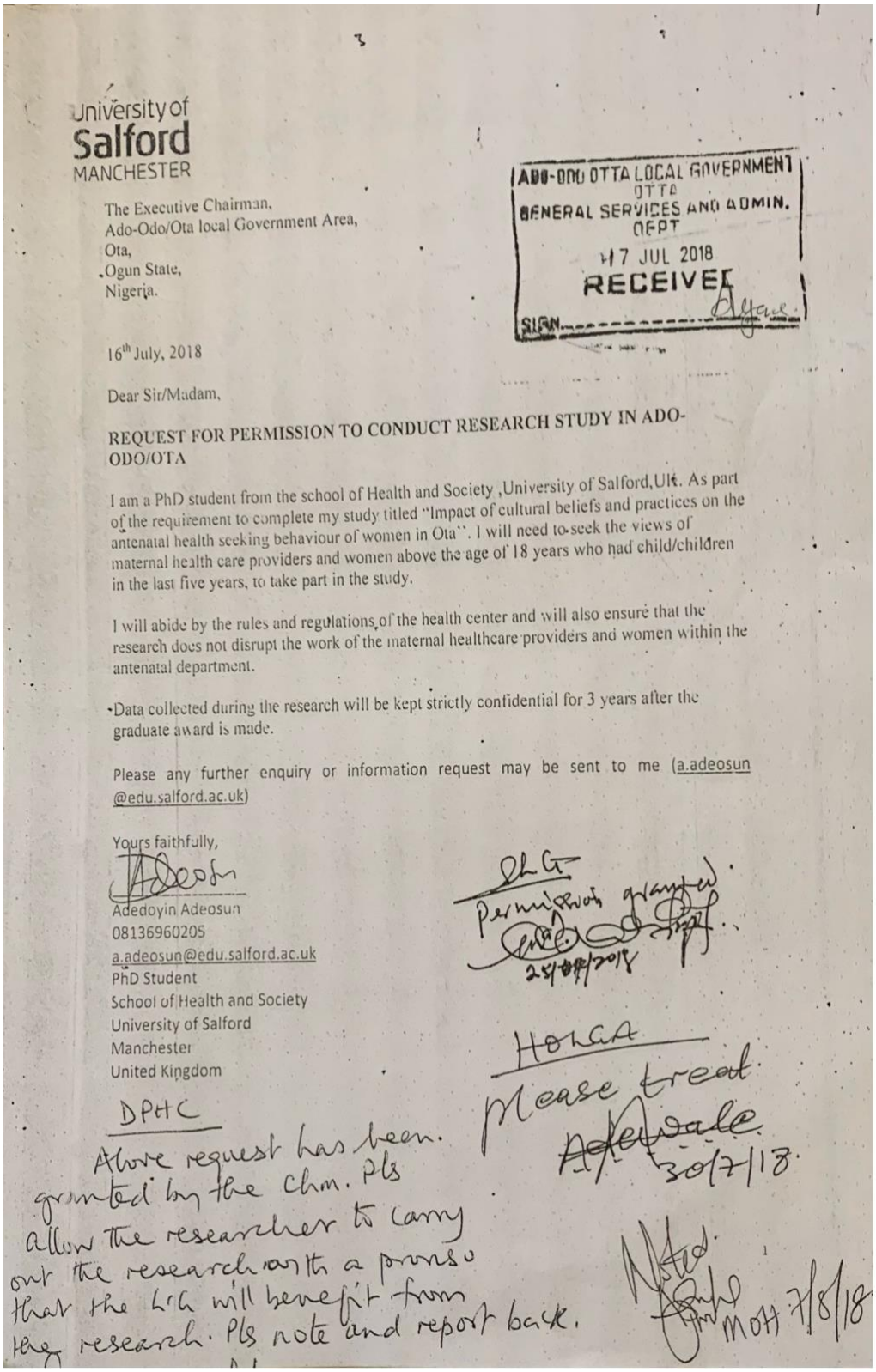
Based on the information that you have provided, I am pleased to inform you that ethics application HSR1718-092 has been approved.

If there are any changes to the project and/or its methodology, then please inform the Panel as soon as possible by contacting Health-ResearchEthics@salford.ac.uk

Yours sincerely,

Professor Sue McAndrew
Chair of the Research Ethics Panel

Appendix 11: Approval letter from the Ministry of Health (Ado-Odo/Ota)



University of Salford MANCHESTER

The Executive Chairman,
Ado-Odo/Ota local Government Area,
Ota,
Ogun State,
Nigeria.

ADO-ODO OTTA LOCAL GOVERNMENT
OTTA
GENERAL SERVICES AND ADMIN. DEPT
17 JUL 2018
RECEIVED
SIGN

16th July, 2018

Dear Sir/Madam,

REQUEST FOR PERMISSION TO CONDUCT RESEARCH STUDY IN ADO-ODO/OTA

I am a PhD student from the school of Health and Society ,University of Salford,UK. As part of the requirement to complete my study titled "Impact of cultural beliefs and practices on the antenatal health seeking behaviour of women in Ota". I will need to seek the views of maternal health care providers and women above the age of 18 years who had child/children in the last five years, to take part in the study.

I will abide by the rules and regulations of the health center and will also ensure that the research does not disrupt the work of the maternal healthcare providers and women within the antenatal department.

Data collected during the research will be kept strictly confidential for 3 years after the graduate award is made.

Please any further enquiry or information request may be sent to me (a.adeosun @edu.salford.ac.uk)

Yours faithfully,

Adedoyin Adeosun
08136960205
a.adeosun@edu.salford.ac.uk
PhD Student
School of Health and Society
University of Salford
Manchester
United Kingdom

Permission granted
25/07/2018

HOSA
Please treat
30/7/18

DPHC
Above request has been granted by the Chm. Pls allow the researcher to carry out the research with a promise that the LGA will benefit from the research. Pls note and report back.

Noted
MOH 7/8/18

Appendix 12: Field note at PHC

Located close to the road

Pregnant women alight from bus or motorcycle

Vendors selling food and other baby materials at the entrance of the clinic

Antenatal clinic is after the postnatal clinic

Antenatal clinic is a big room

Wooden bench for clinic activities

Doctor's room

Matron's office

Delivery room

Prayer before commencing clinic activities

Antenatal songs

Appendix 13: Field note at spiritualist clinic

Gated compound with fence

Prayer session

Bench in the waiting room

Songs

Water in big kegs

Water in small bottles

Bottles of olive oil

Waiting room

Appendix 14: Field note at the herbalist clinic

Local pot

Big compound

Office for consultation

Lots of dry herbs

Lots of herbs in powder form

Room for mixing of herbs

Room for the preparation of herbal mixture

Appendix 15: Field note at the TBA clinic

Shop at the entrance

Women alighting from motorcycle

Tree in the compound

Local pot

Herbs

Appendix 16: Overview of observation

VENUE	TIME OF THE DAY	COMMENTS
Primary Healthcare Centre(PHC)	Morning and Afternoon	Arrival of Patients Prayer session Clinic session Health Education Check the weight of patients Vital Signs Urinalysis History taking Palpation Most pregnant comes to theclinic early Calm in the afternoon

		Few patients stay back in the clinic in the afternoon Reduced number of patientsin the clinic in the afternoon Group antenatal clinic session
TBA Clinic	Morning and Afternoon	Open for Consultation all day Pregnant women comeearly to the clinic Pregnant women comealone to the clinic Pregnant women do not come to the clinic in the afternoon

		Most women that come tothe clinic in the afternoon are those that are trying to

		conceive They go home with herbal medicine They do not come to the clinic when it rains Pregnant women come to the clinic after the rain They go home with herbal mixture after consultation No group antenatal clinic session Pregnant are seen alone in the office
Herbalist clinic	Morning and Afternoon	Open for consultation all day Pregnant women come to the clinic on bike

		Lots of local pot within the premises Lots of herbs within the consultation room Lots of dried herbs in the office of the herbalist Some herbs are prepared daily based on the number of women that comes to the clinic Pregnant women take herbal mixture home Pregnant women consume some form of concoction in the presence of the herbalist No group antenatal clinic session Pregnant women are seen

		alone in the consultationroom Some women come to theclinic with their children Some women attach safetypin to their cloths
Spiritualist clinic	Morning and Afternoon	Women sleepover in the clinic Prayer session is performedas the need arises Anointing oil Holy water Bible Women stay back in the clinic as needed There is no fixed

		time for appointment

		Women join hands with others to pray A gated compound with lots of wooden bench for sitting down

Appendix 17: Observation guide

The location of the clinic: This entails the distance to the main road and means of transport to the clinic

Structural features of the clinic:

The clinic building

The different sections within the clinic

Daily activities within the clinic:

When does the clinic start?

Any specific time for clinic activities

Clinic days

Any requirement for coming to the clinic

Events within the clinic:

What does a day in the clinic look like?

Any difference in activities for each day

Special activities with the clinic: Are there any special events scheduled for a particular day?

Personal thought about each event or activity within the clinic

(Source: Mulhall, 2003)

Appendix 18: Data analysis

Codes are generated from participants experiences (Each participant's experience are reduced into small sizes)

Similar codes are grouped together

Lots of changes were made

One code fit in to several groups

Groups were named

Themes were generated

Codes were distributed into themes

Main Theme

SNAIL IN MY SOUP

Catfish

Fish

Snail

Black fish

Special soup

Supreme God

Supernatural power of the mighty one

MY PEOPLE

Friends

Father

Family member

Elders

Elderly people

Guardian

In-laws

Mother-in-laws

Neighbour

Ancestors

FEAR OF THE UNKNOWN

Walking around

Special bath

Afternoon

Sun

Evil spirits

Safety pin

Family taboo

Taboo

God Almighty

Supreme Being

Ancestors

Fore-fathers

MY PREVIOUS PREGNANCY EXPERIENCE

Complications

Loss of baby

Miscarriage

Tree

God

Power of the Almighty

HERBAL MIXTURE

Concoction

Native Medicine

Bush meat

Herbs

Mighty one power

Ancestors

Fore-fathers

DIVINE FAVOUR

Jesus

Fasting

Religion

Psalm

Vigil

Anointing oil

Almighty God

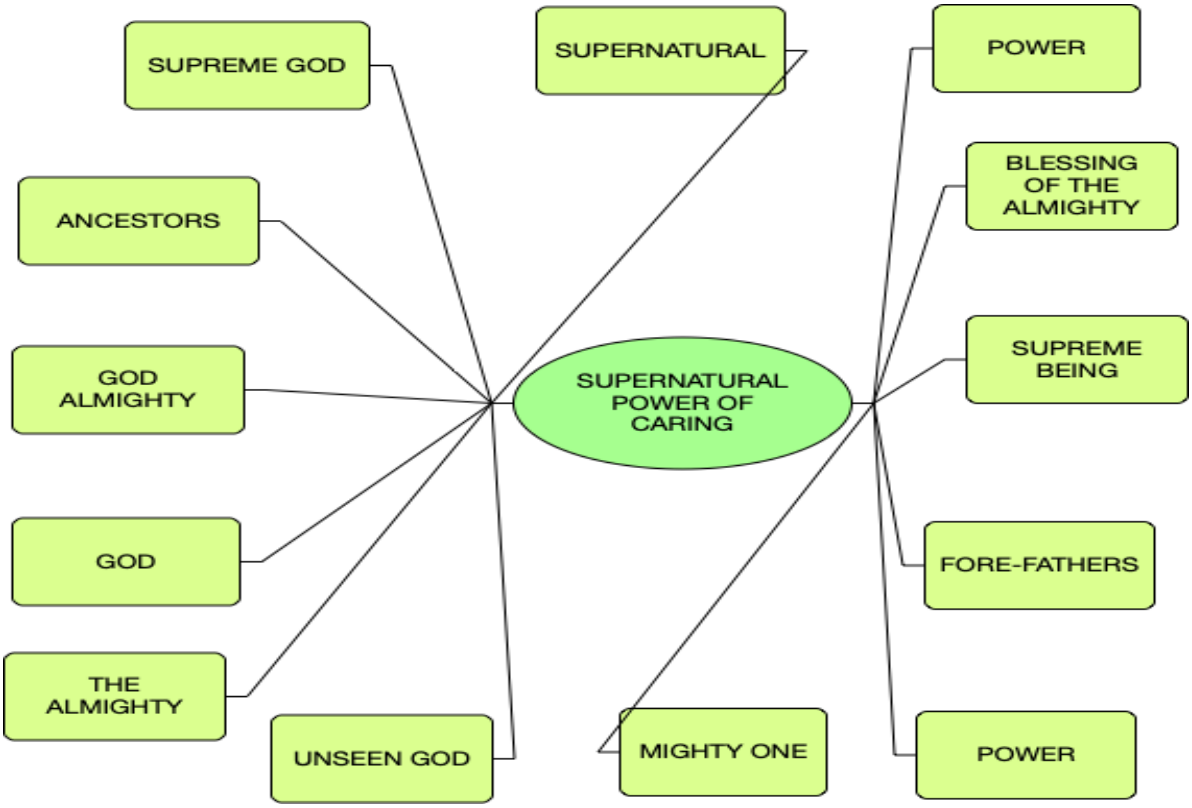
Prayer

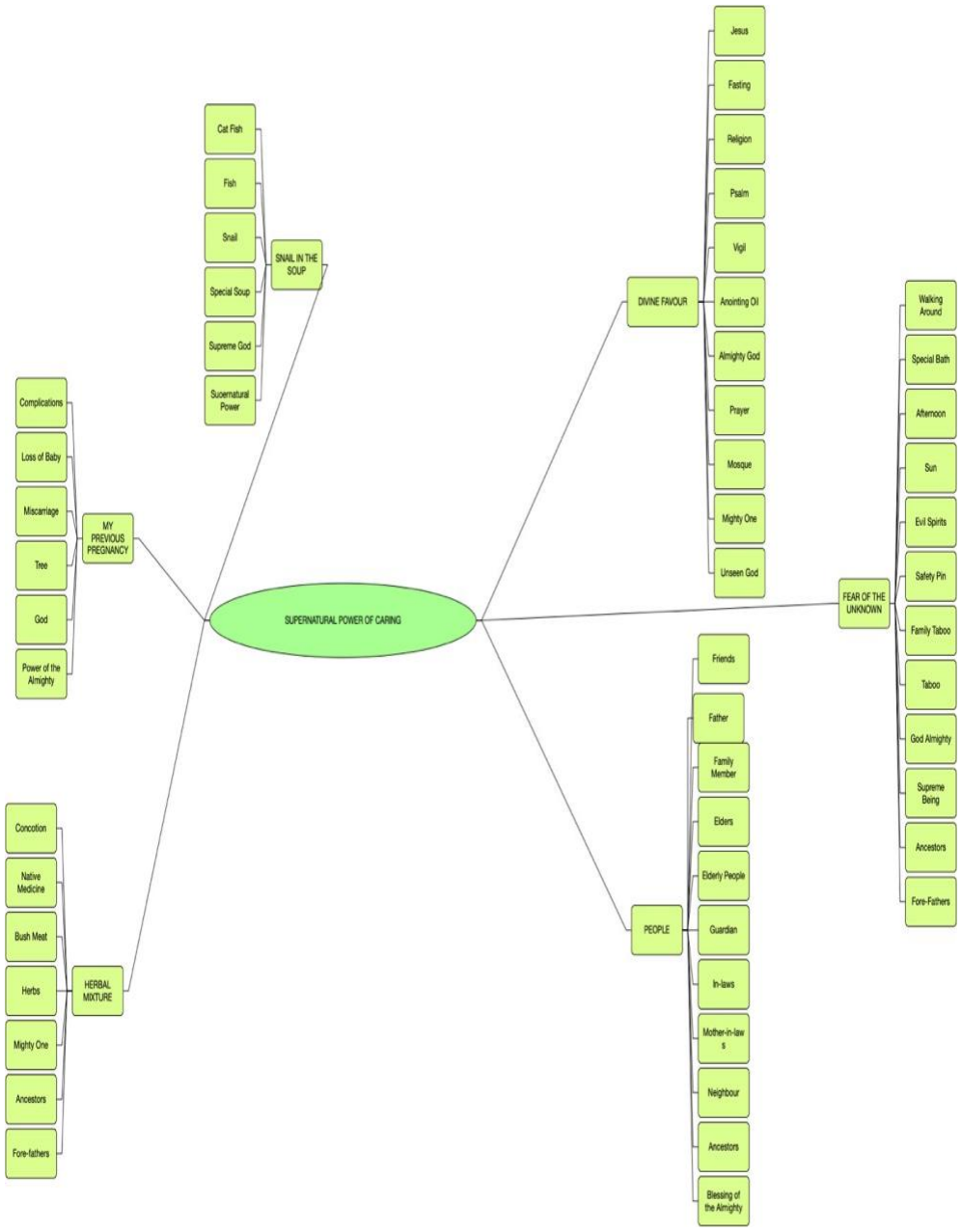
Mosque

Mighty one

Unseen God

Appendix 19: Supernatural power as a theme





Appendix 20: Coding

Appendix 21: Final Themes