EXPLORING SOCIO-CULTURAL` FACTORS THAT INFLUENCE MATERNAL MORTALITY AND PERCEIVED STRATEGIES FOR ITS REDUCTION IN SOUTH EASTERN NIGERIA

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Acronyms

This list is confined to acronyms used more than once, and in more than one place, within the thesis.

Acronyms	Full meaning
WHO	World Health Organisation
USAID	United State Agency for International Development
MDG	Millennium Development Goal
EPMM	Ending Preventable Maternal Mortality
FCT	Federal Capital Territory
MSS	Midwifery Service Scheme
FMoH	Federal Ministry of Health
TBAs	Traditional Birth Attendants
UNFPA	United Nations Fund for Population Activities
UNPD	United Nations Population Division
APHR	African Population and Health Research
MMR	Maternal Mortality Ratio
SDG	Sustainable Development Goals
UN	United Nations
MHTF	Maternal Health Taskforce
MCSP	Maternal and Child Survival Program
PMTCT	Prevention of Mother to Child Transmission
NPC	National Population Commission
NDHS	Nigeria Demographic and Health Survey
STI	Sexually Transmitted Infections
ILO	International Labour Organization
GAD	Gender and Development
WID	Women in Development
WAD	Women and Development
FGD	Focus Group Discussion
CS	Caesarean Section
NBS	National Bureau of Statistics
UNICEF	United Nations Children Emergency Fund

DRC	Demographic Republic of Congo

Abstract

Background: The risk of a woman dying from avoidable complications during pregnancy and childbirth has declined significantly in high income-countries but has remained unacceptably high in most of the middle- and low-income countries. In Nigeria, pregnancy and childbirth have continued to represent a period of sorrow and tragedy for several families. For instance, a woman in Nigeria is more than 200 times per pregnancy and childbirth more likely to die than a woman from other middle or low-income countries. To-date, previous studies indicate a dearth of information regarding the socio-cultural factors that contribute to maternal mortality in Nigeria.
Methodology: This qualitative study aimed to explore and describe the perceived socio-cultural factors impacting on maternal mortality and strategies for its reduction in South-Eastern Nigeria. Data was collected using focus group discussions involving 10 women with children and 10 women without children. Individual interviews were also conducted involving another 19 participants. These comprised women of reproductive age who did not participate in the focus group discussion, doctors, midwives, traditional birth attendants, a village head, a religious leader, a youth leader, and a women's leader.
The findings: show a dominant discourse of culturally based perceptions of deep-rooted cultural and religious belief systems. Most of the community members constructed a system of beliefs about pregnancy, childbirth, and maternal mortality, which shaped decision-making regarding the uptake of maternal services. However, a dichotomy existed amongst the professionals about the use of either culturally based worldviews or biomedical knowledge to inform practice. These culturally grounded perceptions were facilitated by the deliberate or unintentional actions of people in government impacting their lack of will to formulate policies and provide resources that would encourage women to utilise maternity services, as well as motivate professionals to deliver effective maternal health services. This thesis also uncovered knowledge beyond cultural meaning-making and revealed that social complexities, such as economic status, the attitude of the healthcare workers and social networks, were issues contributing to the low uptake of maternity services and potentially the high rate of maternal deaths. Specifically, it was found that the poor economic status of some pregnant women, the unfriendly attitude of healthcare professionals, and negative advice from members of their social networks influenced women's maternity healthcare-seeking behaviour, thereby potentially increasing maternal deaths. Overall, findings revealed that women's behaviour, which might have contributed to the high maternal death rate, stemmed from cultural, social, and contextual factors. Lastly, perceived strategies for the reduction in maternal deaths, such as free-maternal healthcare services, the assimilation of TBAs into hospital-based midwifery practice and culturally sensitive services, were found in this study and could be used by policy makers to improve maternal wellbeing, ensuring maternity services meet the needs of women and families.
Conclusion: The findings suggest the need for cultural shifts in meaning-making and attitude to promote maternal wellbeing. This study contributed to knowledge in this field and can be used to enhance culturally sensitive maternal care, as well as knowledge that is relevant for policy intervention, ensuring pregnancy and childbirth is safer.

CHAPTER ONE

INTRODUCTION TO THE THESIS

1.0 Identification of the broad area of investigation

The death of a woman during pregnancy, childbirth or after childbirth is one of the greatest misfortunes and calamities that can occur within a family, with wide-ranging consequences for the baby, other children, spouses, family members and wider society (Lawson and Keirse, 2013). However, maternal mortality remains unacceptably high, especially in the global South (Alkema et al., 2016). The World Health Organisation (WHO) further stated that approximately 380 women die daily from issues related to avoidable causes during pregnancy and childbirth, and 99% of these deaths occur in low and middle-income countries, such as Nigeria (WHO, 2019). Therefore, it could be extrapolated that globally 302,950 women died in 2018 from causes related to pregnancy and childbirth.

The United Nations inter-agency estimates that the global maternal mortality ratio (MMR) declined by 44% between 1990 and 2015, dropping from 385 to 216 deaths per 100,000 live births (WHO, 2015). Arguably, this shows remarkable progress, but a huge disparity exists in the reduction rate of maternal death globally between the South and the North. Whilst countries within Central and Eastern Europe and the commonwealth of Independent States recorded the lowest numbers of maternal deaths, there is a high maternal death rate in countries within Sub-Sahara Africa, followed by South Asia and then the Middle East and North Africa (WHO, 2015; Alkema et al., 2016). Specifically, Sub-Sahara Africa and South Asia accounted for 88% of maternal deaths globally in 2015, but Sub-Saharan Africa suffered from the

highest MMR, with 546 maternal deaths per 100,000 live births, or 201,000 maternal deaths annually (WHO; United Nations International Children's Emergency Fund (UNICEF); United Nations Fund for Population Activities (UNFPA); World Bank Group; United Nations Population Division (UNPD) 2015). This high mortality rate in Sub-Saharan Africa amounted to 66%, or two thirds, of all maternal deaths per year around the world (WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division 2015). This implies that maternal mortality is a key health challenge specific to this region. The high trend towards maternal death has continued to exist in Sub-Sahara Africa (Doctor et al., 2018). For instance, MMR was noted in 351 per 100,000 live births (Ahmed et al., 2018) in rural areas within six sites in Sub-Saharan Africa (Demographic Republic of Congo (DRC), Ghana, Kenya, Tanzania and Zambia).

In Nigeria, high maternal mortality is particularly worrisome (Oyibo et al., 2016). For instance, it was estimated that the maternal mortality ratio in Nigeria was 545 per 100,000 live births in 2008 (WHO, 2019b). The World Health Organisation further reported that this was the second highest number of annual maternal deaths in 2010, and equivalent to 14% of all maternal deaths globally (WHO, 2019b). The Nigeria Bixby Center for Population, Health and Statistics reported that 59,000 Nigerian women die each year due to pregnancy and childbirth-related causes (Nigeria Bixby Centre, 2012). It was also reported that Nigeria contributed 15% to global maternal mortality, with approximately 58,000 maternal deaths in 2015 (WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division 2015, Alkema et al., 2016). The United Nations International Children's Emergency Fund estimated that 145 women of childbearing age died daily during childbirth in Nigeria in 2016 (UNICEF, 2016). According to the organisation, African Population and Health

Research, this estimate increased to more than 500 women dying each day from causes related to pregnancy and childbirth (APHR, 2017). Therefore, pregnancy and childbirth are a dangerous period for over 9.2 million women and girls who become pregnant each year in Nigeria (APHR, 2017), because 1 in every 13 women is at risk of death during and after pregnancy and childbirth (UNICEF, 2016). This corroborates with the WHO statement that women who live in Nigeria and other developing countries are about 33 times more likely to die from maternal-related causes compared with women living in developed countries (WHO, 2019). Overall, the statistics on the high maternal death rate in Nigeria are an arguably inaccurate representation of the magnitude of maternal mortality in Nigeria. It has been reported that Nigeria lacked effective health information management systems due to the prevalence of cumbersome paper-based and disjointed health data management systems (Adeleke et al., 2015). This is impacted by several challenges, such as shortage of experienced health record personnel, the lack of information technology facilities, the lack of planning in the storage of active records, delays in the transfer of records and a lack of individuals reporting vital statistics to health facilities (Aljumah et al., 2013; Yahaya et al., 2015). This could imply inaccuracy and a lack of recording, thereby indicting that the statistics on maternal mortality are underestimated.

The high degree of uncertainty around pregnancy and childbirth in Nigeria is suggestive that the Nigerian State has failed to ensure the safety and protection of women's lives during childbirth. At the end of the Millennium Development Goal (MDG) era, the United Nations Maternal Mortality Estimation Inter-Agency Group (consisting of WHO, UNICEF, UNFPA, World Bank Group, and UNPD) evaluated the progress made and each country's achievement in the reduction of maternal mortality (WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division

2015, Alkema et al., 2016). This inter-agency group assessed the percentage change in maternal mortality for each country by considering the categorisation of MMR reduction point. A categorisation of the MMR reduction point estimated at ≥ 75% meaning that MDG5A was achieved, whilst ≥ 50% means that progress is being made, ≥ 25% indicates insufficient progress and <25% signifies no progress (WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division 2015). The percentage change in the maternal mortality ratio (MMR) in Nigeria between 1990 and 2015 was 39.7%. This, therefore, indicates that Nigeria has made insufficient progress towards the achievement of MDG 5a. In plainer terms, this implies that Nigeria has not made enough progress to reduce maternal death. This could imply that additional research evidence is required that could be used to contribute to existing strategies to reduce maternal death in Nigeria. Thus, the current study sought to explore the socio-cultural factors that influence maternal mortality and the perceived strategies for its reduction, with a hope that evidence generated from this thesis will contribute to existing strategies to improve maternal health.

In the post-2015 MDG era, the Heads of State and Government in all United Nations Member States met and decided on new Sustainable Development Goals (SDG) designed to complete what MDG did not achieve. The Heads of State, including Nigeria, adopted SDG 3 with a target to reduce the global maternal mortality ratio from 216 per 100,000 live births in 2015 to less than 70 per 100,000 live births in 2030 (UN, 2019). WHO highlighted that achieving SDG 3 requires more research evidence to ensure the development of effective strategies and interventions to improve maternal health and end preventable maternal mortality (WHO, 2016). This thesis not only adds to the evidence base that will help to make recommendations on the development of strategies to reduce maternal death by making SDG 3 a reality. Generally, this study

seeks to present evidence about women's, health professionals' and opinion leaders' experiences, perceptions and attitudes regarding the high rate of maternal mortality, which is currently lacking in the Nigerian context. This study hopes to strengthen targeted interventions to improve maternal health.

1.1 Motivation for the study: No woman should die while giving life

This study is based on the premise that the incidence of maternal mortality is unacceptably high in Nigeria, despite efforts to reduce it and improve maternal health. The study has drawn on my personal and clinical experiences as a Midwife witnessing several instances of women dying during pregnancy and childbirth, and many years of reflection on my close friend's death during childbirth. This study was borne from my desire and passion to contribute towards improving the wellbeing of millions of women in Nigeria and beyond to make pregnancy and childbirth safer so that no woman should die, especially from preventable causes. Also, it was an effort to contribute to knowledge in this field by addressing some of the gaps identified in the existing literature.

In my view, the high rate of maternal mortality in Nigeria is suggestive that Nigeria's health system needs more aggressive action and strategies to drastically reduce maternal death. Cutting down the rate of maternal mortality is achievable because some countries, such as Iran, Laos, Rwanda, and Mongolia, achieved a 75% reduction in their MMR by the end of the 2015 MDG era (Alkema et al., 2016). In addition, if countries, such as Ethiopia, Uganda, Mozambique, Zambia, and Tanzania, can achieve a 50% reduction of MMR by the end of the 2015 MDG era (Alkema et al., 2016), it suggests that a reduction in the rate of maternal death is also achievable in Nigeria. Nigeria is a country in Sub-Saharan Africa with resources, which, if harnessed

appropriately, could provide adequately for the needs of the country and its citizens (WHO*,* 2015).

Finally, I strongly support the statement that no woman should die while giving birth (UN, 2007). Research is a fundamental tool that can provide evidence-based insights that can be used in planning strategies to reduce maternal death in Nigeria. Although many research studies have been conducted in Nigeria, more robust research is needed to contribute towards areas of limited knowledge, such as the exploration of perceived socio-cultural factors impacting on maternal mortality and strategies for its reduction in South-Eastern Nigeria. The study addresses this need.

1.2 Key concepts

The sections above set the scene for this thesis by presenting the magnitude of maternal death in Nigeria in relation to the global picture, by identifying the broad area of investigation and justification for why this current research is timely. In this section, key concepts, such as health, maternal health, reproductive health, and maternal mortality, will be succinctly discussed because they are relevant to the understanding of this thesis.

1.2.1 The Concept of Health

Several attempts have been made to define the concept of health, but the World Health Organisation (WHO) has given the universal and most accepted definition. The WHO (1948) defines health as the '*complete physical, mental and social well-being of individuals and not merely the absence of disease or infirmity'.* Despite the wide acceptance of this definition, some authors still identify problems with it. For instance, Mensha (2008) argued that it is difficult to identify and conceptualise the actual nature

of mental and social well-being, due to the abstractness of these concepts, despite the possibility of measuring their physical dimensions. Similarly, Larson (1999) emphasised that it is difficult to fulfill all dimensions of health as the spiritual aspect of human health was not considered in the WHO (1948)'s definition. These spiritual dimensions are important in the experience of humankind, and particularly in Sub-Saharan African communities (Charlier et al., 2016). The authors argued that the WHO definition is outdated and, therefore, proposed the consideration and inclusion of human equilibrium, accepted spirituality and adaptation in the definition of health (Charlier et al., 2016).

Furthermore, available evidence shows that culture, beliefs, attitude, environment, and practices are some of the key factors that influence health (Aja-Okorie, 2013; Akande and Owoyemi, 2009). Some authors argue that culture, religion, and spirituality are an important determinant of health in Africa and should not be overlooked, since the physical and spiritual dimensions of health are considered to be causes of illness (Asakitikpi, 2008; Mensha, 2008; Babalola and Fatusi, 2009; Azuh et al., 2015). It is, therefore, crucial to consider the cultural context of women's health because the health and wellbeing of individuals are profoundly influenced by cultural beliefs and practices (Asakitikpi, 2008; Babalola and Fatusi, 2009; Azuh et al., 2015).

Ajiboye and Adebayo (2012) noted that good health is a situation where the body, mind, and spirit are in sound condition. In essence, health is the absence of physical, emotional, mental and spiritual pain (Aninyei et al., 2008; Archibong et al., 2010). In Nigeria, various ethnic groups and cultures view health and the causes of disease from different perspectives, depending on their cultural and religious backgrounds. For instance, health viewed in this context includes spiritual (attacks, witches, and

wizards), natural or physical (poisoning, pain) and mystical or ancestral punishments for offences against them (Akitunde, 2006). It is, therefore, necessary to understand the experiences and perceptions of women and other community members on the causes of maternal death and their proposed solutions for its reduction. Findings from a new evidence-informed framework for maternal and newborn care showed that it is important to consult with women in order to understand their cultural beliefs and practices and the effect they may have in contributing to maternal mortality (Renfrew et al., 2014). The information gathered from the community members helps to provide an understanding of people's cultural beliefs to enable the planning of effective intervention/policies to improve maternal health and to reduce maternal mortality.

1.2.2 Reproductive Health

Reproductive health addresses the reproductive processes, functions, and systems in all stages of life (WHO, 2017). Based on the WHO (1948) definition, four components of reproductive health were developed, specifically, family planning, maternal care, infant/childcare and the control of sexually transmitted diseases. Ujah et al., (2005, p. 27–40), clarifies '*the definition of reproductive health and summarized it as not merely the absence of disease or infirmity but the process of accomplishing the reproductive process by the complete physical, mental and social well-being'*. The United Nations International Conference on Population and Development and World Health orgnaisation similarly defines reproductive health *'as the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes'* (WHO, 2019). This, therefore, implies that women have fundamental human rights to proceed

healthily through the reproductive process, from conception (pregnancy) to childbirth as well as after childbirth until the growth and development of their children. The definitions of reproductive health indicate that women ought to enjoy good health while performing their reproductive choice without fear of losing their lives.

1.2.3 Maternal Health

Maternal health is defined as the physical and mental well-being of both the mother and child during pregnancy and puerperium (WHO, 2007). Maternal health involves all aspects of care for both the mother and child before, during and after pregnancy, as well as the health of the child up until the age of five years (Cham et al., 2005; Boyacioglu and Turkman, 2008; Akande and Owoyeni, 2014). Several factors (socio-economic, biological, and cultural) in the form of poverty, malnutrition, educational status, beliefs, values, and early marriage may compromise the health of women and their children (Ezeonwu, 2015). Several authors identified early conception, culture/traditional harmful practices, poverty, and other related issues as multi-dimensional problems that can compromise women's maternal health (Lanre-Abbas, 2008; Aninyei, 2012; Azuh et al., 2015). On the other hand, poverty, a lack of education, poor hygienic conditions, a lack of household income, a lack of food, malaria, HIV/AIDs, tuberculosis, chronic anaemia, a lack of access to health services, and social exclusion are risk factors for poor maternal health (Okonofua et al., 2011; Marchie, 2012). In addition, access to health services, age and nutrition influence women's health and well-being (Delano, 2006; Lahiri-Dutt, 2007; Azuh et al., 2015). There is a need to build a strong evidence base for maternal health to influence, and

thus enhance, health and improve the safety of both mother and child (Okonofua et al., 2011; Aninyei, 2012).

The United States Agency for International Development (USAID) (2010) identifies critical aspects of maternal health that need to be urgently addressed to improve the health of mothers. USAID (2010) outlines the potential issues that need to be addressed as: prenatal care; the prevention/treatment of malaria, anaemia and other related diseases; proper ante-natal care for pregnant mothers to ensure safe delivery; proper puerperal care for both the mother and child, and proper contraception to maintain child spacing. Graczyk (2007) notes that the provision of appropriate care for women during pregnancy should cover all aspects of their lives, such as the provision of employment, social inclusion for mothers, the enablement of schoolgirls to complete and further their education in order to achieve balance and safe motherhood. Nevertheless, despite efforts to ensure quality reproductive care for mothers during pregnancy, maternal death is still a global health challenge, especially in developing countries (WHO, 2013; Ndep, 2014; UNICEF, 2014). The confusion caused by the co-existence of traditional and modern medical practices in Nigeria is arguably one of the issues that influences maternal health (Aziken et al., 2007; Danawi and Ogbonna, 2014). Additionally, the high patronage of non-prescription medicine and abuse of antibiotics (supplied by unqualified health personnel) also contributes to poor maternal health in Nigeria (Essien, 2006; Galadanci et al., 2007; Ekechi et al., 2012). It is recommended that pregnant women attend a consultation with a qualified healthcare worker before conception, and during and after pregnancy to avoid potential risks or harm that may result during delivery (Ben-Joseph, 2007). However, this recommendation may not be feasible in most Sub-Saharan context because such services and support are unavailable, especially in local communities.

In the opinion of Graczyk (2007), women should seek to achieve and maintain good health through adequate diets before conception and during pregnancy. Azuh et al., (2015) further supported that the consumption of adequate diets is an essential component of a healthy pregnancy and good maternal health. It is therefore important in this research to explore the perceptions of the community on these issues to see if such ideas are supported, as this could contribute to the reduction of maternal mortality. The proceeding section explores the concept of maternal mortality.

1.2.4 The Concept of Maternal Mortality

WHO defines maternal mortality as the death of a woman while pregnant or within 42 days of the termination of a 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 (WHO, 2019c). WHO further highlighted that, in order to facilitate the identification of maternal deaths in circumstances in which the cause of death attribution is inadequate, a new concept, known as pregnancy-related death has been introduced. Pregnancy-related death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the cause of death (WHO, 2019c).

Patwardhan et al., (2016) argued that establishing pregnancy status, timing and the causes of death are fundamental to defining maternal death but highlighted that there are global variations in identifying the signs and symptoms, diseases, and reporting of the causes of death affect the definition of maternal death. They also stated that maternal mortality can further be classified, either based on the timing of the death, such as late maternal mortality, or on the underlying causes of death, both direct and indirect. Late maternal death occurs from both direct and indirect causes in more than

42 days, but in less than a year, after the termination of a pregnancy, whereas direct maternal death results from complications in pregnancy and pregnancy-related conditions, such as labour and puerperium (Idowu et al., 2011; Patwardhan et al., 2016). It can also arise due to other problems resulting from aggregates of events related to obstetric complications, unanticipated complications arising due to poor/incorrect treatments and omission, or from a combination of these factors (Patwardhan et al., 2016). In contrast, indirect maternal death results from conditions other than those enumerated above, such as disease or disability which occur due to the effects of pregnancy, labour and puerperium (Izugbara and Ukwuanyi, 2007; Idowu et al., 2011; Patwardhan et al., 2016). Maternal mortality can also be the death of a woman during pregnancy, childbirth, and puerperium as a result of coincidental causes, such as suicide and unspecified causes, because the underlying causes were not determined or were unknown (Patwardhan et al., 2016).

The WHO and other researchers highlighted that the direct causes of maternal death around the world, such as haemorrhage, sepsis, death related to caesarean section, unsafe abortion, obstructed labour, high blood pressure during pregnancy and complications from delivery, account for nearly 75% of all maternal deaths, while the rest are due to causes related to pre-existing illnesses that may be aggravated by pregnancy, such as malaria, diabetes mellitus, AIDS, iron deficiency anaemia and tuberculosis (Say et al., 2014; WHO, 2019c). In Nigeria, evidence from numerous bodies of literature on maternal health and mortality shows that direct and indirect causes of maternal mortality are known (Alobo et al., 2013; Ezegwui et al., 2013; Guerrier et al., 2013; Obiechina et al., 2013; Oye-Adeniran et al., 2014). However, many studies from Nigeria have also reported that maternal death results from the complex interactions of risk factors, such as teenage pregnancy, delays in decisions

to seek medical care, grand multiparity, inadequate education, the non-utilization of ante-natal services and the non-utilization of family planning services, industrial action, inexperienced skilled birth attendants, the attitude of healthcare workers, the costs of care and referral, and communication problems between facilities (Fawole et al., 2012; Igwegbe et al., 2012; Olatunde et al., 2012; Alobo et al., 2013; Ezegwui et al., 2013; Obiechina et al., 2013; Okusanya et al., 2013; Agho et al., 2016). This could imply that educational and early childbearing pratices in Nigeria could be a contributing factor to the inadequate number of midwives and that this may have an impact on the maternal mortality rate (Renfrew et al., 2014; Van Lerberghe et al., 2014; Utz and Halim, 2015). As described in The Lancet Midwifery Series and reaffirmed by several authors, a shortage of midwives is also linked to the limited availability of individuals that can be trained as midwives due to the predominant discourse of early and frequent childbearing as well as insufficient educational opportunities in many parts of Nigeria, especially in the Northeast and Northwest geopolitical zones (Homer et al., 2014; ten Hoope-Bender et al., 2014; Utz and Halim, 2015). As described in the Lancet Midwifery Series, addressing the shortage of midwives could reduce maternal mortality. This implies that efforts to scale up midwifery in Nigeria must address the underlying shortage issues mentioned above.

In agreement with the views of other scholars, I argue that there is a complex interaction between the individual, political, cultural and economic factors impacting maternal deaths in Nigeria (Okafor et al., 2014; Adeniyi et al., 2017; Oladigbolu et al., 2017; Oknofua et al., 2018). Remarkably, the evidence from the scoping review presented in Chapter Three of this thesis shows a dearth of research on the sociocultural complexities that underline the direct and indirect causes of maternal deaths and that no study has explored the socio-cultural issues in the South-Eastern

geopolitical zone of Nigeria. Therefore, this thesis was designed to close this gap in the knowledge by giving voice to the community women, health care providers, traditional birth attendants and opinion leaders and allowing them to tell their stories, by focusing on the socio-cultural factors impacting on maternal death. The evidence generated from this thesis provides a unique contribution that could be used by policy makers and healthcare providers to strengthen the existing strategies or plan new strategies to reduce maternal mortality in the South Eastern geopolitical zone of Nigeria.

1.3 Research questions

The specific focus of the research was chosen following a scoping literature review, as presented in Chapter Three. Therefore, research gaps were identified after the conduct of this review, which informed the broad aim: To explore and describe the perceived socio-cultural factors impacting maternal mortality and strategies for its reduction in South-Eastern Nigeria. To achieve this aim, the following research questions were addressed:

- What are the experiences of women regarding the socio-cultural factors impacting maternal mortality?
- What are the socio-cultural factors impacting maternal mortality as perceived by healthcare professionals based on their experiences?
- What are community leaders' and traditional birth attendants' perceptions of the socio-cultural factors impacting maternal mortality?
- In what ways do these participants consider that maternal mortality could be reduced?

1.4 Choice of research design

The nature of the research questions for this study informed the choice of the research design or approach. The research questions required a methodological approach that enabled an in-depth exploration to gain an understanding of the experiences, perceptions, and interpretations of the participants about the socio-cultural complexities impacting maternal deaths. It was noted that the focus of this current research had not previously been explored in South-Eastern Nigeria; therefore, the research questions were exploratory. Thus, a methodology that allows for the pursuit of meaning, rather than quantification, was required because the research was exploratory. A qualitative research methodology was chosen because it tends to focus on thoughts, experiences, and feelings in order to gain an understanding of the perspectives of participants as well as the meanings they ascribe to their experiences (Steen and Roberts, 2011; Creswell, 2018). Therefore, qualitative research is a form of social enquiry that focuses on investigating the way people make sense of their experiences and interpret the world in which they live.

Finally, I argue that the qualitative approach was most appropriate for the current research as it enabled the exploration of participants' experiences and perceptions of the socio-cultural factors impacting maternal mortality, as well as their perceived strategies for its reduction. The qualitative methods utilised in the current study (focus group discussion and interviews) provided participants with the freedom and flexibility to express their experiences and views, which facilitated an understanding of the issue under investigation. Following extensive exploration and consideration of various qualitative approaches, a general qualitative approach underpinned by interpretivism was used for this thesis. A more in-depth explanation for the methodological choice is presented in Chapter Four.

1.5 Thesis structure

This thesis consists of ten chapters. Chapter One sets the scene of the study by presenting the global and, more specifically, Nigerian picture of maternal mortality, by identifying the broad area of investigation and providing a justification as to why it was necessary to conduct the current research. It also explores the relevant key terms necessary to understand the thesis, and concludes with a recap of the research aim, research questions and choice of study design. Chapter Two presents relevant background information to contextualise maternal mortality and highlights previous programmes and interventions designed to reduce maternal death in Nigeria, as well as the factors that influence the utilization of maternal health services as it is relevant to this study. Chapter Three presents the scoping literature review, exploring what is known about the social and cultural factors impacting on maternal mortality in Nigeria and how it has been studied. The gaps identified from the literature review formed the focus for the current study. Chapter Four describes the qualitative methodology and the chosen study design for this research, which was influenced by the philosophy of interpretivism. This chapter provides a discussion of how the qualitative method was applied in the conduct of the research. Theoretical perspectives that underpin the study and my own epistemological stance are discussed, with a concluding section on reflexivity. Chapter five presented an overview and introduction to finding chapters, detailed the characteristics of the participants and how the findings have been organised.

Three findings chapters are then presented. The first finding chapter presents the analysis of the data from local women (women of reproductive age with and without children), traditional birth attendants, community healthcare professionals (doctors and midwives), and opinion leaders (a religious leader, youth leader, village head,

women's leader) regarding their belief systems about pregnancy, childbirth and maternal death. This chapter reveals that participants used their belief systems (cultural and religious beliefs) to construct meaning about pregnancy, childbirth and maternal death and engaged in cultural practices which were rooted in their understanding and perceptions of pregnancy, childbirth and maternal death. Chapter Seven explores how these culturally based perceptions and ethno-religious knowledge may have contributed to the socio-political and cultural practices that influenced maternal health, thereby potentially leading to maternal mortality. Furthermore, participants' perceptions of the approaches needed to improve maternal health and reduce maternal death rates are addressed in Chapter Eight. Chapter Nine presents the summary of the key findings and original contributions to Knowledge/implications of the findings while Chapter Ten outlines the summary of the thesis, limitation of the study, direction for future research and final reflections.

CHAPTER TWO

THE STUDY BACKGROUND

2.0 Introduction

This chapter reviews some key background issues relevant to this project. The key issues presented include a review of the Millennium Development Goal 5 (MDG 5), maternal mortality in Nigeria, and the social and cultural context of maternal health, particularly issues affecting the health and well-being of women in Nigeria. Reviews of government policies and programmes addressing the improvement of women's health and reducing maternal mortality are also considered.

2.1 The Millennium Development Goals (MDGs): An unfinished agenda for the post-2015 period?

In 1945, the international organisation known as United Nations was founded (UN, 2009). The 193-member states comprising this body strive to maintain international peace and security, protect human rights, promote sustainable development, uphold international law and deliver humanitarian aid. In 1994, world leaders, under the umbrella of the United Nations, attended an international conference on population and development, with a broad vision to fight poverty and its many dimensions (Obaid, 2009). This vision was transformed into eight millennium development goals, which have remained the central global developmental framework for the past fifteen years (UN, 2009). These eight Millennium Development Goals (MDG) focus on: reducing hunger and poverty, child and maternal mortality, environmental threats, gender issues, HIV/AIDS and malaria, improvement in education, as well as sustainable global partnership (UNDP, 2015). Although the reduction of maternal mortality became one of the eight goals for development in the Millennium Declaration, prior to this the

Safe Motherhood Initiative was the first global initiative, formulated in 1987 with the recognition that primary healthcare was not adequately focused on maternal health in many developing countries (Rosenfield and Maine, 1985; Starrs, 2006). The global initiatives to improve maternal health indicate that maternal mortality has long been recognised as a major global health issue and is still one of the current global challenges (Brizuela and Tunçalp, 2017).

The Millennium Development Goal 5 (MDG 5) was set to reduce the maternal mortality ratio (MMR) by 75% between 1990 and 2015 (UNDP, 2015). Now that the 2015 deadline has elapsed, the latest report regarding the MDG indicates that many lives have been saved and peoples' living conditions have improved across the world (UNDP, 2015). However, shortfalls and a lack of progress recorded in some aspects of the MDG program have been acknowledged (UNDP, 2015). As this research is focused on the improvement of maternal health and wellbeing in Nigeria, the review of MDG 5 will, therefore, provide insight into what has been achieved regarding the improvement in maternal wellbeing. This will also reveal the area of unmet goals, which will provide direction for future effort towards the realization of improved maternal health and wellbeing.

2.1. 1. The review of millennium development goal 5: Improve maternal health

Maternal health has long been recognized as one of the critical areas of global development. Olusegun (2012) noted that maternal health specifically addresses issues around childbearing, also encompassing antenatal care, intrapartum and postnatal care. Maternal health also involves other dimensions of healthcare which include family planning, conception, prenatal and postnatal care (Osain, 2011), and

which are also targeted at reducing maternal mortality in order to achieve the 5th goal of the MDG (WHO, 2013).

The key facts regarding the current maternal health situation, as presented in the latest MDG annual report 2015 (UNDP, 2015), show that:

- The maternal mortality ratio has been cut by nearly half since 1990, with most of the reduction occurring in the year 2000.
- In Southern Asia, the maternal mortality ratio declined by 64% between 1990 and 2013, and in sub-Saharan Africa, it fell by 49%.
- In 2014, more than 71% of births globally were assisted by skilled health personnel, indicating an increase from 59% in 1990
- Between 2000 and 2014, only 59% of births in the rural areas of the developing regions were attended by skilled health personnel, compared to 87% in urban areas between 2000 and 2014
- In Northern Africa, the proportion of pregnant women who received four or more antenatal visits increased from 50% to 89% between 1990 and 2014
- Contraceptive prevalence among women aged 15 to 49, married or in a union, increased worldwide from 55% in 1990 to 64% in 2015
- In the developing regions, only half of pregnant women received the recommended four antenatal visits
- Only 51% of the countries have data on the causes of maternal death

The above points are further explained in the paragraphs below:

This report indicates that maternal survival has significantly increased since the adoption of the MDGs. Between 1990 and 2013, there has been a drop by 45%in the global maternal mortality ratio, namely from 380 to 210 maternal deaths per 100,000 live births (UNDP, 2015). Steady progress has been achieved in many developing regions towards improving maternal health, including regions with previously high maternal mortality ratios (Alebiosu, 2014). For instance, in Sub-Saharan Africa, the maternal mortality ratio has declined by 49%, while in Southern Asia it fell by 64% (UNDP, 2015). However, it was acknowledged that, despite this progress, hundreds of women, especially in developing countries, still die during pregnancy and from pregnancy-related complications (UNDP, 2015). In 2013, Alebiosu (2014), in a study of the Nigerian national health system, maternal health and the millennium development goals, reported that maternal mortality was 14 times higher in the developing countries than in the developed countries. In support of this, a global estimate of maternal mortality in 2013 showed that 289,000 maternal deaths occurred in the developing regions, with an equivalence of 800 deaths per day (UNDP, 2015). Available data indicates that the majority (86%) of the maternal deaths recorded in 2013, occurred in sub-Saharan African and Southern Asia (UNDP, 2015). Nevertheless, it is argued that many of these deaths are preventable if the causes are known (Mojekwu and Ibekwe, 2012). The available evidence shows that the majority of the maternal deaths recorded in Nigeria and other developing countries between 2003 and 2009 were a result of a postpartum haemorrhage (Cooker and Tahir, 2013). In addition, the UNDP (2015) noted that the global distribution of maternal deaths resulting from haemorrhage reveals that 27% and 16% of the global maternal mortality occurred in the developing and developed regions of the world, respectively. Additionally, several other complications that resulted in maternal death in Nigeria are

eclampsia, infections, non-communicable diseases, malnutrition, complications following deliveries and unsafe abortion (WHO, 2015). These complications may be effectively managed through appropriate healthcare interventions that take the sociocultural values of members of the community into consideration. UNDP (2015) stated that proper antenatal care during pregnancy, and skilled care during childbirth, including in the weeks after childbirth, are measures that can improve maternal health and reduce maternal mortality. However, despite these measures, MDG 5 is yet un-met in Nigeria. The Secretary General of the United Nations acknowledged that the attempt to improve maternal health is work that must be continued in this new developmental era (UNDP, 2015). Thus, this research intends to uncover the sociocultural issues that militate against maternal health, which will provide insight on targeted interventions to improve maternal wellbeing and reduce maternal mortality.

WHO (2013) noted that one of the key strategies for reducing maternal morbidity and mortality is to ensure that skilled health personnel attend every birth. Skilled birth, or health, personnel entail a medical doctor, nurse or midwife (WHO, 2013). Global efforts through the MDG programme have raised the proportion of skilled birth attendants to a modest level, which is a reflection of the fact that there has been a lack of universal access to care (Odebiyi, 2008; WHO, 2012). This suggests that evidence from robust research is needed, especially in developing countries like Nigeria, to contribute towards the efforts to improve maternal health and wellbeing. The need for skilled birth personnel is based on the report that more than 1 in 4 babies and their mothers are left without access to essential medical care during delivery (UNICEF, 2014). This indicates that there is a huge disparity in the coverage of skilled attendants at births across the regions. The global coverage ranges from low (52%) in Sub-Saharan Africa and Southern Asia, nearly universal (96%) in Central Asia and the

Caucasus, to universal in Eastern Asia (UNDP, 2015). However, as Sub-Saharan Africa and Southern Asia have the highest maternal and newborn mortality rates in the world there is a clear need for these personnel (UNDP, 2015).

In addition, available evidence suggests there are persistent inequalities in access to, and use of, reproductive health services within and across the regions of the world. A 31%-point gap exists between rural and urban areas in the developing regions regarding the coverage of births attended by skilled health personnel (UNDP, 2015). However, this large disparity masks the range of inequalities amongst regions (UNICEF, 2014; UNDP, 2015). The 52%-point gap reported in Central Africa represents the largest difference between rural and urban coverage (UNDP, 2015). This contrasts with the 100% coverage for births attended by skilled health personnel in both rural and urban settings in developed regions (UNDP, 2015). Pregnant women's lack of access to skilled health personnel during childbirth seems to have contributed greatly to why MDG 5a was not achieved before the expiration of the time frame. The recent executive summary for the Lancet's series on the role of midwifery shows that deploying midwives to countries with high maternal mortality rates will be fundamental to the UN post-2015 developmental agenda for improving maternal health (Renfrew et al., 2014). This report demonstrates that up to 21 countries that have successfully reduced the maternal mortality rate by 2.5% achieved this success by deploying midwives for the care of pregnant women during and after childbirth. Evidence from countries, such as Burkina Faso, Cambodia, Indonesia and Morocco, shows that investing in midwives and strengthening other aspects of health systems helped to achieve reductions in maternal and childbirth mortality (Van Lerberghe et al., 2014). However, one of the key messages of the executive summary for the Lancet's series on midwifery is that the views and experiences of women and their

families in the community about the framework for improving maternal health are crucial in revealing the interventions and strategies needed to reduce maternal mortality. Therefore, this research will provide an opportunity for all groups within the community to discuss their views and experiences of what causes maternal mortality and their views on potential solutions to help reduce it.

A minimum of four antenatal care visits to a health professional - usually a midwife - is recommended by the WHO (2012). This is to ensure the well-being of both the mothers and their babies (WHO, 2012). These visits will only yield a positive result if midwives are deployed and are available to provide care to pregnant women during and after childbirth (Van Lerberghe et al., 2014). In addition, it is recommended that these women should be provided with at least a basic care package, including nutritional advice, during these visits (Mojekwu and Ibekwe, 2012; Alebiosu, 2014). Another key issue required during these visits is health education on the warning signs of potential complications during pregnancy, with the provision of necessary support that would enable them to plan for safe deliveries (Olusegun et al., 2012). However, the available report shows that only 52% of pregnant women in the developing regions received this recommended number of antenatal visits during pregnancy in 2014 (UNDP, 2015). Slow progress has been recorded in the past 25 years, with a slight increase in coverage of just 17% points since 1990 (UNDP, 2008). The progress seems to be stagnant in Sub-Saharan Africa, with only a slight increase from 47% to 49% in the number of pregnant women who received the recommended care (UNDP, 2015).

The WHO (2013) noted that the use of contraception contributes to a reduction in the number of unintended pregnancies, unsafe abortions, and maternal deaths. Available

evidence indicates that there has been a global increase in the number of women of childbearing age (15-49 years) who used any method of contraception growing from 55% in 1990 to 64% in 2015 (UNDP, 2015). In Sub-Saharan Africa, this proportion increased by more than double, between 1990 and 2015, from 13% to 28% (UNDP, 2015). A higher proportional increase from 39% to 59% was noted in Southern Asia during the same period (UNDP, 2015). Available evidence suggests that 9 out of every 10 persons (male and female) using contraception used effective methods that included sterilization, oral pills, IUD, condoms, injectable or implants (Abani et al., 2015). Nevertheless, in 2015, 12% of women of reproductive age (15-49 years) across the world wanted to avoid or delay pregnancy but were not using any method of contraception (UNDP, 2015).

Moreover, childbirth in adolescence can result in harmful health consequences for both the mothers (the adolescents) and their babies (Shetty, 2005). A broader form of socio-economic deprivation among teenage mothers may be reflected in early childbearing. Maternal mortality may be reduced by preventing early childbearing and unintended pregnancies among these vulnerable groups (Shetty, 2005). Alebiosu (2014) notes that encouraging them to go to school would enable them to engage in paid employment, which can reduce maternal mortality; this is another way of addressing the problem. In addition, not only will these efforts improve maternal and child health, but they will also contribute to poverty reduction, gender equality and women's empowerment (Odebiyi, 2008; Mojekwu and Ibekwe, 2012). Available data shows that there has been a global reduction in the birth rate among adolescents between the ages of 15 to 19 years. This has reduced from 59 births per 1,000 girls in 1990 to 51 births per 1,000 girls in 2015 (UNDP, 2015). Nevertheless, this global trend shows wide variations across regions and continents. In all, there has been a decline

in the adolescent birth rate across all regions between 1990 and 2015, with the greatest progress recorded in Southern Asia, Eastern Asia and Oceania (UNDP, 2015). In Sub-Saharan Africa, it remains high at 116 births per 1,000 girls in 2015 (UNDP, 2015). Moreover, in Nigeria it was reported by the World Bank to have decreased from 123 in 2007 to 109 in 2016 (World bank 2016).

The MDG programme enhanced the availability and acceptability of basic data on births, deaths, and their causes, as well as health service coverage (Alebiosu, 2014). However, the disparity in the availability of data regarding maternal health hinders efforts that should guide the institution of priorities for national, regional and global health (Odebiyi, 2008). It is, therefore, crucial to keep records and data regarding maternal death because it will reveal areas where interventions are needed to improve maternal health. For instance, the most recent report released by Mother and Babies: Reducing Risk through Audit and Confidential Inquiries across the United Kingdom (MBRRACE-UK) on findings from maternal mortality surveillance 2012 to 2014 in the UK revealed some causes of maternal mortality (Knight et al., 2016). Through the organised record keeping system, the analysis of this data was highlighted some key messages and strategies to prevent future maternal deaths. UNDP (2015) reported that only 51% of all countries of the world have some data on the causes of maternal death. In the developed countries, this data can be easily obtained through civil registration and another organised systems, whereas in the developing regions this data emanates from other means of record keeping (UNDP, 2015). Significant variations in the availability of data exist across regions of the world. Over 90% of countries in Latin America and European countries like the UK have national data on maternal causes of death; in comparison, this is less than 20% in Sub-Saharan Africa (WHO, 2013). Accurate data keeping aligned with maternal death registration, which

is the eleventh core maternal health indicator in the global monitoring framework for ending preventable maternal mortality (Moran et al., 2016). Moreover, it is important to note that, following a launch of a comprehensive paper outlining *Strategies toward Ending Preventable Maternal Mortality (EPMM)* in February 2015 to support the achievement of the SDG global targets, the WHO, the Maternal Health Taskforce (MHTF), and the US Agency for International Development (USAID) along with its flagship Maternal and Child Survival Program (MCSP) developed a common monitoring framework for 2015-2030 aiming to significantly reduce maternal mortality (Moran et al., 2016; WHO, 2015; Chou et al., 2015). Twelve indicators and four priority areas (content of antenatal care, content of postnatal care, respectful maternal care, and meeting the need for emergency obstetric care) were identified for further development and testing. According to Moran et al. (2016), the next step is to develop a similar process to agree upon appropriate indicators to monitor the social, political and economic determinants of maternal health and survival rates, as highlighted in the EPMM strategies. Thus, this thesis is timely because it is focused on identifying the sociocultural factors that impact maternal mortality. The evidence generated from this type of research could contribute to achieving the next target for EPMM.

Furthermore, a concentrated effort to reduce maternal deaths and ensure universal access to reproductive health services was achived by goal 5 of the MDG (UNDP, 2015). However, this is an unfinished agenda in its aim to ensure that all people receive the necessary reproductive and sexual health services. Critical analysis of the MDG reveals insufficient and significantly uneven progress (UNDP, 2015). The global, regional and national reports indicate significant health inequalities, vulnerable groups or subgroups (Osain, 2011). This can be directly or indirectly attributed to their levels of education, places of residence, socio-economic status and age (Odebiyi, 2008).

There are significant inequalities in maternal health across all regions of the globe, with gaps in access to, and use of, reproductive health services, which requires constant monitoring and control (UNDP, 2015). There is a need for all countries of the world, particularly the developing regions, to facilitate the reduction of inequalities in both access to, and availability of, data related to the quality of health, including the registration of births and deaths (WHO, 2015). This data is essential for informed policies, and the prioritisation of interventions targeted at improving maternal health and access to sexual, as well as reproductive, health care (UN, 2007).

The review of the MDG 5 has revealed the remarkable achievements so far made through concerted regional, national, local and global efforts towards the success of the programme. The improvements in maternal health and the reductions in maternal death rates are more evident in the United Kingdom and other developed countries, although many lives have also been saved and people's living conditions improved in developing countries too (Knight et al., 2016). However, this review shows that many women still die during and after childbirth, especially in Sub-Saharan Africa countries such as Nigeria. Lowe et al. (2016) stated that understanding people's cultural values and perceptions is essential to develop targeted intervention and sound strategies that will reduce maternal deaths and improve maternal health and wellbeing. This thesis is, therefore, explores the sociocultural factors that influence maternal health, which it is hoped will contribute towards a reduction of maternal mortality and improve maternal health and wellbeing. This research was conducted in the Nigerian context; therefore, a more focused review of issues associated with maternal mortality in Nigeria is presented next.

2.2 Maternal Mortality in Nigeria

Women of childbearing age in developing countries are faced with a high risk of death as a result of maternal mortality (WHO, 2007). Also, many women in developing countries who escape death during pregnancy are often faced with the risk of injuries, disabilities, and infections during childbirth and the puerperium (Izugbara and Ukwayi, 2007). Accordingly, the WHO introduced a new term known as 'pregnancy-related mortality' in order to more comprehensively captures the meaning of maternal mortality. The WHO defined pregnancy-related mortality as the death of a woman during pregnancy or within 42 days of a pregnancy's termination, irrespective of its causes (WHO, 2010). Maternal mortality is a global health challenge, but 99% of maternal deaths occur in developing countries, such as Nigeria (UNICEF, 2013). The report states that the lifetime risk of maternal death in developed countries is 1 in 4,000, but 1 in 51 in developing countries (UNICEF, 2013).

The high rate of maternal death in Nigeria has reduced the country to an object of concern because Nigeria has the strongest economy in Africa and is thus regarded as 'the Giant of Africa' (Ezegwui et al., 2013). The government of Nigeria has put much effort into the fight to reduce maternal death; however, not much positive outcome has been recorded. (FMoH, 2009) This is probably because of the lack of research evidence that could be used as the basis to plan effective strategies to reduce and prevent maternal death, including a lack of trained midwives in the community, no hospitals in the rural areas and financial constraints.

Globally, an effort to raise awareness about the need to improve the health of women and to reduce deaths associated with the complications of pregnancy and childbirth can be traced back to 1987, when Safe Motherhood Initiatives were launched in

Nairobi, Kenya (Starrs, 2006). The global health actors, such as the WHO, UNFPA, UNICEF, and UNDP, are continually making efforts to assist developing countries in the fight against maternal mortality. However, Hanson (2010) pointed out that the apparent failure in the effort to reduce maternal mortality globally has been the most difficult threat to global health. However, it was anticipated that the target to achieve Millennium Development Goal 5a (MDG 5a) by 2015 was an unrealistic dream for Nigeria, based on the evidence from research papers (Adegoke et al., 2008; Ezegwui et al., 2013; Oye-Adeniran et al., 2014). This became reality as the earlier review of the MDG annual report 2015 indicated, as Nigeria did not meet the MDG 5 goal (UNDP, 2015). This suggests that more effective strategies are needed to reduce maternal death in Nigeria. The available strategies and interventions, such as national HIV/AIDS and the prevention of mother to child transmission (PMTCT) policy and strategic plan, the national blood policy, the midwives service scheme, the national reproductive health policy, the national guideline and strategies for malaria prevention and control during pregnancy, which were designed to fight maternal mortality in Nigeria are mostly based on medical models (Kana et al., 2015). These health policies, strategies, and guidelines have been criticised based on the fact that they are not sensitive to the socio-cultural needs of people in their various communities in Nigeria, where the incidence of maternal death is higher (Adegoke et al., 2008; Oye-Adeniran et al., 2014). The lack of success in the effort to reduce maternal death might be attributed to the neglect of the belief and customs of rural communities (Ezegwui et al., 2013). It has been found that cultural and traditional health practices dictate, to a greater extent, what happens during childbirth in countries where maternal mortality remains high (Geller et al., 2006). Research is therefore needed in these countries to find out how cultural influences affect maternal health. This research is focused on

gaining an understanding of the communal socio-cultural perspectives on ways to reduce maternal death. It is based on an assumption that exploring the socio-cultural influences on maternal health will help to illuminate the barriers to quality maternal health and well-being.

2.3 Programmes/Interventions Designed to Reduce Maternal Mortality in Nigeria

Maternal mortality is recognised as one of the major public health challenges in Nigeria (Doctor et al., 2012; Kana et al., 2015) and the Nigerian government is making efforts to reduce maternal death and improve maternal wellbeing. The health policies, strategies and guidelines to reduce maternal mortality in Nigeria from 2003–2014 are shown in the Table 2.1. Some of the most relevant of these interventions/programmes are discussed in more detail.

Table 2.1: Maternal health policies, strategies and guidelines in Nigeria from 2003–2014, (Source: Kana et al., 2015:11)

S/N	YEAR	NAME OF THE INTERVENTION/ STRATEGIES/ GUIDELINES/ POLICIES
1	2003	National HIV/AIDS and prevention of mother to child transmission (PMTCT) policy and strategic plan
2.	2006	National blood donation policy
3.	2007	Organisational guidelines for blood transfusion practice in Nigeria
4	2007	Policy on the health and development of adolescents and young people in Nigeria

5.	2009	Midwives service scheme (MSS)
6	2010	National reproductive health policy
7	2010	National guideline and strategies for malaria prevention and control during pregnancy
8	2010	National guidelines for the prevention of mother to child transmission of HIV (PMTCT) revisited.
9	2010	Training manual on the use of magnesium sulphate
10	2010	National family planning and reproductive health services protocol and policy guidelines and standard of practice

2.3.1 The Midwife Service Scheme (MSS)

This strategy was launched in December 2009 to engage newly graduated, unemployed, and retired midwives to work temporarily in rural areas to help reduce maternal mortality in Nigeria (Kana et al, 2015). Thus, 815 healthcare organisations, comprising 652 primary healthcare centres and 163 general hospitals were selected in each of the six geopolitical zones of Nigeria, based on the burden of maternal mortality (Abimbola et al, 2012). Each primary healthcare centre selected for this scheme was provided with basic equipment for the care of pregnant women, with basic diagnostic facilities for anaemia and malaria. While the selected general hospital provides 24-hour services, such as antenatal care, child delivery, postnatal care, family planning, comprehensive emergency obstetrics care, the prevention of mother-to-child transmission of HIV (PMTCT) services, administration of antibiotics, intravenous fluids, and treatment of pre-eclampsia (Abimbola et al., 2012; WHO,

2017). The general hospital has at least 12 maternity bed spaces, a functioning operating room, a blood bank, and stand-by alternative power supply; it receives referrals from primary health care centres. Following an initial nationwide recruitment exercise, 2,488 midwives were deployed to the designated primary health centres and general hospital in the 36 states and Federal Capital Territory (FCT) for a one-year period from 2009 to 2010. Specifically, four midwives were deployed in each of these facilities to care for all the women that attended the facility during pregnancy, labour and peuperium. It could be argued that the four midwives deployed in each facility were insufficient to provide effective care during pregnancy and childbirth. This number suggests a shortage of midwives, which is against international best midwifery practice. For instance, in the United Kingdom (UK), a pregnant woman during labour is entitled to at least one midwife for the provision of personalised care sensitive to individual needs (NICE, 2019; MBRRACE-UK, 2016).

The one-year evaluation of the progress of this scheme at all the facilities showed uneven improvement in maternal, newborn, and child health indices across the six geopolitical zones of Nigeria (Abimbola et al, 2012, WHO, 2017). Although, there was an overall improvement in the maternal and child health indices, the facilities in the North-east and South-east geopolitical zones in Nigeria reportedly did not show any decrease in the maternal mortality rate (Abimbola et al, 2012). The majority of women delivered their babies at home, despite encouragement for full participation in this scheme and the availability of midwives in the facilities. This particular finding suggests that there may be some social and cultural barriers as to why these women refused to access the midwifery services (Abimbola et al, 2012). The MSS in Nigeria seems to have been unsuccessful due to the weak implementation of the scheme, and poor and unpaid salaries of the midwives, and the distance from home to the health centres.

These findings further dampened the expectation of significant improvements to maternal health (Ikpeazu, 2018).

Nevertheless, evidence shows that the deployment of midwives has been pivotal in the reduction of maternal mortality in many countries (Lerberghe et al., 2014, Renfrew et al., 2014) A lack of implementation of the Memorandum of Understanding agreed between the Federal government and the State governments about the scheme, the lack of availability of qualified midwives, the low retention of midwives and the capacity building of midwives has impacted upon the effectiveness of the MSS in Nigeria (Abimbola et al, 2012; WHO, 2017). In addition, poor coverage, poor funding, and a lack of consideration of sociocultural issues, such as beliefs, customs, and practices in the implementation of this scheme in Nigeria could have perhaps contributed to the failure of MSS in Nigeria. WHO acknowledges that any schemes, policies or strategies for the reduction of maternal mortality, which fail to consider people's cultural beliefs and practices, are likely to have less impact (WHO, 2015). Therefore, current research is focused on investigating the sociocultural issues that cause maternal death, and solutions for its prevention. The findings will provide insight into more relevant approaches and strategies for the reduction of maternal mortality in Nigeria.

2.3.2 Life-Saving Skill Programme

This is a programme engineered by the Federal Ministry of Health, which is targeted at ensuring the availability of quality maternal health services with the hope of improving women's access to skilled attendants who are capable of handling their maternity needs (FMoH, 2004a). Following the introduction of this programme, special training emerged to equip the midwives with critical skills that would enable them to

handle issues related to five key factors that result in maternal mortality, namely, haemorrhage, unsafe abortion, sepsis, eclampsia and obstructed labour (FMoH, 2004a). However, the training could not continue due to lack of a continuity in government and government fundiing.

2.3.3 Basic Obstetric Care Initiative

This programme was initiated by the Federal Ministry of Health in 2004 (FMoH, 2004a), and was designed with the intention of equipping the national healthcare system to be able to respond to, and address, issues related to pregnancy, labour and childbearing, by enhancing capacity/standards for skilled personnel as well as medical equipment (Babalola and Fatusi, 2009). Although the focus of this programme was clear, available evidence indicates that it failed to take off, as there was no implementation policy provided for its execution (Abdulkarim et al., 2010).

2.3.4 Making Pregnancy Safer Initiative (MPSI)

This programme was developed in response to the recommendation of the World Health Organization in 1999 (WHO, 2000). The Making Pregnancy Safer programme was targeted at responding to issues related to maternal mortality and drew significantly from the experiences gained in the Safe Motherhood project (FMoH, 2004b). Meanwhile, the actual implementation of this initiative commenced in the year 2000. Its key focus was on ensuring that skilled attendants were available within the healthcare system to enable access to obstetric and child care by mothers, with the aim of reducing mortality in the country (Babalola and Fatusi, 2009). Although the implementation of this intiative contributed to improvements in maternal health, it can

be considered unsuccessful because the skilled attendants were not available in all areas of the Nigerian healthcare system.

2.3.5 Population Policy and Contraception in Nigeria

In 1988, the Nigerian government adopted the National Policy for Development, Unity, Progress and Self-Reliance. This policy was revised in 2004 and included maternal health, with the aim of reducing maternal mortality by 75% in 2015 (National Population Commission (NPC) 2010). This was in accordance with the Millennium Development Goal Number 5 (NPC, 2010). Since its inception, this policy has encouraged open discussion and the promotion of family planning. Accordingly, the NPC (2010) reports that this policy was targeted at enhancing people's standards of living, to foster the good health and welfare of the masses through the reduction of the deaths and disabilities among women and children, and to achieve reduced population growth through birth control. A critical evaluation of the success of this policy indicates that it failed to achieve its target. The Nigerian population has an estimated annual growth rate of 3.0%, with a current population of over 150 million (NPC, 2010). Again, Nigeria has also failed to achieve the Millennium Development Goal target for 2015 (NDHS, 2018). In addition, the current annual contraceptive prevalence is approximately between 15% and 25%, which is far from the estimated 80% in 2000, 2010 and now 2015 (NDHS, 2010). The NDHS (2014) notes that the reasons for the inability of the Nigerian government to achieve these goals were: a lack of funds, political instability, uncoordinated strategies, and a lack of proper education of its citizens.

2.3.6 Family Planning

The WHO (2009) notes that policies which are inclusive of socio-economic and cultural factors, including the regulatory issues that limit women's control over their reproductive and sexual health, should be addressed properly to enable women and their families make informed choices about when and how to bear children. WHO stated that early contraception among women who are very young and those already having many children, including unwanted pregnancies, are likely to increase the rate of maternal mortality (WHO, 2009). This national family planning/reproductive health service was formulated to facilitate the provision of reproductive health services in Nigeria. This policy addresses issues such as the methods of family planning, sexually transmitted infections (STIs), HIV/AIDS, infertility, routine screening and care for reproductive health cancers, post-abortion care (PAC), and infection prevention techniques (FMoH, 2010). It aims to improve the quality of care at service delivery points. The Nigerian government increased its expenditure on the educational training of its citizens regarding family planning methods as a result of the rapid population growth experienced in the country (NDHS, 2010). The health care facilities provide education and offer contraceptive services to people who desire them (FMoH, 2010). It is reported that more than 70% of women in Nigeria are aware of family planning, but less than 4% use contraception due to socio-cultural reasons (Abimbola and Ajiboye, 2012).

2.4 Limitations of the above stated interventions

Several arguments have been noted regarding the levels of achievement recorded by these interventions or programmes designed to address maternal mortality in Nigeria. These arguments consider whether these programmes have successfully attempted

to either reduce the magnitude or scope of maternal mortality in Nigeria. Despite the initiation of these programmes, the Nigerian government, through its healthcare policies, has not been able to record significant success in reducing maternal mortality within the country (Dairo and Owoyukun, 2010). Nigeria's maternal mortality remains high despite the special assistance gained from agencies, such as UNICEF, WHO, UNFPA and United Nations (Ewa et al., 2012). There are undoubtedly indications of improvement in Nigeria's healthcare service, particularly concerning maternal issues but there is no available evidence, judging from the statistical information obtainable within the country, to prove that significant success has been achieved in this regard (Kistiana, 2009).

Available evidence shows a lack of adequate and appropriate equipment for personnel who have been specially trained to undertake obstetric services (Lawoyin et al., 2007). A substantial amount of training and re-training has been initiated to achieve success in the Life-Saving Skill Initiative but, due to a lack of adequate equipment, these skills have not been clearly applied (Ewa et al., 2012). Some argue that hospital settings within the country are organized to render effective emergency services, but this only exists in principle (Kabir et al., 2005). Several authors (Kabir et al., 2005; Ewa et al., 2012; Okeshola and Ismail, 2013) argue that most hospital settings, especially in developing countries, do not have properly trained staff and minimum safety measures, including inadequate equipment to provide quality maternal care to women. One of the key factors that militate against various interventions designed to address maternal mortality in a lack of proper monitoring and supervision (Okeshola and Ismail, 2013), which has potentially contributed to the inaccessibility of these health services for women (Okeshola and Ismail, 2013). There is a need to review the country's policy in order to address the menace of maternal death. Moreover, it is obvious from this

review that a lack of focus in the policy framework, poor monitoring, and a lack of supervision from the policies are major factors militating against the government's efforts to reduce maternal mortality in Nigeria. As these interventions have not significantly reversed the trend of maternal death in Nigeria, the findings from this research will be used to suggest new interventions and strategies to reduce maternal death, based on data elicited from the local population. It is suggested that interventions or programmes that may effectively reduce maternal death and improve maternal well-being should be based on the needs and perceptions of the local population, who are those with the greatest experience of this menace (Kana et al., 2015). Therefore, this research will also seek the views of community members on what could be done to reduce the maternal death rate and improve maternal wellbeing.

2.5 Factors influencing the use of maternal health services in Nigeria

The National Demographic Health Survey (2010) noted that more than 33 million women in Nigeria experience several obstacles that limit their access to healthcare. Some of these factors, such as the high cost of health care, the lack of health facilities, long distances to health facilities, poor levels of education and poor road transportation networks, have been found to be key barriers restricting women's access to health services in Nigeria. These form part of the themes presented in the following scoping review chapter. However, some of the factors uncovered in the reviewed papers in Chapter Three, which were considered crucial for this thesis, are also presented in this section.

Traditional Medicine

Even though traditional medicine practice is endorsed by the WHO, it has not been properly utilized to solve health problems (Kayne and Whitehouse, 2009). Traditional medicine is defined as the health approach that incorporates knowledge, beliefs,

animals, plants and minerals, spiritual care, manual techniques, and exercise either in combined forms or single use, in diagnosing, treating/preventing illnesses in order to achieve the optimum health and well-being of the populace (WHO, 2009). Traditional medicine practice is often shaped by culture and belief systems (Azuh et al., 2015; Uneke et al., 2015). Moreover, it is often seen as an alternative to modern medical care in Nigeria and some other developing countries, as people patronise it more than modern medicine (Uneke et al., 2015). Meanwhile, patronage of traditional medicine is often shaped by culture and beliefs, with increased use when people perceive that modern healthcare is significantly costlier than traditional health services (Ibeh, 2008; Marchie and Anyanwu, 2008). The WHO (2012) noted that over 80% of Africans depend on traditional medicine for their healthcare, whilst 58% of children suffering from malaria in Nigeria, Ghana, and Mali are treated with local herbs (WHO, 2010).

In Africa, traditional birth attendants are also considered part of traditional medical practice (Ibeh, 2008). Moreover, Ibeh noted that women are much more comfortable with traditional medicine practices because they are more familiar with those providing the care; in contrast, they are often frightened of the unfamiliar western form of health service they receive in advanced healthcare centres. However, scientific evidence regarding the efficacy or effectiveness of traditional medicine remains unclear and ambiguous. The relationship or interlink between medical practice and traditional medicine has instead created more problems in terms of safety relating to its use or combination (WHO, 2012). Also, in most cases, traditional medicine is not based on, or uses, any known scientific standard of measurement (Adetoro et al., 2012).

Quality of Care

Quality of care entails whether patients/clients/service users are satisfied with the level of healthcare services they obtain (Kabir et al., 2005). Meanwhile, potential deficiencies in healthcare systems can be ascertained by measuring patient satisfaction (Lawoyin et al., 2007). It is considered important to ascertain patients' perceptions of the quality of care they receive as this enables an in-depth view or understanding of the quality of available healthcare services (Archibong et al., 2010). There is a correlation between an individual's level of utilization and their perception of the quality of care (Adetoro et al., 2012). The individual's ability to seek healthcare services may be affected by their perception regarding the quality of care in terms of the attitudes of healthcare personnel, the knowledge and abilities of the staff, their availability, their level of satisfaction with the diagnosis, and the efficacy of the treatment provided (Ogun et al., 2012). Ogujuyigbe and Liasu (2007) found that patients' dissatisfaction can lead to a loss of confidence in the public health facility, which may negatively affect the health of vulnerable groups, such as children and women. There is a significant association between maternal health and primary health care, as this is the first point of entry to healthcare in Nigeria (Alenoghena et al., 2014). Thus, good quality healthcare at the primary level can enhance women's confidence in public health facilities, which might improve their access to healthcare services and the consequent improvements in their health outcomes (Adetoro et al., 2012; Marchie, 2012). A continuous lack of health facilities and trained personnel, and the unavailability of essential drugs undermines the quality of care available for women at grass roots, which, if continued over a long period, erodes the confidence of women, and deters them from seeking health care services in public facilities (Marchie, 2012). Also, Ogun et al., (2012) stated that women who receive adverse health outcomes in

a given healthcare facility while pregnant are less likely to visit that particular facility in their subsequent pregnancies.

Culture

Culture influences people's ways of life in a range of ways. Meanwhile, the concept of culture can be viewed from different perspectives, namely from materialistic and idealistic standpoints (O'Neill, 2006). Culture, when viewed from the materialistic angle implies people's patterns of behaviour, customs, and ways of life (O'Neill, 2006; Longhurst et al., 2008 and Giddens, 2012). In comparison, an idealistic perspective focuses on the ideas, knowledge, and beliefs that portray a given group of people, but excludes their behavioural characteristics (Giddens, 2012 and Longhurst et al., 2008). While neither of the two perspectives offer a satisfactory definition of culture, they clearly point out the key features (behaviours, ways of life, beliefs, and ideas) that influence human lives. Geertz (2000) noted that culture forms an integral part of human lives through its various dimensions, which define it as a pattern of behaviours and ideas that are peculiar to a particular social group. These ideas and behavioural patterns involve religion, affinity, belief, knowledge, and childbearing practice (Geertz, 2000). Culture is learned and shared or transmitted from one generation to another (Giddens, 2012). However, people's knowledge and understanding of culture, including existing dynamics, can generate new knowledge, ideas or meaning (O'Neill, 2006; Giddens, 2012). In essence, culture can be described as the way a particular social group, family, religious group, or ethnicity, assign meaning to their values and belief system (Mensah, 2008).

The duel conceptualization of culture as either a static trait characteristic of a given social group or as a dynamic process indicates that, whilst culture has a common set

of meanings, it can also be interpreted differently by every individual and can change over time (Kao et al., 2004). From the static perspective, Kao et al., (2004) argue that culture is external to the individual. Culture exists independently and has its own domain and laws, whilst people only serve as carriers with little or no control over it (Kessing et al., 2013). Judging from this standpoint, culture can be predicted and measured directly without entering people's inner worlds (Kao et al., (2004). It has also been argued that culture determines human behaviour (Longhurst et al., 2008 and Hunt, 2007). From this tradition, culture is viewed as either a pathology causing bad behaviour or as concrete traits guiding people's actions or presenting obstacles to actions, which might result in poor health outcomes (Kao et al., 2004). Furthermore, the dynamic nature of culture presents it as non-concrete reality and an abstract concept that exists as an inference in the mind of an individual (Kao et al., 2004). From the interpretive and anthropological work of Geertz (2000), culture has shared symbols that are the collective construction of human minds and can be viewed as a cognitive system. Culture forms the unit or entity in which knowledge is generated, learned, and transmitted within social groups or families (Obot, 2005; Longhurst et al., 2008). This tradition views culture as a complex set of concepts and understandings that result in an intricate web of values or goals (Obot, 2005). Thus, culture is dynamic, flexible and forms the basis on which people's behaviours, construction, and creativity are created and amended, depending on the prevailing situation (Kao et al., 2004). Moreover Obot (2005) states that culture forms the basis for knowledge interpretation and is highly flexible, dynamic and can change at any time. Similarly, O'Neil (2006) notes that culture is subject to continuous change as new cultural traits are added, while some old ones may be lost when they are no longer considered important.

Culture, through several dimensions, influences women's health. In Nigeria, women's actions towards illnesses are shaped by their culture (Erinsho, 2005). Factors that are classified as cultural include gender, norms, child marriage and early pregnancy, cultural practices that prohibit women from eating nutritional diets, particularly during pregnancy, and female genital mutilation (Joseph et al., 2007; Azuh et al., 2015). The adverse consequence of these practices is damage to the health of women and young girls, which can result in poor quality health generally (Joseph et al., 2007). Culturally, these influences interact with other factors, which may be due to preferences for the male child, especially in developing countries (Azim and Lotfi, 2011). Women's reproductive choices, in terms of the number of children and their spacing, are shaped by these cultural factors (Erinsho, 2005; Lanre-Abass, 2008). In Nigeria and many other developing countries, women do not have autonomy regarding their reproductive intentions as only their husbands are culturally empowered to make decisions about whether or not a particular treatment or contraception will be adopted (Abimbola et al., 2012; Ezeonwu, 2015). In Nigeria and some other developing countries, women often fear that their husbands may prevent them from accessing some treatment options, which in most cases results in covert treatment, particularly in the use of birth control devices (e.g., family planning) (Ekechi et al., 2012). This implies that women's rights to their reproductive choices are limited by such cultural practices.

Meanwhile, beliefs or perceptions of appropriate health behaviour may negatively affect the way health information is interpreted, which can subsequently reduce access to health services and might result in poor quality health (Ezeonwu, 2015). Cultural practices and taboos restrict women from seeking proper health information, as they are not permitted to freely discuss their health needs (Ezeonwu, 2011; Ezeonwu, 2013). Furthermore, due to existing cultural norms only husbands can make decisions

about women's health and reproductive choices (Azuh et al., 2015; Olaitan, 2011). This implies that women's health decisions about when to seek medical attention are dependent on their husbands, which can lead to unnecessary delays. Moreover, women are not allowed to raise issues or concerns regarding their reproductive health. For instance, in some parts of Nigeria, particularly in the North, women never discuss issues such as irregular menstrual bleeding and the use of birth control devices with their husbands (Abdulikarim et al., 2010; Dairo et al., 2010). Women's health needs are often left unattended until they become so complicated that urgent help is required (Ezeonwu, 2015; Tayo et al., 2011).

Additionally, belief systems in different societies shape people's perceptions about their illnesses (Azimi and Loffi, 2011). As the fact that disease-causative organisms are biological, cultural norms and behaviour often prevail, this mean that some anti-social habits can negatively affect people's health behaviours (Cham et al., 2005). For instance, a pregnant woman is not allowed to eat egg or snail while pregnant. In Nigeria, people rely on home remedies to resolve some health problems because they believe that they should not always go to the hospital (Delano, 2006). Historically, grandparents were known to handle the health problems of their wards without recourse to external help or medical attention (Eckersley, 2006). Common issues that can result in increased risks of complication or death among women are delays in identifying their health problems, delays in seeking medical attention, and delays in visiting health facilities because of untrue beliefs about pregnancy (Essien, 2005). Overall, knowledge about cultural influence on maternal health and maternal mortality exists in some parts of Nigeria but evidence from the literature, as presented in the next chapter, shows that research into how social and cultural factors impact maternal

mortality is lacking in South East Nigeria. Therefore, this study sought to address this gap.

Age at Marriage

Chronologically, age is measured from a person's date of birth and, as a concept, it is socially structured within a hierarchy (Ewa et al., 2012). Age is an indicator of superiority in terms of thinking ability and decision-making (Jegede, 2010). In reproductive health, age determines the readiness of the physiology of potential mothers (Jegede, 2010). Child marriage and early pregnancy can result in complications and deaths (Oladeji, 2008; WHO, 2010). Increased maternal mortality in Nigeria and other countries has been partly attributed to early childbearing and/or early marriage (Oladeji, 2008; NDHS, 2010). There is a culture of being married off to a man at a very early age in Nigeria (Oladeji, 2008). Adolescents who become pregnant at the time when their reproductive organs are not yet fully developed suffer disproportionately from complications related to childbirth (Idowu et al., 2011; Olaitan, 2011; Abimbola et al., 2012). Early marriage and early pregnancy increase fertility rates (Ezegwui et al., 2013; Ezeonwu, 2015). However, increased fertility rates can imply an increased risk of maternal death (Ezegwui et al., 2013). Additionally, early conception and childbirth increases the susceptibility of young mothers to disease complications and death (UN, 2007; WHO, 2007).

Role Conflict

Omoruyi et al., (2008) identified the interrelationships that exist between work and family. A reciprocal relationship exists between these two spheres of social life (family and work) that has been found to cause conflict and tension (Omoruyi et al., 2008). Women, in most cases, occupy multiple positions and play several roles, which include

wife, mother, homemaker, employee, or caregiver to an elderly parent (Osunbor et al., 2006). Women often experience stressful situations in multi-tasking to meet these simultaneous demands (Stephenson et al., 2008; UN, 2009). Meanwhile, Akintunde (2006) suggest that women's choices have to be prioritized. Conflicting situations often arise when women are exposed to these multiple roles (Omoruyi et al., 2008; Mordi and Ojo, 2011). In most developing countries, women are compelled to choose between the options of pursuing a future career or spending time with the family (Mordi and Ojo, 2011). There is a clear difference between the modern workplace and home-life, as the workplace seems to encourage the useful or judicious use of time in pursuing organizational efficiency and commitment (Mordi and Ojo, 2011). In contrast, life at home is oriented towards the domain of relief from work-related pressures (Mordi and Ojo, 2011).

Omideyi et al., (2011) acknowledged that a relationship exists between the conflicts arising from interactions between competing claims of children, spouses, or kin. Mordi and Ojo (2011) noted that women continue to perform bulky household duties, particularly when they choose to, or are required to, work outside their home. Moreover, Rosenfield (2009) states that women perform more household tasks than men, have more sleepless hours per night, and perform an extra month of work annually. The implication of an increased workload with less rest is accumulated stress, which can present obstacles to women's health (Mordi and Ojo, 2011). Furthermore, the relationship between hours of work and perceived work-family conflict is a reflection of a women's subjected position within the prevailing dialogue of family and the inherent stress in violating the role of the '*good mother'* (Sawyer, 2010). Most pregnant women in Nigeria continue their work until the time of delivery, while

some have little or no time for rest; in addition, they may still have to keep working when they get home after office hours (Mordi and Ojo, 2011).

Poduval and Poduval (2009) argue that women try to maintain their position as mothers and sacrifice their rest in order to balance commitments both at home and in the workplace. Nevertheless, the adverse effect of this accumulated stress is that their health can be compromised (Sawyer, 2010). Idowu et al., (2011) added that this adverse impact on women's health is higher in the developing countries because of the cultural connotation of greater preferences for men in patriarchal societies. A patriarchal society describes a general structure in which men have power over women, while a society is the entirety of the relations of a community (Berlant, 2008). A patriarchal society consists of a male-dominated power structure throughout organized society and in individual relationships (Desmond, 1997; Wiegman, 2014). The concept of patriarchy has been central to many feminist theories. However, in today's more progressive Nigerian society, a few women work in executive positions, maintain leadership roles in organizations, and are often decision-makers in their households. In comparison, in rural areas, which is the focus of this study, women are not enlightened to take up leadership positions to allow for opportunities in decision-making (Idowu et al., 2011). Moreover, women taking employment leads to a reduction in the amount of time available to care for themselves, particularly during pregnancy (Idowu et al., 2011). In addition, increased workload amongst women is associated with increased risk factors for poor quality of health, which can lead to maternal death. Most women in developing countries face a huge manual workload, including housekeeping, childcare, cooking, fetching water and firewood, which may lead to chronic fatigue and other related health problems (Oxaal and Baden, 2006).

Working Conditions

The increasing rate of unemployment amongst men, as well as household economic pressures, has led to an increase in the number of women seeking paid jobs. Giddens (2012) noted that most households require income from both the husband and the wife so as to meet family demands. Moreover, Gallie (2013) suggests that the way work is organized, as well as its nature, is essential to both personal well-being and social cohesion. Most women from developed countries have access to a good job that can accrue income that will enable them to overcome poverty and work in safe conditions (Gallie, 2013). In most developing countries women concentrate more on traditional jobs that can only attract poor income and many of these occupations are not covered by a traditional and social protection system to guarantee their safety and access to healthcare (International Labour Organization (ILO), 2010). There are huge numbers of women working in unsafe and at-risk conditions, especially in African and Asia, where maternal mortality is rated the highest (ILO, 2010). In Asia and Africa, most women work in informal settings that lack protection for care during pregnancy, such as medium or small-sized industries, food factories, restaurants, and wine production factories (ILO, 2010). Not only do these women receive meagre pay from these settings but the working conditions to which they are subjected are very poor (Gallie, 2013).

In Nigeria, recent economic policies and the deregulation of the downstream oil sector could imply that many women will be forced to increase the number of hours they spend on household and other domestic work. The available literature indicates that efforts to reduce maternal mortality focus on health services and family planning but notes that mothers are also workers who need to be supported, to protect their health and guarantee their economic security during pregnancy and after birth (ILO, 2010).

The UN (2007) noted that women work more hours in most developing countries to meet their economic needs. The ILO (2010) noted that the key causes of maternal mortality are poverty, poor working conditions, and issues related to gender inequality. Judging from the available information so far recorded in this review, one would observe that women need more time for work. However, creating more time for work implies less time for rest and relaxation (Giddens, 2012). Giddens stated that, even where women have well-paid jobs, the organizations in which they work often seek to increase their size and efficiency by downsizing and streamlining, which creates fear and anxiety among employees over the security of their positions (Giddens, 2012). In this process, employee performances are then assessed and putting in a longer working day may be judged as working harder, hence offering a higher performance (Oxaal and Baden, 2006). The implication of this increased stress on women is that they require more time, as they tend to create unrealistic expectations.

The International Labour Organization (2010) noted that the importance of paid jobs in people's lives make it necessary to ensure that the quality of a work environment favours women's reproductive health as well as that of men. Poor working conditions can negatively affect the lives of both men and women. However, differences exist that are specific to gender, particularly to women workers, as there are specific issues associated with their biological make-up (Oxaal and Baden, 2006). Greater dangers are posed to women workers, as their physical and reproductive health may be severely affected by poor working conditions, while the state of pregnancy may also be threatened (Gallie, 2013). The ILO (2010) outlined issues relating to poor working environments that negatively affect maternal health, which include: poor wages, long working hours, lack of rest/break, hazardous working conditions and a lack of social protection. Pregnant women are expected to use the last three months of their

pregnancy to rest and increase their weight (Oxaal and Baden, 2006). However, this does not happen in most of the developing countries, as women continue their work until the time of labour, only to resume work shortly after childbirth (Oxaal and Baden, 2006). This can be severely detrimental to maternal health.

Social Support

Stress is noted as a socio-economic factor that influences individual health. However, its impact on an individual's health does not only depend on the nature of these stressful events, but also on the degree to which they are socially supported by both their family and relatives or other members of their social network (Stroebe, 2010). Findings from recent studies have reported a significant relationship between social support and mortality. A retrospective study by Akande and Owoyemi (2009) assessed the relationship between social support and mortality among men and women between the ages of 25-60 in a given Nigerian community. They revealed a positive association, as those within a low social network index expressed a higher risk of death than those with a higher score. Similarly, marital status, and a lack of support from their spouses, has been found to influence an individual's life. Babalola and Fatusi (2009) found that other aspects of women's lives are negatively affected by their conjugal relationships, as decision-making between spouses can have negative influences on women's health. Women's health can be negatively affected when their conjugal roles are deprived through strained relationships within marriages (Stroebe, 2010). This is evident when women in Nigeria seek divorce because they are not happy with their marriage or feel they did not make the right choice of husband (Babalola and Fatusi, 2009). Recent findings show that women who experience violence in their marriage are less likely to exercise sexual rights or be allowed to make appropriate decisions about their reproductive choices (Stephenson et al., 2008). Meanwhile, the way

women view their experiences during pregnancy differs. Although these feelings are normal, an individual woman might come to terms with changes in her own way, depending on the support available within the family or amongst relatives (Adindu et al., 2012). The degree to which an individual woman views the support available to her determines her coping ability in Nigeria (Ajiboye and Adebayo, 2012). Available evidence indicates that women who are offered stronger social support have a lower risk of physical impairment and mortality than those with weaker support (Adindu et al., 2012).

2.6 Summary of the chapter

This chapter presented a review of some background literature relevant to the research. The evidence shows that maternal mortality is high in Nigeria and one of the key reproductive health challenges. Despite the high rate of maternal death across all regions of Nigeria, the findings from the analysis of MDG 5 shows that Nigeria did not make good progress in the reduction of maternal mortality, unlike some other sub-Saharan African countries. It is, therefore, no longer satisfactory for women to continue to die while giving life, and a solution to reduce maternal deaths in Nigeria is vital. Also, because the number of pregnancies and childbirth will continue to rise in Nigeria and other sub-Sahara Africa countries (Renfrew et al., 2014), efforts are needed to make childbirth as safe as possible. It is reassuring to note that some women in some developing countries continue to experience safe childbirth with minimal risks. For instance, a confidential enquiry report into maternal death shows that less than 9 in every 100,000 women die in pregnancy and around childbirth (MBRRACE-UK, 2016). It is, therefore, possible for women in developing countries like Nigeria to experience safer pregnancy and childbirth.

Some of the causes of maternal mortality seem to be known in Nigeria but there is a need to explore the potential impact of the sociocultural context of maternal mortality in order to understand the root causes of maternal mortality. Evidence shows that culture influences maternal mortality in developing countries (Evans 2013, Say et al., 2014). It is, therefore, necessary to understand the social and cultural influences on the causes of maternal death in rural areas of Nigeria. This can make a vital contribution to the evidence-based development of Nigerian strategies. Moreover, WHO advised that interventions, policies, and strategies for the reduction of maternal death should be sensitive to the culture of its community.

CHAPTER THREE

SOCIAL AND CULTURAL FACTORS IMPACTING ON MATERNAL DEATH IN NIGERIA: A SCOPING LITERATURE REVIEW

3.0 Introduction

The previous chapter presented the global picture of maternal mortality, primarily highlighting the high numbers of deaths associated with pregnancy and childbirth, especially from women in low-income countries. It also began to identify some of the potential influences on, and causes of, this. This chapter presents the scoping literature review of social and cultural factors, focusing on Nigeria, which will provide the base, and therefore inform, the current study.

A scoping literature review is a method to assess the breadth and depth of literature in a particular field, such as midwifery (Brien et al., 2010; Pham et al., 2014). It provides an overview of a broad topic (Moher et al., 2015) and is deemed appropriate given that it aims to: identify the types of available evidence in a given field; clarify key concepts; examine how and what research has been conducted on a certain topic and identify and analyse gaps in the knowledge of a particular field (Munn et al., 2018). In addition, a scoping literature review also provides greater flexibility, and allows for the use of diverse relevant studies originating from diverse methodologies, which is mostly not feasible with other reviews, such as systematic and meta-analysis (Levac et al., 2010; Pham et al., 2014). Indeed, Davis et al., (2009) highlighted that a scoping review is a suitable alternative to a systematic review when the literature is vast, heterogenous and complex. Interestingly, several authors consistently pointed out that a scoping literature review can produce valuable evidence and provide a foundation

for further study that contributes to research, practice, education, and policy (Levac, et al., 2010; Rumrill et al., 2010; Tricco et al., 2016). However, scoping literature reviews have been criticised, due to variations in methodological rigour (Davis et al., 2009); therefore, the recommendations by Levac et al., (2010) on enhancing a scoping literature review methodology were utilised in this study. This chapter will identify, analyse, and critique existing literature on the social and cultural factors impacting maternal death in Nigeria, with the aim of identifying the research gaps and establishing a foundation to advance knowledge that is consistent with the aim of a scoping literature review.

3.1 Methodology of the scoping review

Similar with systematic processes completed in other types of review, the methodologies to conduct a scoping literature review, as developed by Arksey and O'Malley (2005), will be adopted for this review. This consists of the following six step process: identify the research question, identify relevant studies, select the studies, chart the data, and collate, summarise, and report the data; moreover, a seventh optional step includes consultation (Arksey and O'Malley, 2005).

Furthermore, some further recommendations published by other authors have been utilised to enhance and clarify the methodological framework when conducting a scoping review (Levac et al., 2010; Daudt et al., 2013). For instance, they recommend that the rationale of the scoping review should be explicit, whilst the research questions and target population should clearly articulate, and the concepts of interest defined in order to clarify the focus of the review and establish an effective search strategy. I, therefore, adopted the definition of maternal death presented in the background chapter (section 2.2). I have also utilised specific questions to guide

decision-making around the scope of this review. These review questions are described in the next section.

3.1.1 Step one: Identify the research question(s)

According to Munn et al., (2018) the key difference between a scoping and systematic review is the review question. In a scoping literature review, the research question is broad in nature because it seeks to provide breadth and depth of coverage (Arksey and O'Malley, 2005). Several scholars have highlighted that identifying the review question is fundamental in providing a roadmap for the subsequent steps of the scoping review (Arksey and O'Malley, 2005; Levac et al., 2010; Pham et al., 2014), implying that review questions must be clearly defined as they are contingent to the search strategy and will enable relevant decision-making to enable the success of other steps (Levac et al., 2010). Thus, the review questions are outlined below.

- What is known about the social and cultural factors impacting maternal death in Nigeria?
- How have the questions relating to social and cultural factors impacting maternal death been studied in Nigeria?

3.1.2 Step two: Identify relevant studies

This second step begins by identifying relevant research studies, which is followed by decisions on where to search for the literature, including the key search terms, language, and time span (Arksey and O'Malley, 2005).

Database to search

In this scoping literature review, relevant literature was identified by searching various electronic databases, manually looking through the reference lists of identified papers,

and by searching Google Scholar and key midwifery journals. This is shown in Table 3.1 below.

Table 3.1: Databases and other sources searched

S/N	**Search mechanisms**	**Examples**
1	Electronic databases: University of Salford database known as SOLAR Library Search	Intermid, Medline, CINAHL, Internurse, Science Direct, Web of Science, PubMed
2	Manual search	Reference lists of the key empirical papers and all review papers, African Journal of Midwifery, British Journal of Midwifery, Global Women Health, African Journals online, Journal of West African College of Nursing
3	Search engine	Google Scholar

Search terms and strategy

The keywords searched across the above sources include: maternal death, the death of women, midwife, Nigeria, pregnancy, childbirth, factor, women's view, complications, belief, culture, maternal mortality, maternal health, spiritual, religion, obstetrics, trends, maternal health utilisation, barriers, sociocultural, social, cultural, community perception, socio-cultural, causes, reduction, and preventive measure.

The search strategies utilised in this review were as follows: Electronic searches across different databases using key term phrases as a single search, and a combination of key terms used in different ways with Boolean operators, truncations, and wildcards symbol. The Boolean operators used were 'AND' 'OR' and the truncation symbol used was '&', whilst the wildcard symbols used were '#', '$', and '*'.

These helped to expand the search when combined with relevant keywords, which yielded better and broader results. Furthermore, manual searches and citation tracking was conducted on the reference list of articles identified from the electronic search, whilst specific journals searches were also undertaken. Finally, Google Scholar and some key African Journals were searched to ensure that articles not indexed in the databases consulted were also retrieved and included.

Time span and Language

Levac et al., (2010) emphasised that balancing breadth and comprehensiveness in a scoping review with the feasibility of resources and the practicalities of the search was one of the challenges of identifying relevant studies when conducting a scoping literature review. Decisions regarding the literature retrieval timeframe were challenging because there is no generally accepted period for a scoping review. It could therefore encompass nine, ten years or more, and could depend on, though not be limited to, resource availability, the amount of literature, and the reviewer's expertise (Khanlou et al., 2017; Machiyama et al., 2017; Woodman et al., 2019). The literature published in English between January 1998 and December 2018 was searched and included. This decision was based on evidence that empirical research on the social and cultural factors impacting maternal mortality in Nigeria was first published in 1998 (Okolocha et al., 1998).

3.1.3 Step three: Study selection

The study selection was based on inclusion and exclusion criteria, as recommended by Arksey and O'Malley (2005), and shown in Table 3.2.

Table 3.2: Eligibility criteria

Inclusion criteria	Exclusion criteria
• Paper published in English language • Empirical studies published between January 1998 and December 2018 • Empirical studies that use a qualitative, quantitative, or mixed design to address social and cultural factors impacting on maternal death in Nigeria • Studies conducted in Nigeria irrespective of population group but that focus on social and cultural issues impacting maternal mortality	• Not published in English • Non-empirical studies, such as editorial, reviews, opinions of healthcare providers were not included in the study. This is the reason papers from these sources originating from Nigerian context are mostly published in predator journals, thus the evidence from such sources is arguably not trustworthy • Studies not focused on social and cultural factors in Nigeria • Studies using secondary data from Nigeria Demographic and Health Survey

3.1.4 Step four: Charting the data

Data from the included articles were charted in relation to the author(s), publication year, country, title, methodology, aim/objectives, and relevant key findings. The table in **Appendix 1 presents the data extraction for articles that met the inclusion criteria.**

3.1.5 Step five: Collate, summarize, and report the results

As shown in the PRISMA diagram in Figure 3.1, 9,738 articles were originally identified and after duplicates and articles that did not meet the inclusion criteria were removed, 41 papers were identified as eligible for inclusion in the review. Guided by the inclusion and exclusion criteria stated above, the selection process involved the initial assessment of the title and abstract of all 41 articles, which were evaluated for relevance. The articles considered to meet the inclusion criteria at this stage were further assessed by reading the full text; this led to a further selection of papers. A

quality assessment for these studies was not conducted because it is not a required element of a scoping review; instead, I focused on comprehensiveness and breadth, which are the important elements in a scoping literature review (Arksey and O'Malley, 2005; Brien et al., 2010).

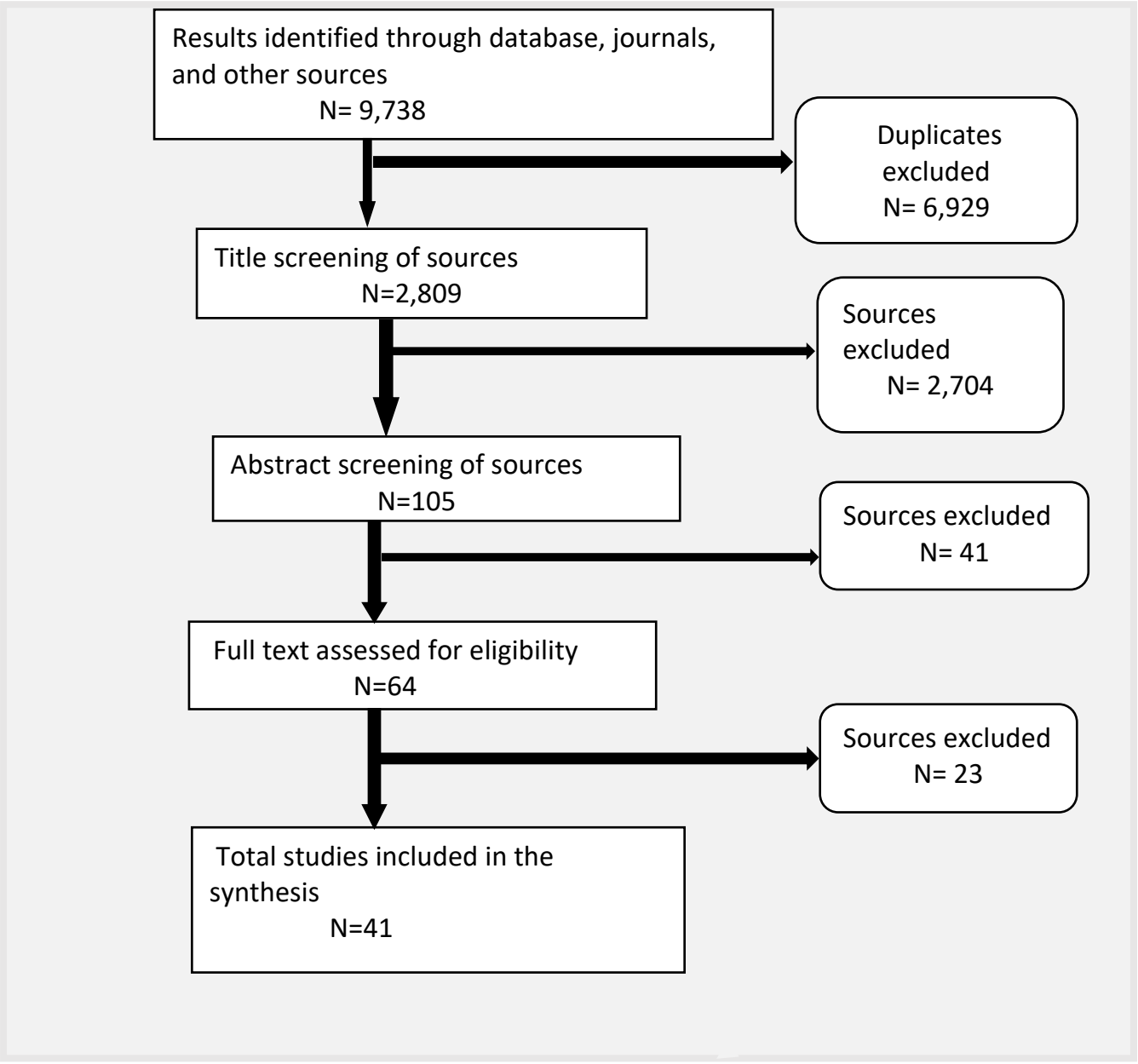


Figure 3.1 Literature identification and selection process

3.2 Findings

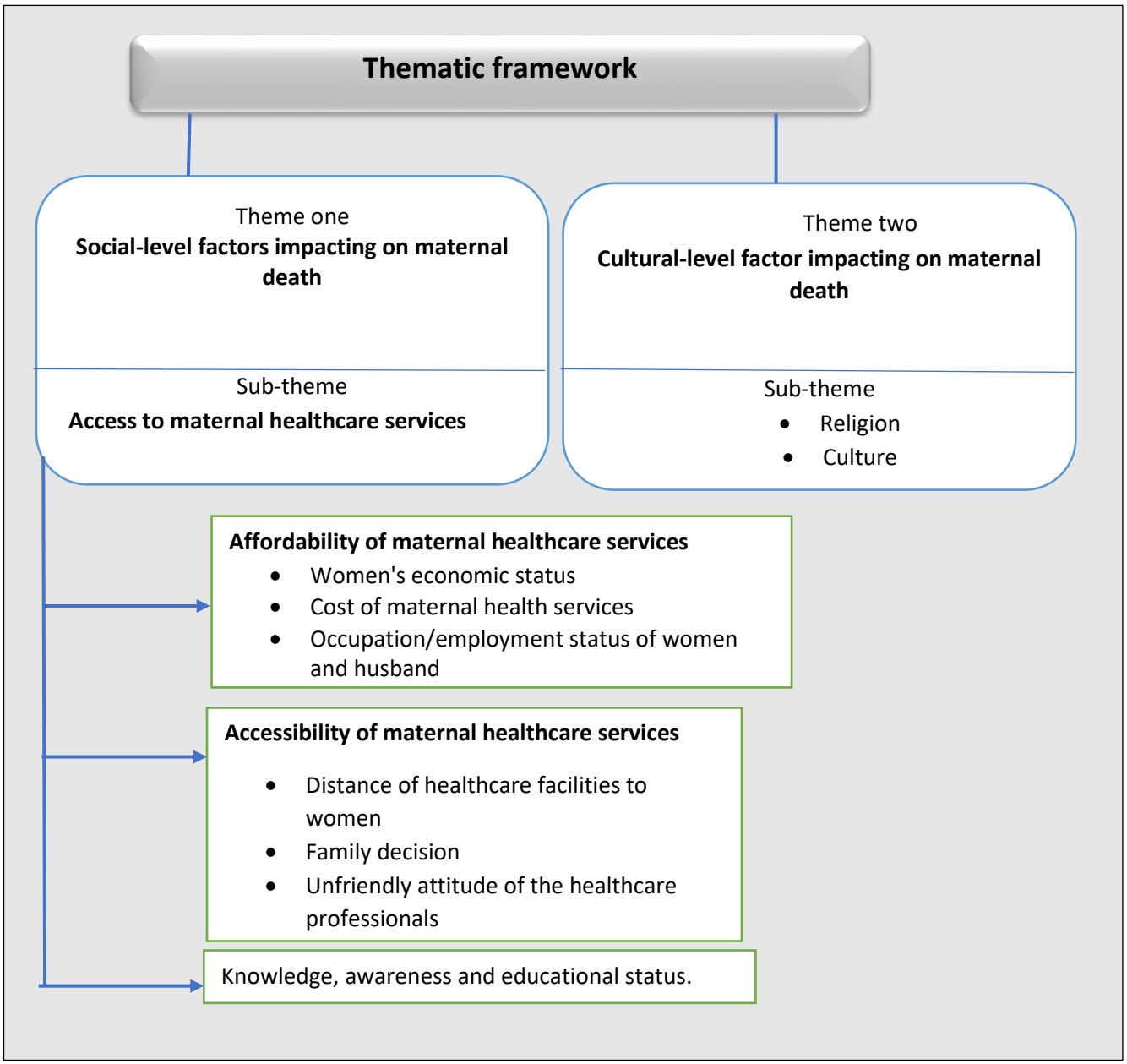
A descriptive ‘thematic summaries’ narrative approach was applied to analyse the papers included in the review (Snilstveit et al., 2012). This approach has been utilised by previous researchers to synthesise findings of a scoping review (Yeheskel and Rawal, 2018). It is useful in providing an overview of the breadth and depth of what has been done in line with the aim of a scoping review, as recommended by Arksey and O’Malley (2005). Specifically, the papers were read several times to develop greater familiarisation and understanding. Again, using the data extraction sheet, codes were generated inductively by reading the papers. The codes were then reviewed to arrive at a single pattern that portrayed single ideas, which formed themes,

as shown in Figure 3.2. Relevant findings from the analysed research were utilised to form narratives within the identified themes. A data extraction table from the selected papers can be found in Appendix 1.

Figure 3.2: Themes and Sub-themes

3.2.1 Theme one: Social-level factors impacting on maternal death

The theme named 'social-level factor' comprised of the subthemes or issues within



social boundaries with direct or indirect influences on the utilisation of maternity care. This theme is presented with a subtheme named 'access to maternal healthcare

services. This subtheme was further grouped into three categories comprising issues related to affordability as well as the accessibility of maternal healthcare services and women's knowledge, awareness, and educational status, as shown in Table 3.3.

3.2.1.1 Access to maternal healthcare services

Thirty-three studies originating from a Nigerian context found that access to maternal healthcare services was contingent on the distance from healthcare centres/hospitals, the affordability of maternal healthcare services in terms of cost of care, and women's economic status, age of marriage and employment status/ occupation of the women and/or their husbands. This subtheme, named 'access to maternal healthcare services', will be presented in three sub-headings for better understanding and clarity.

Affordability of maternal health services

The affordability of maternity care was one of the dominant issues featuring in 24 papers and was found to be conditioned by the complex interactions of women's economic status, the cost of maternal health services, women's occupation and/or employment status or that of their husbands. Six studies, conducted in Plateau, Oyo, Rivers Kano, and Kastina, used a descriptive survey design and found that women's poor economic status was one of the fundamental reasons why an overwhelming number of pregnant women had not sought maternal healthcare services (Adamu and Salihu, 2002; Adegoke et al., 2010; Moore et al., 2011; Ewa et al., 2012; Envuladu et al., 2013; Adewemimo et al., 2014). Other papers that utilised interviews and focus group discussions to collect data from pregnant women similarly found that poor economic status was a contributory factor to the low utilisation of midwifery services (Yar'zever and Said, 2013; Okafor et al., 2014; Azuh et al., 2014a; 2016; Okonofua et al., 2017). Another study that recruited participants from three northern states of

Nigeria (Kastina, Yobe, Zamfara), utilised quantitative surveys to collect data from 6,882 married women as well as qualitative methods (interviews, focus group discussion) to elicit information from community and local government leaders, healthcare providers, traditional birth attendants, and women who had sought midwifery services, found that the lack of financial ability to pay for the cost of care and to get to the hospital discouraged women from seeking maternal healthcare services (Doctor et al., 2012). Evidence from these studies implies that the inability of women to pay the cost of antenatal and postnatal care influenced their negative attitude towards utilising midwifery care. However, a descriptive cross-sectional study by Akinwaare and Adejumo (2015) reported a contrary finding that no statistically significant relationship was found between women's economic status and their choice of place of birth. However, in another study, 18 out of 395 women reported that 'no money' was one of the reasons for the choice of place of birth (Akinwaare and Adejumo, 2015), which supports the findings of studies reported earlier (Doctor et al., 2012; Okafor et al., 2014; Okonofua et al., 2017).

Although the descriptive study designs by Dairo and Owoyokun, (2010) and Ndikom et al. (2017), which were both conducted in Oyo state, reported no statistical relationship between the income of women or their husbands and their choice of health care providers, 58.4% of 400 women who participated in the study by Dairo and Owoyokun, (2010) reported that their inability to afford the cost of antenatal care was the reason for the non-utilisation of this service. On the other hand, the study by Ndikom et al. (2017) showed that, although the high cost of care limited some women's access to midwifery services and choice of healthcare provider, women considered a healthy outcome as a priority that shaped their choice of place for maternal health services. Notably, the income and occupation of women of childbearing age and their

spouses were found to be connected to women's economic status (Ibor et al., 2011; Envuladu et al., 2013; Yar'zever and Said, 2013; Adewemimo et al., 2014; Azuh et al., 2014a; Ibrahim, 2016; Oyetunde and Eleri, 2014). However, Adewemimo et al. (2014), who utilised both open and close-ended questionnaires in their study, found that women's occupation was not associated with their use of skilled birth attendants in Kastina State of Northern Nigeria. Instead, their level of education and knowledge had a greater impact on their use of midwifery services. Overall, a high number of women in both rural and urban areas were reported to accept and prefer maternal healthcare service in a hospital, but utilisation was unfortunately limited by their financial circumstances and other factors reported below (Ibor et al., 2011; Yar'zever and Said, 2013; Okafor et al., 2014 Akinwaare and Adejumo, 2015).

Although a household's poor social economic status impacted on the utilisation of maternal healthcare services, several other papers that utilised descriptive cross-sectional designs and questionnaires as data collection methods found that the perceived high cost of maternal healthcare services in hospitals further impacted the use of antenatal and postnatal care services (Onah et al., 2006; Osubor et al, 2006; Iyaniwuru and Yussuf, 2009; Dairo and Owoyokun, 2010; Envuladu et al., 2013; Odetola, 2015; Azuh et al., 2017a; Azuh et al., 2017b; Anastasia et al., 2017). This promulgated and faciliated the attitude of most women to either give birth at home without assistance or at spiritual homes and other non-orthodox centres perceived to be cheaper or compared with orthodox maternal healthcare services (Iyaniwuru and Yussuf, 2009; Doctor et al., 2012; Okafor et al., 2014; Akinwaare and Adejumo, 2015; Ndikom et al., 2017; Azuh et al., 2017a). In addition, several studies in Nigeria which used descriptive cross-sectional designs conducted across many parts of Nigeria similarly showed that many women considered their ability to pay for services as well

as the quality of services, complications, the opinion of others, the availability and accessibility of professionals, healthy outcomes, the safety and cleanliness of a hospital in their decision to seek antenatal care services and delivery in hospitals or maternity homes (Utoo and Utoo, 2013; Azuh et al., 2015; Alenoghena et al., 2015; Akinwaare and Adejumo, 2015).

Finally, the findings from the reviewed papers showed that many women still patronise the services of unskilled attendants during pregnancy and childbirth. Specifically, the study by Doctor et al., (2012) reported that, although many women in northern Nigeria attended antenatal care they did not deliver in the hospital for various reasons, such as the perception that it did not fit their way of life, and to avoid the shame of exposing their body to a male healthcare provider. The lack of hospital childbirth and other maternal services was reported as linked with high maternal complications, such as prolonged labour, lacerations, fetal distress, retained placenta, and bleeding, which saw the highest occurrences (Adamu and Salihu, 2002; Adewemimo et al., 2014; Azuh et al., 2014; Ndikom et al., 2017; Okonofua et al., 2017), and could lead to maternal death in Nigeria (Ajiboye and Adebayo, 2012; Okonofua et al., 2017).

Accessibility of maternal health services

Twenty-nine of the articles included explicitly discussed the accessibility of maternal healthcare services; this was influenced by the proximity to healthcare/maternity centres, family decisions, and the unfriendly attitudes of healthcare professionals. In studies conducted in various parts of Nigeria, such as Rivers, Kano, Ogun, Kastina, Yobe, Zamfara, Enugu, Plateau, Lagos and Oyo State, the long distance of healthcare facilities to women was found to be significant in shaping their attitude to utilising maternal healthcare services (Adamu and Salihu, 2002; Onah et al., 2006; Iyaniwura

and Yussuf, 2009; Dairo and Owoyokun, 2010; Moore et al., 2011; Doctor et al., 2012; Ewa et al., 2012; Adewemimo et al., 2013; Envuladu et al., 2013; Utoo and Utoo, 2013; Yar'zever and Said et al., 2013; Azuh et al., 2014; Akinwaare and Adejumo, 2015; Odetola, 2015; Ibrahim, 2016; Ndikom et al., 2017; Anastasi et al., 2017; Azuh et al., 2017a). It was reported that some pregnant women would need to travel, mainly by foot, for up to 2-10 kilometres or more from their homes in order to access maternal healthcare services, such as antenatal care (Ewa et al., 2012; Azuh et al., 2014; Odetola, 2015; Azuh et al., 2017; Azuh et al., 2017b). However, the distance to a health facility was not reported as statistically significant in a population-based survey that used structured questionnaires to collect data from 400 Muslim women from Funtua Local Government Area (LGA) of Katsina state in Northern Nigeria (Adewemimo et al., 2013). This finding was because 343 of the 400 participating women were reported to reside within a 30-minute walking distance of facilities (Adewemimo et al., 2013), thus explaining why distance was not a significant factor impacting the use of maternal healthcare services. Moreover, Azuh et al., (2017a, 2014) and Ibrahim (2016) reported that statistical analysis indicated that the proximity to healthcare facilities has a negative influence on pregnant mothers' use of maternal healthcare services. Significantly, these two studies were conducted in a rural community whereby pregnant woman would need to travel long distances to access maternal healthcare services.

The distance to healthcare facilities was further complicated by poor road networks, a lack of money to pay for transportation, a lack of means for transportation, a lack of ambulance for obstetric emergencies, seasonal problems such as being cut off by fast-flowing rivers, security concerns, especially when labour started at night, and the refusal of commercial drivers to accept passengers with obstetric complications

(Iyaniwura and Yussuf, 2009; Moore et al., 2011; Doctor et al., 2012; Yar'zever and Said et al., 2013; Adewemimo et al., 2013; Azuh et al., 2014; Azuh et al., 2017b). These problems therefore compelled pregnant women to seek maternity services from traditional birth attendants who live in their neighbourhood (Salako et al., 2006; Ewa et al., 2012; Azuh et al., 2014; Odetola, 2015; Azuh et al., 2017a). This predisposes a pregnant woman to seek care with providers whose activities could contribute to avoidable death of women during pregnancy, childbirth, and puerperium because they lack adequate skill to manage pregnancy and childbirth. However, the study by Marchie (2012), who used married women of reproductive age as participants from urban and rural areas of Edo South Senatorial District, reported contradictory findings, namely that the majority of participants stated they had access to means of transportation whenever they needed to seek maternity care at a health facility. She further reported that roads both in urbans and rural areas were in a good condition and accessible by vehicles, and thus concluded that the means of access to maternity care by participants does not make a significant contribution to maternal mortality (Marchie, 2012). This importantly revealed that the determinants of, and influences on, maternal death could vary within different parts of Nigeria.

In addition to the proximity of the healthcare facility, family decision-making was consistently reported as significant in several papers influencing where and when women accessed healthcare services during pregnancy, childbirth, and the post-natal period. For instance, several descriptive cross-sectional studies that utilised questionnaires to collect data from their respondents found that the majority of the women highlighted that their husbands, other family members and friends made decisions about where and when to seek maternity care (Osubor et al., 2006; Iyaniwura and Yussuf, 2009; Adewemimo et al., 2013; Akinwaare and Adejumo, 2015;

Anastasi et al., 2017; Azuh et al., 2017; Ndikom et al., 2017). This decision often related to a refusal to use modern maternal health services, and instead women sought maternity care with traditional birth attendants (TBAs) to please their husbands and other relatives (Adamu and Salihu, 2002; Salako et al., 2006; Ewa et al., 2012; Doctor et al., 2012; Yar'zever and Said et al., 2013; Azuh et al., 2014). The reasons given were that TBAs were perceived to be cheaper and to possess special skills to administer the care believed to prevent complications during childbirth (Salako et al., 2006; Ewa et al., 2012; Okafor et al., 2014; Ndikom et al., 2017). Other reasons for seeking care from TBAs include the perception that they could cure some diseases that the healthcare professional would be unable to manage, they could assure privacy for women, offer a traditional approach to care, and incur shorter waiting times (Salako et al., 2006; Ewa et al., 2012; Okafor et al., 2014; Ndikom et al., 2017). However, some women in the study that was conducted in Kastina, Yobe and Zamfara states which are all in Northern Nigeria, mentioned that their spouse and their family approval were enablers for childbirth in a hospital (Doctor et al., 2012; Adewemimo et al., 2013).

Finally, it was found in several articles that the attitude of maternal healthcare professionals in the hospitals were important to women in their decision for maternity care during pregnancy and childbirth. Specifically, unfriendly, or bad attitudes amongst maternal healthcare providers, such as nurses, midwives, and doctors, was identified as a factor that impeded any willingness to use modern healthcare services and this contributed to maternal mortality (Adegoke et al., 2010; Dairo and Owoyokun, 2010; Moore et al., 2011; Adewemimo et al., 2013; Envuladu et al., 2013; Utoo and Utoo, 2013; Akinwaare and Adejumo, 2015; Okonofua and Ogu, 2017). This was contrary to a finding from a descriptive cross-sectional study by Egharevba et al. (2017) that utilised structured questionnaires to collect data from 200 pregnant women in a faith-

based hospital located in Ebonyi State, which found that women attending antenatal clinic were satisfied with the service received from maternal healthcare providers. This finding could be connected to the reason that hospitals used for this study were part of a profit-making organisation, thus the healthcare would be expected to be friendly to the service-users in for it to attract them to seek healthcare service and thus maximise profit.

However, a descriptive study by Ndikom et al., (2017), who adopted questionnaires for data collection, and a qualitative study by Okonofua and Ogu, (2017) clearly showed that the majority of women perceived that midwives and nurses were wicked, abusive, unfriendly, disrespectful, and uncaring. This was contrasted with TBAs whose approach to care, communication pattern and attitude was understood to be more favourable (Ndikom et al., 2017). Interestingly, most of the women who participated in the study by Akinwaare and Adejumo, (2015), Oyetunde and Eleri, 2014, Iyaniwura and Yussuf, (2009) and Osubor et al., (2006) also highlighted that a good approach by healthcare workers, is a determining factor for their choice of place of birth, thus highlighting the relevance women attach to how they are being treated during maternity services. However, a high number of women in the study by Doctor et al. (2012) considered the attitudes of healthcare workers as unimportant in their decision to use maternal healthcare services. Notably, only two studies (Adegooke et al., 2010; Okonofua and Ogu, 2017) utilised a qualitative approach while other studies employed questionnaires as the method of data collection. Due to the methodology limitations of these studies, this could imply that there is limited knowledge about what is known regarding the influence of maternal healthcare professionals' attitudes. This limitation and other methodological issues are discussed further at the end of this section.

3.2.1.2 Awareness, Knowledge, and educational status

The influence of awareness, knowledge and the educational status of women and their households on maternal healthcare utilisation was reported in the 29 papers included in this review. Most of the women of childbearing age in the study conducted at Ogun and Kano State were reported to have admitted that their awareness and knowledge of the place and programs contained in maternal care services influenced theor decisions (Ewa et al., 2012; Yar'zever and Said, 2013; Azuh et al., 2014; Azuh et al., 2017a; Azuh et al., 2017b), although access was limited by the previously discussed issues, such as high cost of care. Nevertheless, a few of the women were unaware of places to seek maternal healthcare service (Ewa et al., 2012; Azuh et al., 2017b). In addition, 112 out of 156 women in the descriptive cross-sectional study conducted in Oyo state thought that ignorance was why women patronise the service of traditional birth attendants (Ndikom et al., 2017). Ignorance or a lack of knowledge leading to the delay or non-use of maternal services was also found to be among the reasons why women die during pregnancy, childbirth, and puerperium (Okonofua et al., 2017).

Remarkably, it was found that age at marriage was linked to knowledge of maternal healthcare services in Kano, as most women were reported to have married at under 18 years, especially in rural areas (Yar'zever and Said, 2013). Plausibly, women at this age would be prone to more complications during pregnancy and childbirth especially if maternal care services were not utilised. However, in considering knowledge, the findings by Okolocha et al., (1998), Osubor et al., (2006) and Azuh et al., (2017b) reported that many of their respondents knew at least one cause of maternal mortality. The mixed method pilot study conducted by Adegoke et al., (2010) in Oyo State and a study by Okonofua et al., (2017) in various hospitals situated in the four geopolitical zones in Nigeria similarly showed that some of their respondents

identified medical causes of maternal death to include issues such as haemorrhage, complications from caesarean sections, malnutrition, anaemia, eclampsia, malaria, prolonged labour, retained placenta, and underlying diseases. Arguably, this shows a fair degree of knowledge about the medical causes of maternal mortality. Notably though, these complications were perceived to have either spiritual/traditional or physical/natural aetiology or origin (Osubor et al., 2006). Spiritual complications, such as threatened abortions, recurrent abortions and repeated seizures during pregnancy or childbirth were believed to be caused by witchcraft, which was understood to be best treated by traditional maternal healthcare providers or spiritualists. In comparison, natural complications were thought to be better handled by healthcare providers such as midwives (Osubor et al., 2006).

Moreover, poor knowledge and awareness appeared to be due to women's educational status. For instance, several papers revealed that most of the women attained primary and secondary levels of education and that many of these women hold no formal educational qualifications (Ejidokun, 2000; Onah et al., 2006; Envuladu et al., 2013; Adewemimo et al., 2014; Azuh et al., 2014; Oyetunde and Eleri, 2014; Alenoghena et al., 2015; Ibrahim, 2016; Azuh et al., 2017a;). Notably, the location of the study (either rural or urban) and the states where the study was conducted were factors that appeared to contribute to the potential differences in women's levels of education across the included papers. For instance, the study by Egharevba et al., (2017) conducted in Ebonyi State, which one of the newest states in Nigeria, found that 23.78% of 200 pregnant women of child-bearing age acquired a post-secondary level of education. However, the percentage of women who acquired a post-secondary level of education was higher in studies conducted in older states in Nigeria. For instance, studies carried in Oyo and Anambra state respectively reported that 28.1%

of 231, 37.5% of the 328, 45% of 302 and 83.5% of 156 women of child-bearing age had a tertiary education (Ibor et al., 2011; Emelumadu et al., 2014; Odetola, 2015; Ndikom et al., 2017). These states were created several decades ago and are more educationally developed. Other studies in some areas showed very few or no women with tertiary educational level attainment (Envuladu et al., 2013 Adewemimo et al., 2014; Azuh et al., 2014; Oyetunde and Eleri, 2014; Alenoghena et al., 2015).

Statistically, educational status was said to be positively associated with the use of maternal care services, implying that women with a higher level of education were more likely to utilise healthcare facilities for maternal healthcare services (Onah et al., 2006; Marchie, 2012; Yar'zever and Said, 2013; Adewemimo et al., 2014; Azuh et al., 2014; Emelumadu et al., 2014; Akinwaare and Adejumo, 2015; Egharevba et al., 2017; Azuh et al., 2017b). The findings that women's level of education informed their positive choice and utilisation of maternal healthcare services may not be surprising, as Odetola (2015) argued that women with a higher education level are likely to gain good employment, and thus will earn more to afford the cost of maternal care. As such, they are thereby empowered to overcome most of the obstacles pertaining to accessibility, as previously discussed. In agreement with Ibrahim, (2016), these findings imply that educational status contributes significantly to maternal mortality. Studies by Envuladu et al., (2013) and Emelumadu et al. (2014) offering further evidence found that women with either no formal education or primary school level were more likely to give birth at home or with TBAs. However, two studies (Oyetunde and Eleri, 2014; Azuh et al., 2015) found no statistically significant relationship between their respondents' level of educational attainment and their use of maternal healthcare services. Notably, the study by Azuh et al., (2015) showed that 10 out of 260 participants had attained a post-secondary level of education while that of

Oyetunde and Eleri, (2014) show that about 15% of their study population achieved a higher level of education. Azuh et al., (2015) assumed that this finding could be due to the strong influence of gender roles and other cultural complexities because many people in Nigeria tend to consider cultural understandings over western acquired knowledge in decision-making. This implies that research is required in Nigeria to explore how factors other than education, such as cultural beliefs, could be impacting the utilisation of midwifery services and thus contributing to maternal mortality.

Synthesis of theme one

Theme one shows that social-level determinants impacting on maternal death encompassed complex interactions of the main issues pertaining to knowledge, affordability, and the accessibility of maternal care services. Based on evidence from the papers reviewed in this theme, it can be deduced that awareness and knowledge, which were determined by the women and their spouse's level of education, were contingent to most of the issues related to affordability and accessibility. For instance, most of the studies consistently found that when women and their husbands had a higher level of education, they were more likely to be employed and therefore receive income. To further understand this finding, Ajzen's (1985) Theory of Planned Behaviour argued that the extent to which people have the requisite resources and consider that they can manage any obstacle they may encounter will boost their confidence in performing an action or behaviour. Thus, most women and their families who earn an income are potentially able to overcome financial barriers, such as service and travel costs, especially where a healthcare facility is far from their place of living. This shows that income increases female autonomy and favoured positive decision-making in the uptake of maternal healthcare services (Matsumura and Gubhaju, 2001). Therefore, this increases the utilisation of maternal healthcare and

reduces the likelihood of maternal death during pregnancy, childbirth, and the puerperium. However, the finding from this review also showed that decision-making on the use of maternal healthcare services was also associated with poor road conditions, the effect of age at marriage, family decision-making and the unfriendly attitudes of healthcare professionals, which reveals the complexities surrounding the use of maternity care and maternal mortality.

Most studies reviewed on this theme used quantitative methods, adopting questionnaires for the data collection; however, a few recent studies have utilised qualitative approaches (Adegoke et al., 2010; Doctor et al., 2012; Okafor et al., 2014; Azuh et al., 2017; Okonofua et al., 2017). The use of quantitative methods in most of the studies were useful as they revealed a statistical association between women's socio-demographic information and their attitude to the uptake of maternity services. However, the methodological limitations of a cross-sectional research design could indicate alimited understanding about most of the issues related to social-level determinants impacting on maternal death. For instance, women had no opportunity to explain what unfriendly attitudes were and how these impacted on them, due to the methodological limitations (use of questionnaires). Instead, the researcher assessed what they considered important, without giving providing a space for the women to tell their stories. Finally, most of these studies were conducted in states within either Northern or Southern Nigeria. This clearly shows a dearth of evidence in the Eastern part of Nigeria.

3.2.2 Theme two: Cultural-level factors impacting on maternal death

This theme, named 'cultural-level factors', comprised the two key identified issues, which are culture and religion. These had a direct or indirect impact on the utilisation of maternity care and were capable of leading or contributing to maternal death during

or after pregnancy and childbirth. The findings related to these are explicitly shown in the 20 articles included in this study and are considered below.

3.2.2. 1 Religion and culture

The affiliation of women to religion, such as Christianity, Islam, and African traditional religion, was documented across many of the articles included in this review. It was noted that a relationship exists between women's religion and their utilisation of maternal healthcare services. For instance, it was reported that 57 out of 1000 women in the descriptive study conducted in Kano state selected religious reason as the reason why they did not utilise maternal care services (Yar'zever and Said, 2013). Notably, the use of a questionnaire in this study did not offer an opportunity for participants to provide more information about their religious reason. In addition, some studies (Ona et al., 2006; Iyaniwura and Yussuf, 2009; Dairo and Owoyokun, 2010; Ibor et al., 2011; Akinwaare and Adejumo, 2015; Anastasia et al., 2017; Ndikom et al., 2017) reported that compliance with religion and culture, and cultural beliefs were some of the reasons for the choice of place of birth and the use of TBAs by women. The use of a structured questionnaire in all these studies (Ona et al., 2006; Iyaniwura and Yussuf, 2009; Dairo and Owoyokun, 2010; Ibor et al., 2011; Akinwaare and Adejumo 2015; Ndikom et al., 2017; Anastasia et al., 2017) implies that the respondent had no opportunity to provide an explanation regarding these religious and cultural reasons or beliefs. Statistically, it was reported that women who are traditional worshippers were unlikely to have utilised maternal care services compared with Christian and Muslim women (Iyaniwura and Yussuf, 2009). This is probably because traditional worshippers would be more likely to seek care from a TBA because their services are aligned with their traditional or cultural beliefs. In studies conducted in Enugu and Ogun States (Ona et al., 2006; Salako et al., 2006) more Christians than

Muslims gave birth in healthcare facilities, possibly because these are Christian predominant states. However, Dairo and Owoyokun, (2010) reported that Christians were less likely to attend ante-natal clinics compared with Muslims, which could be attributed to the larger number of Muslims consulted in this study in Oyo state.

However, the quantitative aspect of the studies conducted in Oyo, Kano and Edo States provide further information about religion, and reported that some participants, irrespective of their level of education, perceived that maternal mortality could be caused by spiritual attacks, evil spirits, God's wishes, God's wrath, prayerlessness, and a loss of faith in God (Adamu and Salihi, 2002; Osubor et al., 2006; Adegoke et al., 2010). These and other studies further highlighted that participants commented that it was due to the will of God that women died during pregnancy or childbirth as they were destined to die (Adegoke et al., 2010; Okonofua et al., 2017). Furthermore, in another descriptive cross-sectional study conducted in Cross-River State, trust in God for safety was highlighted as a religious reason for giving birth outside orthodox centres in another descriptive cross-sectional study conducted in Cross-River State (Utoo and Utoo, 2013). A qualitative study by Okonofua et al., (2017) conducted in hospitals located across seven states (Kano, Kaduna, Oyo, Ogun, Niger, Delta, and Edo) situated within four (North-West, South-West, North-Central and South-South) out of the six geopolitical regions of Nigeria, found that maternal death was associated with a lack of divine protection by participants. Thus far, all papers that reported findings on the influence of religion on maternal deaths utilised structured questionnaires for their data collection; the main exception to this was the study by Okonofua et al., (2017). This implies that there is limited in-depth knowledge about participants' understandings of how religion impacts on maternal death.

In addition to the influence of religion on attitudes towards the uptake of maternal healthcare, cultural beleifs were reported to significantly influence the uptake of maternal healthcare services (Ibor et al., 2011), and therefore contributed to maternal mortality. Adegoke et al., (2010) and Marchie (2012) reported that cultural issues, such as early marriage, female genital mutilation, and polygamy, were identified as causes of maternal mortality. However, no explanation was provided about these cultural issues, which is possibly due to the limitations regarding the use of structured questionnaires to elicit data. Nevertheless, another similar study that utilised both questionnaires and interviews found that women from northern Nigeria (Kastina, Yobe and Zamfar states) considered that male maternal healthcare providers were un-cultural and such women indocated that they would instead return home rather than receive maternity care from a man (Doctor et al., 2012). This probably explains why male midwives are not desirable in some Nigerian societies.

A study conducted more than two decades ago in Ekpoma situated in Edo State Nigeria, elicited information about the socio-cultural factors that influence maternal mortality. This study found that haemorrhages were suffered by women who were believed to have committed an offence, such as adultery, illicit sex, or disobedience to their husband, alternatively it was suggested that this was the will of God or that participants further believed that orthodox maternal care could proffer solutions to complications arising from evil forces, eating sweet food, indulgences, or providence (Okolocha et al., 1998). A year later, a similar study conducted in Lagos utilised various qualitative approaches, such as observation, focus group discussion and interviews, to elicit information from their participants. It was found that participants thought a pregnant woman was culturally mandated to visit a traditional healer, who would perform incarnations regarding her pregnancy and decide the outcome of the childbirth

(Ejidokun, 2000). It was further reported that participants said advice to pregnant woman was given, such as taboos in pregnancy including the avoidance of some food items, not being allowed to go out at mid-day or after dark, and the advice to carry sharp objects as she moves about her daily activities (Ejidokun, 2000).

More recently, another study conducted in Lagos State utilised a focus group discussion to gather information from their participants; this also reported participants' emphasis on the role of traditional beliefs, such as an herbal concoction to prevent maternal complications during pregnancy and childbirth and to promote healthy pregnancies as they progress through the stages of pregnancy until birth (Okafor et al., 2014). It was further reported in another study conducted in Ogu community in the Badagry area of Lagos State that participants believed every pregnant woman must undergo a cultural ritual, and women that failed to participate in such rituals would experience a negative birth outcome, such as giving birth through caesarean section and/or maternal death (Abimbola and Ajiboye, 2012). It was also reported that a higher number (83.1%) of respondents disagreed that cultural practices could have negative impact on pregnancy outcomes (Abimbola and Ajiboye, 2012). It indicates that these participants lacked insight on the impact of culture on maternal mortality. However, in a qualitative study conducted in Ekpoma in Edo State, Mboho et al., (2013) found that pregnancy and childbirth was perceived by participants to be an inevitable destiny/gift from God and that children provided economic and social security to their parents, especially during their old age.

The impact of religion and culture means that women who subscribed to these beleifs sought maternal care either through traditional or religious therapies. One example is a written prayer dissolved in water, which is given to pregnant woman to drink in line with Islamic religious rites (Okonofua et al., 2017). Pregnant women were also

reported to have sought care with TBAs who they perceived to have skills to manage some traditional illnesses unlike midwives and doctors (Mboho et al., 2013; Okafor et al., 2014). However, pregnant women seeking care with TBAs could mean that they will be prone to the mismanagement of pregnant and labour, thus leading to the possibility of an avoidable maternal death. In summary, this review clearly shows that in-depth research, especially about the influence of religion and culture, is lacking in the South-Eastern region of Nigeria. This will be further highlighted in the following section.

Synthesis of theme two

This theme shows that, across different parts of Nigeria, religion and culture were relevant in shaping attitudes and behaviour towards the uptake of maternal healthcare service and how this can contribute to maternal mortality. For instance, several studies reported that religion was the reason why women did not utilise maternal care services, but these studies did not explain specific detail about how religion impacted maternal death, possibly due to methodological limitations associated with the use of structured questionnaires. There were only a very few qualitative studies conducted in a small number of states within Northern and Southern Nigeria that provided further detail and in-depth knowledge about participants' perceived causes of maternal mortality and the relationship to their religious worldview.

Furthermore, nine studies explicitly recognised that cultural issues impacting on maternal healthcare utilisation had negative consequences on maternal mortality. Two of these studies (Adegoke et al., 2010; Marchie 2012) asked women about the cultural issues they (researchers) considered relevant to the impact on maternal death. Another six additional papers used qualitative approaches to explore in more depth

from women's perspectives about cultural issues and how they influence the utilisation of maternal healthcare. Remarkably, these studies were conducted in states in Northern (Kastina, Yobe and Zamfara states) and South-Western (Lagos State) and South-South (Edo State) Nigeria. This clearly shows that studies exploring the cultural-level factors in South-Eastern Nigeria are needed because there is a lack of evidence on whether and how social and cultural factors impact and influence maternal mortality in this region of Nigeria.

3.3 Summary of the chapter

This scoping review revealed a range of factors influencing the utilisation of maternal healthcare, or the lack of which can lead to maternal mortality during pregnancy, childbirth, and puerperium. It specifically revealed that women's decisions around the uptake of maternity services was socially and culturally informed and influenced. Thus, women's autonomy and capacity to make decisions regarding their own health was inhibited by socio-cultural circumstances. Women indicated that they lacked satisfaction with maternity care in the hospital, but this requires further exploration to reveal the cultural complexities and dissatisfaction regarding this issue.

Lastly, practice, policy and research implication have been raised in this review. First, it identified religious and cultural issues from a Nigerian perspective, which could be used by nurses, midwives, and other healthcare providers to enhance their cultural knowledge and competence in order to provide culturally appropriate midwifery services that could promote greater utilisation. However, more research, especially in South-Eastern Nigeria, is required to contribute to knowledge about cultural complexity in Nigeria, which could be used to plan policies for service improvement. Secondly, this review shows that more healthcare promotion activities are required in Nigeria to

raise awareness through the provision of health information that could change existing attitudes towards the use of maternal healthcare services, thereby reducing maternal death. Thirdly, it was found that most of the research papers reviewed adopted a cross-sectional quantitative research design; therefore, more rigorous in-depth studies adopting an interpretive qualitative study design are needed to explore social and cultural issues in more detail and depth, especially in South-Eastern Nigeria.

This review is not without limitations; there is a possibility that some studies relevant for this review have been missed. This is because not all the studies conducted in Nigeria are indexed in electronic databases. Extensive hand searches across major journal booklets that publish health issues in Nigeria, and electronic search and retrieval strategies used in this review have reduced the chance of omitting relevant articles. Although not all journal booklets available in Nigeria were accessed because of difficulties related to access and availability, the potential for the omission of articles in this review is minimal. It is unlikely that the overall results of this review would have been altered due to the omission of some papers. This is because all the studies reviewed under social and cultural influences showed similar patterns in their findings.

3.4 Gaps in literature that inform the current research focus

Following a comprehensive search of existing literature about social and cultural factors impacting on maternal death in Nigeria, I found that limited knowledge exists about the social-level influences on maternal mortality, and particularly how these social factors impact on maternal death across the six geopolitical zones in Nigeria, especially in the South-Eastern region. This was because most existing studies utilised quantitative approaches, and predominantly used structured questionnaires for the data collection. Again, there is an almost complete lack of research exploring the

socio-cultural factors impacting on maternal mortality in South-Eastern Nigeria, as was acknowledged in a recent systematic literature review about maternal mortality in Nigeria (Piane, 2019). This shows a clear gap in evidence that has been used to provide focus for the current study with the study aim and research question outlined below. Again, most of the papers reviewed focused on women as their participants. This means that the voices of other individuals whose actions and decisions could impact on maternal health and maternal mortality are not well considered. Thus, the current study has been designed to elicit data from women with or without children, midwives, doctors, TBAs, and community opinion leaders, such as village heads, religious leaders, youth leaders and women's leaders. These decisions to provide an opportunity to various people whose voices have not been heard concerning their experiences, perceptions and views on maternal mortality and maternal health. Information elicited from these participants could yield robust findings to inform change in practice and policy action.

Study Aim

To explore a community's perceptions of the socio-cultural factors impacting on maternal mortality and strategies for its reduction in South-Eastern Nigeria. To achieve this aim, the following research questions were addressed:

- What are the experiences and perceptions of women regarding the socio-cultural factors impacting maternal mortality?
- What are the socio-cultural factors impacting maternal mortality, as perceived by healthcare professionals on the basis of their experiences?
- What are community leaders' and traditional birth attendants' perceptions about the socio-cultural factors impacting maternal mortality?

- In what ways do these participants consider that maternal mortality could be reduced?

CHAPTER FOUR

METHODOLOGY AND METHOD

4.0 Introduction

The previous chapter on the scoping review about the social and cultural factors impacting on maternal death in Nigeria showed a dearth of evidence on the socio-cultural complexities influencing maternal death in Nigeria. It specifically found that the social level influences comprised of key issues, such as knowledge, awareness, and educational status, and secondly, issues related to unaffordability and the inaccessibility of maternal healthcare services which then interact to impact on maternal mortality. Cultural-level influences, such as religion, culture, traditional beliefs, and practices, were also found to impact on maternal death. Several gaps in knowledge were revealed from conducting this review, such as a limited understanding of the reasons for women's lack of satisfaction with maternity care, limited knowledge about the social-level influences regarding the utilisation of maternal healthcare and how these impact on maternal death across six geopolitical zones in Nigeria. Often this was because most of the existing studies utilised quantitative approaches that were not able to unearth and describe in detail and depth the experiences and perspectives of a range of people who participate in this, such as the women, healthcare providers, traditional birth attendants and community leaders. The most compelling finding was the complete lack of research that explored socio-cultural factors impacting maternal mortality in South-Eastern Nigeria. Therefore, this thesis focuses on understanding the socio-cultural factors impacting maternal mortality as well as the perceived strategies for its reduction in South Eastern Nigeria.

In this chapter, the philosophical and theoretical perspective chosen to frame the research questions posed in this study is explained. This is followed by a discussion

of the methods used to collect the data, namely interviews and focus groups, and to analyse the data, namely thematic analysis. Firstly, the chapter begins with a discussion regarding the underpinning philosophical assumptions and the theoretical framework of the research (Guba and Lincoln, 1994). This is significant because Crotty (1998) and Gray (2014) stated that a framework forms the basis upon which to investigate or make sense of the social world. Thus, it is fundamental to make explicit my epistemological and ontological assumptions because they constitute the context, or lens, though which to understand this study. A section on reflexivity is presented at the end of this chapter.

4.1 Philosophical perspectives of the study

Philosophy is essential to research because it is concerned with fundamental questions about the goal of research knowledge, the idea of truth and the possibility of objectivity in research (Hammersley, 2006). Philosophical perspectives could be regarded as assumptions individuals hold about the social world that signify a value system upon which the beliefs that guide actions develop (Spirikin, 1983; Guba, 1990; Evely et al., 2008;). Arguably, researchers deliberately or unknowingly bring a kind of philosophical assumption to their work. It is generally accepted in a qualitative study that these assumptions guide researchers to formulate research questions in a certain way and lead to preferences for certain approaches and methods to investigate an aspect of the world in an effort to construct knowledge (Crotty, 1998; Denzin and Lincoln 2011; Kawulich, 2012). Interestingly, Moon and Blackman (2014) added that philosophical perspectives influence how meanings are derived from data when constructing knowledge. These assumptions have been called worldviews or paradigms. According to some scholars, this concept refers to how we see the social

world and it informs the way in which problems are formulated and addressed (Guba and Lincoln, 1994; Schwandt 2001; Creswell, 2009; and Kroeze, 2011). Worldviews comprise ontology, epistemology, and methodology, which then inform or underpin research (Guba and Lincoln, 1994; Crotty, 1998; Moon and Blackman, 2014; Creswell, 2018). This chapter first describes these elements and then discusses the position I adopted for this research.

Epistemology is the theory of knowledge, which considers how knowledge is produced and the basis for the knowledge claim (De Villiers, 2005). Furthermore, Denzin and Lincoln (2011) considered that the researcher's position or way of knowing constitutes valid knowledge, which encompasses how it can be acquired. Similarly, Cohen et al., (2013) stated that epistemology is concerned with the basis of knowledge, whether hard, real, and transmittable in a concrete form or subjective and based on individual experiences. Epistemology explores how communities understand and describe aspects of reality, how they gain these insights and what constitutes valid knowledge (Kroeze, 2011).

Guba (1990) refers to ontology as the nature of the knowable or the nature of reality. It systemically describes how different communities have looked at realities in a different period (Kroeze, 2011). Similarly, Denzin and Lincoln, (2011) support that ontology asks about the nature of the social world, forms of reality and what can be known about it. It is related to the individual's view of reality (De Villiers, 2005). The methodology is concerned with how we gain knowledge about the world (Denzin and Lincoln, 2011; Ritchie et al., 2013). The philosophical foundation that underpins a research study helps to clarify questions around the research methodology (Dieronitou, 2014).

4.1.1 The Researcher's Epistemological and Ontological Position

Denzin and Lincoln (2011) maintained that researchers are bound by these philosophical assumptions. This implies that epistemological and ontological assumptions that underpin research must be made explicit; therefore, these are discussed in this section. Notably, in the conduct of a study, the researcher's beliefs in the conduct of a study inform the choice of a paradigm/worldview that orients their research. These beliefs must explain the nature of reality (ontology) and the way of knowing (epistemology) (Weaver and Olson, 2006). From an ontological perspective, I agree that reality has a plurality and that individuals will offer multiple social constructions (Descombe, 1999). Reality is, therefore, specific, and uniquely constructed in accordance with the beliefs, views, and experiences of the individual who holds them (Preissle, 2006). As such, Monti, and Tingen (1999) argue that there is no reality independent of perceptions. This study will adopt a relativist ontology which assumes that reality is intersubjectively constructed between the participants and researcher (Guba and Lincoln, 1994). This ontological stance is based on the premise that multiple realities exist based on individual perceptions and experiences. In this study, the researcher sought to understand and learn about the constructions of realities regarding the sociocultural factors influencing maternal mortality in a Nigerian South-Eastern community and strategies to reduce maternal death, as empirical evidence shows that these factors are under-researched.

This research follows the approach of Markula and Silk (2011) who argued that what exists in the social world is what an individual perceives or thinks to exist and is based on their experiences. However, this does not mean that the social world exists in an individual's brain but rather that the individual's mind, experiences, and thoughts influence our interpretation or the meaning we assign to the social world. The social

world is therefore constructed based on the individual's values, culture, subjectivity, emotions, and interests (Löhr, 2019). Although individual sense-making is emphasised, it is also understood that social reality is a product of how people individually and collectively make sense and interpret the world in which they live (Markula and Silk, 2011).

Epistemologically, I believe that knowledge is built through social interpretation of the world. The creation of knowledge about the social realities that exist in people's minds is obtained through the interaction of the researcher and the researched (Appleton and King, 1997). This implies that an interactive and co-constructive activity involving the participants and the researcher is a way to create knowledge in the research process. The participants' experiences, perceptions, and views lie at the core of an enquiry on the creation of knowledge. The researcher is part of the social world where the study is conducted and would not deny the impact of previous knowledge and personal background on the knowledge claim under construction (Guba and Lincoln, 1994; Appleton and King, 1997). Based on this premise, the researcher adopts the epistemological stance of constructivism. The creation of knowledge in the stance of constructivism is the creation of knowledge between the participants and the researcher during the research inquiry (Guba, 1990). I agreed with Guba and Lincoln (1994) that researchers cannot disentangle themselves from their previous knowledge of the phenomenon under investigation during research. This implies that the researcher, along with women of a childbearing age with and without children, traditional birth attendants, community members, religious leader and healthcare practitioners were involved in the co-construction of knowledge about the socio-cultural factors that influence maternal mortality and the measures to reduce maternal death. My position as a woman, as a member of the culture being investigated, and

my previous training, knowledge, and experiences as a midwife have influenced the knowledge construction of this project. My knowledge and experiences will be considered and clearly stated as to how they may or may not influence the knowledge claim in this thesis. This is important because, as Flax (1990) argued, researchers cannot know reality without acknowledging and recognising their role as a researcher. I, therefore, adopted a reflexive approach in this work, which Lincoln and Guba (2000) highlighted as a way that a researcher can develop a greater understanding of themselves within the research project.

In summary, a researcher makes claims about the reality (ontology), how we know about something or the reality (epistemology) and how we find out about the reality or the process of studying the reality (methodology). Notably, there is a relationship between these philosophical assumptions that provides a framework for understanding different research approaches (Gubba and Lincoln, 1994). Again, there are different paradigms but three of the most dominant and competing in the social sciences are positivist, critical realism and interpretive (Guba and Lincoln, 1994; Dieronitou, 2014). The similarities and differences among these three paradigms are summarized in Table 4.1 in terms of the study's ontology, epistemology, and methodology.

Table 4.1: Similarities and differences between positivism, interpretivism, and critical theory

Criterion	Positivism	Interpretivism	Critical theory
Ontology	Reality is real and apprehensible	Multiple local and 'constructed' realities	Reality is 'real' but only imperfectly and probabilistically apprehensible
Epistemology	***Objectivist*** Findings are true	***Subjectivist*** Created findings	***Modified Objectivist*** Findings are probably true
Methodology	Quantitative	Qualitative	Qualitative and/or be quantitative

4.1.2 Paradigm to this study: Interpretivism

The paradigm that informs this study is interpretivism underpinned by feminism and particularly, Gender and Development (GAD) theory. The choice is based on the foundation in that the interpretive paradigm aims to gain an understanding of the social world or phenomenon in the context of culture and society (Williams, 2008; Potrac et al., 2014). Interpretivism is a philosophical assumption that focuses on reality as a human construction, which can be understood subjectively (Kroeze, 2011). The emphasis of subjectivity in interpretivism implies that researchers discover reality through participants' views and experiences (Yanow and Schwartz-Shea, 2011). The core idea of this philosophical system is to grasp the subjective meanings that already exist in the social world; this means acknowledging and reconstructing them, understanding them, avoiding any distortion of them, and using them as building

blocks in theorizing (Goldkuhl, 2012). Interpretivism best suits this research because my study seeks to explore participants' perceptions, experiences and views about the sociocultural issues that cause maternal mortality and their perceptions regarding solutions for its reduction. The paradigm of interpretivism has influenced, and is relevant to, my adoption of a Feminist and GAD theory approach because I want to understand the social and cultural world of my participants (both men and women) through gaining an insight into their views, experiences, and beliefs about the issues that affect women. Focusing on women and the social relations and interactions between men and women to enable them to find the root causes of the inequality affecting maternal death would proffer a strategic solution for the betterment of women's lives (feminism). Additionally, a male-inclusive approach is one of the strengths of a GAD perspective (Jackson, 2001). It is acknowledged that a feminist struggle for the betterment and advancement of women, which brings about gender equality, increasing women's wellbeing such that they reflect the same levels as those enjoyed by men in their households and communities (Kabeer, 1994). Therefore, interpretivism usually seeks to understand a particular context and allows reality to be socially constructed by both genders, which aligns with a GAD perspective (Willis and Jost 2007). The GAD theoretical perspective is discussed in a greater detail in section 4.2 of this chapter.

Furthermore, interpretivism rejects the belief that people, culture, social organization and social practices can be understood by the methodologies natural scientists use to examine physical world (positivism) (Potrac et al., 2014). It is rather grounded on the basic precept that our knowledge of the world is based on our understanding and interpretation of what happened and not just a consequential product of having had experiences (Ritchie et al., 2013). This implies that our experiences and perceptions

do not automatically constitute our knowledge of the world but rather signify our interpretation of what our senses tell us. The interpretive paradigm of a qualitative approach emphasised the need and value for a human interpretative aspect of knowledge about the social world (Gray, 2014). I agree with this statement but in addition, the researcher's understanding, and interpretation are also significant in a qualitative approach (Flax, 1990). Markula and Silk (2011), and Patton (2005) support this view, confirming that the social world is complex, and that the researcher and participants interpret and define their own meanings within their respective social, cultural, and political settings. Similarly, Willis (2007) acknowledged that an interpretive paradigm accommodates multiple perspectives of truth, is opened to change, and practiced iteratively. In the context of this research, the interpretive paradigm provides a context that allows me to examine what the participants (females and males, in line with GAD approach) have to say about the sociocultural context of maternal mortality. The multiple worldviews are based on the premise that different people and groups have diverse perceptions of the world (Willis, 2007). The multiple perspective tenets of interpretivism often lead to a more in-depth and comprehensive understanding of the situation under investigation (Morehouse, 2012; Potrac et al., 2014). In this research, a consideration of the differences and similarities that exist in the voices of the participants will contribute to the comprehensiveness, credibility, and robustness of the knowledge claim for this study. Also, the research findings will inevitably be influenced by the researcher's perspectives, education, position, knowledge, and background and by her membership of the culture being investigated. However, the researcher will declare and ensure transparency around her assumptions and engage with the concept of reflexivity throughout the research process.

Sarantakos (2012) highlighted that understanding the natural subjective experiences of an individual or group is grounded in the paradigm of interpretivism. Guba and Lincoln (2005) echo this view, arguing that the interpretive researcher gains an understanding about the phenomenon in question by analysing the participant's interpretation of their experiences and perceptions. Furthermore, Weaver and Olson (2006) noted that the interpretive paradigm highlights the understanding an individual assign to their actions and the reactions of others. This fits well with the aims of this study that strives to understand the socio-cultural interpretation of poor maternal health and high maternal mortality, and in so doing, reveals the factors that influence maternal death in the cultural settings of this study. Nevertheless, the paradigm of interpretivism could be challenged due to its lack of objectivity (Weaver and Olson, 2006). Although, it is possible that objective or concrete reality exists, social realities are less objective/concrete because they are created by cultural communities (Kroeze, 2011).

Furthermore, Sarantokos (2012) argued that criticism of the lack of objectivity of the interpretive paradigm lacks merit because the social world is not necessarily governed by a set of laws, but rather mediated through meaning and human agency. As such, the social researcher's concern is to explore and understand the social world through the participants' and researcher's interpretation of it (Sarantakos, 2012). Research adopting an interpretive paradigm is also criticized as it lacks generalization; this is because of the consultation with a small number of participants who do not necessarily reflect the entire population (Hammersley, 2009; Dieronitou, 2014). However, Williams (2000) argued that generalization is inevitable in interpretive research because every study contains some form of generalizing claim. It is further noted that the interpretive paradigm is more concerned with an in-depth and comprehensive understanding of

the social world (Thanh and Thanh, 2015; Capps, 2019). Besides, one of the tenets of interpretive paradigm is that all interpretation is based in a particular moment (Kroeze, 2011), which implies that they are present in a particular context and time. An interpretive paradigm is also criticized for being biased and value-bound because the knower and the known are inseparable (Smith, 1983). However, although the researcher and the researched cannot be separated, if the researcher declares the way they may have impacted on the research process by engaging with the concept of reflexivity then this criticism can be addressed.

4.2 Theoretical perspective of the study

The theoretical perspectives of feminism and development are considered relevant to guide the understanding of the social and cultural factors that influence maternal mortality and the strategies for its reduction in a Nigerian context. These frameworks provide a systematic way of examining socio-cultural issues and providing recommendations for positive change (Parpart et al., 2000). It is recommended that research on women, gender and development issues require a thorough understanding of both development and feminist theoretical frameworks (Connelly et al., 2000).

4.2.1 Theories of feminism

The meaning of feminism though is contested and has a different use by many people, it is mostly used as either a political movement or an intellectual commitment with the overarching aim to abolish sexism and to seek justice and fairness for women (Alaimo et al., 2007). Notably, some scholars used the term feminism to mean a belief system that indicates injustices against women, while other writers used it as a specific political movement particularly in the United States and Europe (Heywood, 2002). The

notion of a feminist political movement is rooted in the idea aimed to mobilise women believed to be suffering in the United States and Europe in the late 19th century and early 20th century, although political activism seeking to achieve fairness and obtain justice for women can be traced earlier than this period. This political movement in the United States has been described to occur in three 'waves (Freeman, 1996). Based on the wave model, the period during the late 19th century and early 20th century is regarded as the first wave whereby the political activism in the United Kingdom and the United States centred on the promotion of equal contract, and property rights but with a primary focus at the end of the 19th century on women's suffrage to gain political power and the right to vote. The second wave feminism commenced in the early 1960s and ended in the late 1980s. This period was characterized by agitation and campaign for the legal and social rights of women and its main focus was on the issues of ending women's discrimination and equality for both sexes in areas of life such as education, homes, and workplace. The third wave feminism was born due to criticism of the second wave for disregarding the differences among women concerning religion, race, nationality, ethnicity, and class, but still held the view that identity and the intersection of identities should be central to gender struggle.

Whilst some feminist favoured the model of wave feminism, others disapprove this on the basis that this political movement did not take enough account of male domination that exist in several cultures (Cott, 1987). In agreement with Alan et al., (2004), one of the ways to resolves differences in the classification system is to view feminism as a set of ideas or belief systems rather than a political movement. However, Harrison and Boyd (2003), argued that feminism could be viewed based on the two groups of claims which are normative and descriptive. The normative claim is pertained to the standard upon which women should be viewed and not be perceived as well as the acceptable

ways they should be treated based on morality and justice. Whereas the descriptive claim focuses on how women are perceived, treated, and viewed and it is argued that women are not duly treated based on moral standards. Therefore, the normative and descriptive claims favour the position that women are subjugated and thus their conditions need to be changed by adopting the various measure, an indication that feminism can be viewed as both a political and intellectual movement. It is useful to declare that the term feminism has been used in this thesis not as a political movement but as a theoretical lens to understand women injustices during pregnancy and childbirth, with the intention to enhance a deeper understanding of the factors that favour high maternal mortality in a Nigerian context. Overall, it can be argued based on the historical account of feminism that it first began as an attempt to explain the oppression experienced by women globally (Parpart et al., 2000). Precisely, it was after the International Women's Conference that was held in Paris in 1892 that the term feminism was regularly used in English to mean a belief in and advocacy for women justice and equality of the sexes (Harding, 1986).

Feminist theoretical perspectives come from the premise that women face multiple oppressions because they are distinctively disadvantaged based on their gender and social status (Ujah et al., 2005). Susan James further added that women's oppression is illegitimate and unjustified (James, 1998), thus effort should be made to improve the circumstances of women, a mission sought in this thesis. Feminism illuminates the forces that create and support the inequality, injustice, and oppression that women suffer in the social world. Many feminist theorists focus on the question of how gender inequality manifests in institutions, such as the workplace, home, and other public spheres, while others explore the range of practices that have come to be defined as masculine or feminine and how gender is constituted in relation to other social relations

(Harding, 2004). Therefore, the feminist lens aims to modify and change conditions affecting women's lives by investigating women's experiences, establishing non-hierarchical relationships, and solving problems through research that will benefit women and society (Moser, 1993). Feminists believe that gaining an in-depth understanding of a woman's nature and how they are different will enable the identification of these multiple oppressions (Hardings, 2004). For instance, in the developing world illiteracy and poverty are associated with gender; women are believed to be closely linked to illiteracy and poverty because they are at higher risk of remaining uneducated and poor than men (Cree et al., 2012).

It is relevant to acknowledge that over the years, there has been the emergence of numerous sub-movements of feminist ideology but some of the major sub-types are socialist and Marxist feminism, radical feminism, liberal feminism, and black feminism (Renzetti, 2018; Ann et al., 2017, Harrison and Boyd, 2003). Liberal feminism emphasises the equality of men and women which can be achieved through political and legal reform (Renzetti, 2018). Liberal feminists argued that the root of women's oppression is linked to cultural patterns that constraint women from competing with men in society because of the false belief that women are naturally less mentally and physically capable compare to men in the area of politics, finance, medicine and law (Harrison and Boyd, 2003). The liberal feminists insisted that this is discriminatory, therefore pursue an agenda for women to enjoy equal rights with men on all aspects of life endeavours such as a workplace, education, voting, sexual harassment, reproductive and abortion rights, on the basis that both sexes are a human being. The proponents of this feminist ideology believe that this agenda can be achieved without altering the structure of the society. The socialist ideology emerges due to the criticism of liberal feminist thinkers. The supporters of this ideology link oppression of women

to the Marxist idea about oppression, exploitation, and labour. They hold a view that oppression faced by women can be resolved through a social revolution that would give women economic freedom or economic equality and believed that this can be achieved through a change that affects the entire system and not at the individual level.

In contrast, radical feminism holds a view that societies are inherently oppressive to women because of the dominating patriarchal system (Crow, 2000). This means that radical feminists believe that the male-controlled capitalist hierarchy that exists in societies is a fundamental issue that shapes the oppression experienced by women. Those in support of this view commenced a crusade against patriarchy, male-based authority or domination, and power structures that facilitate the oppression of women and inequality (Crow, 2000). Radical feminists strongly maintained that to achieve their goals, the patriarchal system must be uprooted completely in society. The attack on family structure, church, traditional ideologies about sex and reproductive rights was the first step undertaken by radical feminists to overthrow patriarchy's institutions and reproductive rights.

Radical feminism is classified into radical libertarian and radical cultural feminists (Tong, 1998). Notably, contention exists about their views on women's oppression and approach to solving this problem in society. For instance, radical libertarian feminists hold a view that the key source of women's oppression is the burden of human reproduction which the society placed on the women. They believed that natural reproduction is not in the best interest of women, instead, they suggested that this should be replaced by technological reproduction such as in-vitro fertilisation or ex-utero gestation. This idea was based on the premise that if women are freed from the

role of reproduction, they will no longer be an object for men to penetrate in order to maintain human procreation (Firestone, 1970). One of the radical libertarian feminists, Shulamith Firestone, argued that natural reproduction is neither to the best interest of women nor men. Instead, that either male or female should be a polymorphous being to eliminate masculine identities of men and feminine distinctiveness of women and to encourage the genders to have the choice to become masculine or feminine (Firestone, 1970). Overall, radical libertarian feminists argued that irrespective of political, educational, and economic equality of women, the oppression of women will continue unless there is a shift in the dominant discourse of women's reproductive role. The public and some radical feminists criticised the ideas of radical libertarian feminists, arguing that women may not gain true liberty by either refusing to bear children or choosing to become androgynous. This disagreement leads to the birth of another group of radical feminists known as radical cultural feminists.

Contrary to the view of radical libertarian feminists, the radical cultural feminists perceived that technological reproduction is not a good option for women because it will lead to a situation whereby men will have control over women’s procreative powers (Rich, 1976). They thus, rejected the radical libertarian feminists’ idea of androgyny, instead suggest that women’s features of ‘femaleness’ should be upheld (Echols, 1983). For radical cultural feminists, this implies features associated with women such as the absence of hierarchy, trust, nature, joy, peace, sharing, interdependence, connection, and emotion should be promoted while features associated with men such as hierarchy, autonomy, domination, independence, war, death, transcendence, and intellect should be discouraged (Jaggar, 1992). The central belief of radical cultural feminists is that sex, often regarded as heterosexual is more dangerous than pleasurable for most women and therefore women should disentangle themselves

from any institution that favours heterosexuality (Rich, 1994). This central idea is based on their understanding that heterosexuality is an ideology linked with sexual objectification, whereby woman is considered as an object for sex that should be submissive to the male who is the subject or master (Ferguson, 1984). They insisted that heterosexuality is about men seeking to control women's sexuality and that women should not be subjected to sex as men want it. Women's liberation according to radical cultural feminists will be achieved if women start to perceive themselves as better than men and when the attributes of women are generally promoted and that of men demoted.

Other stances of feminism include multicultural and postmodern feminism. So far, it is established that distinct ideas about the causes of women's subordination and of how to abolish women's oppression exist. Despite its varieties and different points of view, basic assumptions are binding all the traditions or stances of feminism. For example, feminism pursues the idea of human equality and opposes the discrimination of women based on gender. It strives for justice for women to ensure that women have a similar opportunity to men in all aspects of life (Solli, 2002). Overall, feminism is about emancipatory commitment to change and women's liberation (Kemp and Squires, 1995).

Feminism as an ideology has been successfully used as a lens used to view and understand the inequalities and degrading issues experienced by women (Heywood, 2002), such as maternal mortality. Therefore, the theory of feminism particularly the radical stance fits well in the context of this research as evidence from the reviewed literature shows that poor maternal health that leads to high maternal mortality in Nigeria could be linked to women's subordination and patriarchal system. Women are

culturally disadvantaged and denied access to several basic needs that affect their health and development in Nigeria (Monjok et al., 2009). In addition, due to the low level of education, women are subjected to multiple oppressions, which are deeply rooted in the country's cultural system (Ujah et al., 2005). An understanding of the interplay between social status, culture, and gender could provide a useful insight into why there is high maternal mortality in Nigeria. A change toward improved maternal health and a reduction of maternal mortality is possible because the subordination of women and the dominance of men is not a natural phenomenon. According to feminist theory, the ways women negotiate the world differ among women in different cultural, social, religious, and ethnic locations (Connelly et al., 2000; Adkins and Skeggs, 2004). As such, this study focuses on investigating the socio-cultural factors that influence maternal mortality in a community within southeastern Nigeria. Nigeria is a multi-cultural and ethnic country with varied cultural values. If the socio-cultural issues that militate against maternal health are uncovered in different cultural regions in Nigeria, then specific policies and interventions for different cultures could be put in place to improve maternal health and reduce maternal mortality across Nigeria. This means recognizing that factors, such as social class, ethnicity, social status, age, and sexual orientation, shape perceptions and experiences, which point to the social character of gender and gender relations.

Finally, the condemnation by feminist theorists (Moser, 1993) of the consistent failure of the development plan (improvement in wellbeing) for women in the developing world led to the intersection of international development with feminism. This influenced the development of approaches to effectively address women's issues (Connelly et al., 2000). The theory of Gender and Development (GAD) and Women in Development (WID) are two key competing feminist developmental frameworks that are widely used

because they try to explain the reproductive and productive inequalities that exist between a man and a woman in different societies. GAD theory is considered particularly useful to underpin and orient this study. This is because its main focus is on addressing the root inequalities that lead to the problem's women experience in their daily lives by considering the social relationships between women and men. Unlike feminist approach that focuse primarily on how male created and maintained patriachial system that facilitated female subordination and oppression. In comparison, the WID approach fails to consider the underlying factors that impact gender inequality (Moffat et al., 1991) and instead focuses on the biological differences that exist between men and women that lead to women's subordination (Moffat et al., 1991). To understand the factors that contribute to the problem of maternal death in a Nigerian community, the interplay between men and women in relation to their underlying socio-cultural norms should be considered holistically. Similarly, Moser (2012) stated that advocates of GAD theory recognize that women's development is a complex issue that requires a holistic investigation of social, cultural, economic, and political life. Therefore, the use of GAD facilitated a broader view and exploration of the roles of both genders (male and female) in causing maternal morality in a Nigerian context.

Gender and Development (GAD) Theory

The socially constructed role of a man and a woman in different societies is referred to as gender (Hare-Mustin and Marecek, 1995). This concept of gender arose as feminist theorists strived to comprehend the complexities of women's subordination (Parpart, 2000). GAD theory emerged in the 1980s from grassroot organizational experiences and the writings of Third World feminists and Western socialist feminists interested in developmental issues. It emerged in response to the deficiency of WID

and other feminist developmental theories (Elson, 1992). GAD is an approach to development that focuses on global and gender inequalities through a critical examination of the productive and reproductive activities of men and women (Parpart, 2000). This theory argues that women's status in society is severely affected by the nature of patriarchal power and their position at various levels - nation, community, and household (Moser, 2012). For instance, in different societies in Africa, the cultural norm and assumption are that women's primary activity is reproduction while men are involved in productive activities (Oppong, 2006). GAD theory, therefore, offers a relevant lens through which to understand and uncover the socio-cultural inequalities that contribute to women suffering poor maternal health that leads to maternal death in Nigeria.

GAD theory examines how relationships, women's positions, patriarchal authority, and structures at both community and household levels affect both women and men (Moser, 2012). It is worth noting that culture is the major determinant and influences the specific roles and duties assigned to men and women in society, and this shapes women's positions and patriarchal authority (Parpart, 2000). This was supported by Connelly et al., (2000) who stated that patriarchal authority and women's material conditions are both defined and shaped by the societal acceptable norms and values that define the role of men and women in a particular society. This suggests that culture plays a core role in gender roles and relations and the construction of the gender role and gender relation is, therefore, the focus of GAD theory. The focus is geared towards addressing women's needs and interests to improve their condition, especially in developing countries, through an investigation of the patriarchal structures, social position, material condition, and cultural issues and beliefs that define and maintain women's subordination and the unequal power relations which

prevent the equitable development of women (Parpart et al., 2000). Poor maternal health that leads to maternal death, especially during pregnancy and childbirth, can be influenced by the role that women play during reproduction or production and these are strongly influenced by cultural issues, patriarchal authority, and social position, as reflected in GAD theory. To improve maternal health and reduce maternal mortality, we need to consider the reproductive lives of women, and the beliefs, norms, practices, customs, and societal values that influence maternal health, as GAD theory argues that these factors affect women's development (Moffat et al., 1991).

The empowerment of disadvantaged women, sustainable development, and transformation of the unequal relations is the goal of GAD theory (Moser, 2012). The GAD approach to women's empowerment is multi-dimensional and goes beyond addressing the socio-economic needs of women. Rather, it means changing the socio-cultural issues and system that contribute to gender inequality in a society (Connelly et al., 2000). GAD theory does not only focus on women's development and empowerment but strives to identify and address practical gender needs and strategic gender interests for both men and women (Moffat et al., 1991). The practical gender needs of women and men are both short-term and immediate, as defined by their gender roles in the society, while the strategic gender interests are the longer-term needs which cause and maintain women's subordination in the society (Connelly et al., 2000; Moffat et al., 2000). Practical needs tend to be short term and addressing them can improve immediate conditions, but addressing strategic needs can empower women, improve their position in society, and transform gender relations and attitudes (Moffat et al., 1991, Nielson et al., 2008). Most of the women in developing countries experience inequalities and thus a disadvantaged position compared to men. These inequalities could facilitate the high rate of maternal death, especially in developing

countries. GAD theory is, therefore, concerned with addressing the root causes of the inequalities between women and men that create many practical and strategic problems which women experience in their daily lives (Moffat et al., 1991).

GAD theory emphasizes that both men and women create and maintain society and therefore any intervention for gender development should benefit both men and women. However, Dieronitou (2014) argued that women should receive greater focus because they are disadvantaged and suffer more than men in society (Parpart et al., 2000). This fits well with the present research that tries to understand the social and cultural issues that affect women during pregnancy, childbirth, and puerperium, which aims to identify evidence that may be used to plan interventions to improve the health of women and reduce maternal mortality in Nigeria.

The tools for GAD analysis

The improvement of women's health and wellbeing requires the consideration of a complex interwoven network of issues. The societal norms, values and other cultural processes determine the responsibilities or type of work with which men and women engage in society (Parpart et al., 2000). The differences in gender responsibility and the division of labour constitute the inequalities that are seen in various societies nowadays. Culture is recognised as a powerful force that facilitates these inequalities. Culture is defined as a system of interrelated values which are sufficiently active to influence and condition perception, judgment, communication, and behaviour in a given society (Kroeber and Kluckhohn, 1952). The factors that hinder or promote maternal health and wellbeing are, to some extent, influenced by factors such as gender relations, culture, environment, religion, and political situations (Kawuwa et al., 2007; Abdulkarim et al., 2008; Adegoke et al., 2010). The researcher argues that, if

these factors are uncovered, those influencing maternal death in Nigerian communities can be better understood.

The condition and position of a woman are other GAD analysis tools, which suggest that a woman's state and position makes her vulnerable and subordinate to a man (Kabeer, 1994). Developmental projects tend to focus on improving women's short term and immediate condition (practical needs), but little attention has been paid to enhancing women's positions to meet their strategic interests. This research focuses mainly on investigating the social and cultural issues (strategic needs) that influence maternal health so as to enhance and contribute to the empowerment of women to take control and become involved in decision-making on their own health to reduce maternal mortality. GAD theory affirms that there is the potential for transformation to enhance the lives of women through a societal change in its attitude towards women (Connelly et al., 2000). The implication for gender relations in reproductive, productive and community management roles are uncovered through GAD theory. This research aims to identify evidence that will be used to better the lives of women during pregnancy and childbirth to reduce maternal death and improve maternal health.

Strengths and weakness of the theoretical frameworks: GAD

The criticisms of WID (Women in Development) and WAD (Women and Development) as effective developmental frameworks influenced the birth of GAD theory. These approaches to development have enhanced people's understanding of the need to improve the welfare of women (Moser, 2012). However, the WID model was criticised as non-confrontational in that it accepts the existing social structure and power relations by focusing on practical needs without considering women's strategic needs (Moser, 2012). Additionally, the WID paradigm sees women's subordination and lack

of participation as a problem but does not challenge the root cause of these problems (Visvanathan et al., 1997). The concept of WAD arose due to the criticisms of WID. Marxist feminists supported WAD's approach and advocated the need for a developmental approach to women that recognised the danger of integrating women in the patriarchal world (Chant, 2000). WAD emphasised that the power of women should be recognised and that women should be empowered to contribute and benefit from development (Tinker, 1990). WAD was criticised for focusing only on women and in primarily protecting women's interests from patriarchal domination (Barientos et al., 2004). Furthermore, WAD ignored the existence of social relations between men and women and their impact on development (Parpart, 1993). Thus, the weaknesses of WID and WAD led to a more comprehensive approach to women's development, namely to GAD theory. This approach is more acceptable because it is concerned with addressing the root inequalities of both gender and class that led to the problem's women experience in the world, such as maternal mortality. Unlike the WID approach, it addresses the strategic needs (such as equal participation with men in decision-making, improving women's position, empowering women for more opportunities, and greater access to resources), which emanate from women's disadvantaged social position in relation to men. Although a GAD approach is celebrated for the ability to focus not just on women but also on the social relations between men and women, it is not without criticism. Parpart et al., (2000) criticised the GAD model for assuming that women are a homogenous group in developmental issues. It argued that, whilst at one level all women in developing countries, particularly in Africa, have similar needs, experiences, goals, problems, and aims, GAD fails to acknowledge that women in urban and rural communities have different and specific developmental needs (Parpart et al., 2000). Therefore, I focused on rural communities to examine their

specific experiences. However, this criticism is not peculiar to the GAD model but can also apply to the WID and WAD approaches to women's development.

Nevertheless, some gender theorists argue that men are marginalised in GAD policy and practice (Chant, 2000; Jackson, 2001). These theorists maintain that the GAD model still overly focuses on women rather than both genders. White (2000) claimed that the GAD model fails to adopt a truly relational and integrated approach to developmental issues. As the analysis of men as a gender is arguably still missing in the GAD perspective, Jackson (2001) emphasised the importance of a male inclusive approach in the framework. Jackson (2001) further advised that interdependencies between men and women should be considered in finding lasting solutions to developmental problems. In agreement with the views of Jackson, I considered the experiences of women and the views of opinion leaders and healthcare workers - both men and women - in the Onuenyim Agbaja community when examining the sociocultural factors that influence maternal mortality and the intention to improve the wellbeing of women.

Summary of the theoretical perspectives in relation to the current research

Empirical evidence from the analysis of research on maternal mortality in Nigeria shows that the rate of maternal mortality is still high in Nigeria. In developing countries, especially in Africa, men are the decision-makers, productive agents, and household head while women are viewed as passive beneficiaries, housewives, and 'at-risk producers' (Kabeer, 1994). This indicates gender marginalisation and inequalities. The present study focuses on the investigation of the social and cultural issues that influence maternal mortality and the strategies for its reduction in the community in South-East Nigeria. This is because the medical causes of maternal mortality in

Nigeria are known, but there is a paucity of research on the sociocultural influences on maternal death across different geopolitical zones of the country.

Feminist theory, and particularly the GAD framework, is used as a lens to understand the sociocultural factors that influence maternal mortality and the strategies for its reduction. GAD theory, including WID and WAD frameworks, empower, liberate, and promote an equitable distribution of resources (Moser, 2012). Specifically, the GAD framework questions the root cause of inequalities that women suffer. This is particularly relevant to this research because the focus of this study is to determine the root causes of maternal death in a Nigerian community. GAD theoretical frameworks promote women's recognition during decision-making on the issues that affect them. The United Nations and other international agencies continue to address women's issues, such as maternal mortality; however, most women, especially those who live in rural areas in developing countries, have continued to suffer marginalisation and preventable death during and after childbirth. This research gives voice to rural women to discuss the causes of maternal death because it mostly affects them. GAD theory lays the foundation for gender equality and equity with the intention to improve the lives of women and even men, especially in developing countries. The paradigm of interpretivism discussed in this (methodology) chapter has influenced feminism, and particularly GAD theory, which is demonstrated in the next section

4.3 Qualitative research approach

This study seeks to understand the experiences, perceptions and opinions of community members, traditional birth attendants, and healthcare practitioners concerning the socio-cultural factors that cause maternal mortality, and the measures to reduce maternal death in a Nigerian South-Eastern community. This research was stimulated by the high occurrence of maternal mortality in Nigeria despite government

efforts to improve maternal health (Alkema et al., 2016). Research evidence has revealed the medical causes of maternal mortality in Nigeria. However, evidence of the socio-cultural influences on maternal mortality is limited in all parts of Nigeria but almost unknown in the South-Eastern region. An understanding of the impact of cultural dynamics and their impact on maternal health is therefore needed to enable effective public health interventions to improve maternal health. This is because culture plays a vital role in determining the health of individual, family, and community (Airhihenbuwa et al., 2014). It is therefore plausible that an understanding of the socio-cultural factors that influence maternal mortality may facilitate efforts to improve maternal health and reduce maternal mortality in Nigeria. Therefore, this study seeks to investigate the socio-cultural factors that contribute to maternal mortality and the measures to reduce maternal death in a Nigerian South-Eastern community. As such, and in the light of the adoption of the interpretative paradigm discussed above, a qualitative methodology was considered most appropriate to investigate this topic, as it has the potential to facilitate the achievement of the research aim. This is because the methods used in a qualitative methodology provide an opportunity for participants to talk about their experiences and express their views and opinions about the issue under investigation (Gray, 2014).

A qualitative methodology is a form of social inquiry that focuses on the way people make sense of, or interpret, the social world in which they live (Gray, 2014). In addition, Silverman (2011) noted that a qualitative approach is most suitable when we seek to understand a social situation about which we have limited knowledge and understanding, as in the case of this study. Creswell (2014) also supports this view, highlights that a qualitative methodology is employed in research when the social

situation under investigation is not understood because little or no work has been conducted in the area.

The qualitative research approach is concerned with how the social world is understood, experienced, constructed, and interpreted by research participants (Gray, 2014). This fits well with this study as it strives to understand how community members, traditional birth attendants, religious leader, and healthcare practitioners understand and interpret the social and cultural context that impacts on maternal mortality in Onuenyim Agbaja community of Ebonyi State in Nigeria. Furthermore, the qualitative approach provides rich and in-depth views of the participants to illuminate the phenomenon under investigation (Bryman, 2012). Similarly, Sarantakos (2005) noted that a qualitative approach is informative, context sensitive and detailed in nature, and so allows for rich and deep descriptions and understandings of the issue under investigation. This implies that the use of a qualitative approach in this project will enhance the generation of rich evidence to understand participants' views and perceptions about the sociocultural context of maternal deaths and will offer insights that could be used to plan or strengthen existing strategies to reduce maternal mortality and improve maternal health in Nigeria.

However, despite the strengths of a qualitative approach, it is not without criticism. A qualitative approach can be criticised as too subjective because of its inability to connect variables and determine causal relationships enough to inform policies. Additionally, it is difficult to replicate, is time-consuming and often lacks generalizability (Denzin et al., 2006). In response to these criticisms, Ritchie et al., (2013) argued that many accounts of social realities exist; therefore, a qualitative approach is not interested in the doctrine of replicating research findings but is rather focused on plausibility and trustworthiness. Qualitative research stands on the premise that

objective reality does not exist; therefore, researchers strive to understand an aspect of social reality within a specific context in the present time that offers a deep cultural understanding of the phenomenon under investigation (Sarantakos, 2005). In response to the criticism of generalisation, Ritchie et al., (2013) stated that, although qualitative research does not seek to generalise the research outcome, there is the potential to pursue representational, inferential, and theoretical generalisations. In the context of this research, the findings may not be generalised to the whole of Nigeria because of the cultural and ethnic variations. The findings may be generalised to the entire southeast geopolitical zone because all communities within this zone are bound by the same culture. In addition, the evidence generated from this study may offer an insight that may be theoretically generalised across Nigeria and even to other Sub-Saharan African countries.

4.3.1 Choice of qualitative methodology

Research methodology refers to the way the researcher finds the knowledge they believed can be known (Guba and Lincon, 1994). Therefore, it is recommended that inquirer should choose a methodology because it functions as a strategy or plan of action that lies behind the selection and use of a particular method (Crotty, 1998). The decision about the most suitable research methodology was particularly challenging, as I was required to explore a range of qualitative approaches and make appropriate selection that would enable me to explore or answer the research questions for this PhD. The core qualitative methodologies that are predominantly employed to study the social world, such as phenomenology, grounded theory, case study and ethnography, were extensively explored and considered in order to make the most appropriate choice.

Phenomenology is an approach that explores human's lived experiences through the detailed description and interpretation of the people being studied (Wilson, 2015; Creswell, 2018). The goal of phenomenological research is to identify or seek an understanding of meaning as well as to value the perspectives of individuals in context through an accurate description of a person's lived experience of a studied phenomenon (Crotty, 1996; Ball, 2009). Using this methodology, human experiences of phenomena, such as insomnia, being left out, anger, grief, undergoing coronary artery bypass surgery (Moustakas, 1994), or even pregnancy, can be explored to grasp what Van Manen (1990) regarded as the essence of the very nature of the things. It is expected that researchers adopting this approach must collect data from persons with experience of the phenomenon, because they would be expected to provide information consisting of what they experienced and why they experienced it in order to develop a composite description or interpretation of the essence of the experience (Creswell, 2018). Although this approach would have set out a rich description and/or interpretation to gain insight into the 'lived experience' of mothers regarding pregnancy, it would not have provided a focus on the socio-cultural context about maternal mortality intended to obtain from multiple participants in alignment with the aim set to be achieved in this research. Thus, phenomenology was not adopted for this study.

Grounded theory was also considered to be used for this study. In 1967, Barney Glaser and Anselm Strauss developed this methodology in sociology because they felt that the theories used in research were often unsuitable or inappropriate for the participants under study. They highlighted that grounded theory is concerned with the discovery of theory from data, which are systematically obtained through social research (Glaser and Strauss, 1967). The fundamental intent of a grounded theory

study is to transcend beyond description but to generate an abstract analytical schema of a process, action, or interaction (Strauss & Corbin, 1998). In other words, it seeks to identify basic social processes and develop explanatory models of human behaviour, which are grounded in the context in which they occur (Glaser and Strauss, 1967; Charmaz, 2006). It is expected that all participants in such a study would have experienced the process, and the subsequent development of the theory could help to explain practice or provide a framework for further research (Creswell, 2007). Therefore, this approach was considered unfit for the current study because it was impossible for participants to have experienced maternal death and still be alive. Besides, some of the intended participants may not even have experienced pregnancy or participated in providing care to pregnant women, although they would have knowledge of the social or cultural issues that could impact on maternal death. Again, Crooks (2001) highlighted that this methodology is ideal for exploring integral social relationships and the behaviour of groups or individuals, especially where there has been a paucity of research on the contextual factors that affect individuals' lives. However, this methodology does not focus on grasping the cultural complexities of human behaviour, which is the core issue for this research. Finally, theory development, which is the explicit goal of grounded theory, is not the central aim of this study.

Case studies have gained popularity in the social sciences and can be especially useful in research pertaining to practice-oriented fields, such as midwifery; as such, this was considered for the current study. This methodology involves the study of an issue that is explored through one or more cases over time within a bounded system, such as a setting or context, through the in-depth collection of data from multiple sources in order to report a case description or case-based themes (Creswell, 2018).

However, some scholars argue that this qualitative approach appears unclear due to its divergence on meaning, focus, what counts as a case, and the type/classification of a case study (Verschuren, 2003; Gerring, 2004; Starman, 2013). Notwithstanding, the disagreements on the definition of a case study, following a critical review that sought cohesion amongst such definitions, Simons (2009:21) suggested that a case study is *'an in-depth exploration from multiple perspectives of the complexities and uniqueness of a particular project, policy, institution, program or system in a 'real life''.* This qualitative methodology is said to be valuable when an inquirer is set to identify structures, variables, forms, and order of interactions among participants in a social situation; alternatively, it is required when knowledge about progress in development is needed (Stake, 2005). Moreover, Sturman (1997) further highlighted that a case study methodology is required when researchers seek to analyse and describe each person individually, or a group of people, distinct institutions, processes, a phenomenon, or event in a particular organisation(s) but focus on the context over a particular period of time. Yin (2009) stated that a case study is appropriate when researchers seek to answer 'how' and 'why' questions, particularly when the behaviour of participants cannot influence or when there is an intention to understand the contextual conditions underlying the phenomenon of interest.

Qualitative case studies are distinguished by the size of a bounded case, such as whether the case involves one individual, several individuals, a group, an entire program, or an activity. This methodology appeared to broadly align with the focus of the current study, which seeks to understand the socio-cultural context of maternal mortality within the boundaries of several individuals and groups. However, it does not lend itself to explicating the complexities around culture in order to understand the socio-cultural intricacies that impact on maternal mortality, which is the aim of the

current study. In addition, its methodological 'looseness' and disagreements, such as preference for selecting a representative, typical case, atypical case (Yin, 2009; Starman, 2013; Thomas, 2011) as well as debates into what comprises a unit of research (Starman, 2013) were considered as additional factors for its rejection as the methodology for this current study.

Lastly, ethnography was considered. Ethnography, as a methodology, is an interpretative qualitative approach with its origins in the early 20th Century. It was first used as an approach to describe 'primitive' or colonised tribes/cultures away from Europe whereby the inquirers had to travel to a new environment and immerse themselves within the culture for many years to grasp what Malinowski termed as the 'native's point of view' (Malinowski 1922:25). The emergence of the Chicago School of Urban Sociologists ushered a modification or change in the tradition, whereby researchers can choose to study sites close to their homes (Hammersley and Atkinson, 2007). Ethnography is therefore defined by scholars in various ways, such as *'Study of social interactions, behaviours, and perceptions that occur within groups, teams, organisations, and communities'* (Reeves et al., 2008:*1*). Whilst Atkinson et al., (2001:4) defined it as *'the first-hand experience and exploration of a particular social or cultural setting based on (though not exclusively by) participant observation'.* This methodology focuses on understanding the cultural perspectives of the group in their natural setting (Atkinson et al*.,* 2001*;* Reeves et al., 2008). This approach is endorsed when researchers require access to socio-cultural perspectives (Savage, 2000). Therefore, it was considered appropriate in this current study, which sought a socio-cultural understanding of the factors that influence maternal mortality during pregnancy, childbirth and post-delivery.

Furthermore, ethnography could have allowed for participation with participants' activities, such as traditional birth attendants in the context of the current study as well as engaging with pregnant women whilst they sought care from traditional providers. The researcher could have observed, questioned, and listened to them, to discover the social and cultural context, and the 'taken for granted' issues that facilitate the construction of knowledge and provide insights on issues that impact on maternal mortality from the perspective of those studied (Brewer, 2000).

Although I was prepared to apply the theoretical principles and knowledge of ethnography during fieldwork, this was not possible in relity, due to the contextual and practical problems encountered during the data collection. Participant observation is generally known to be fundamental in data generation during an ethnographic study because it advances the investigator's comprehension of the situation and improves credibility of the data as ethnographers participate in the routines of their participants to learn, see, and understand what they do in context (Fetterman, 2010; O'Reilly, 2012; Patton, 2015; Spradeley, 2016; Creswell, 2018;). I intended to use this method and planned to participate in the activities of traditional birth attendants in order to develop an understanding of a culture that could be contributing to maternal mortality. Prior to the commencement of the study, I approached 15 TBAs to seek consent but ten declined my observation. The few of them that accepted to participate in the study signed consent for observation and interview. I therefore had several days of attempting to observe them based on our scheduled appointments but did not witness any of their activities for several visits over the four months duration of data collection. As they use their houses for the provision of care to pregnant women, it was practically impossible to constantly remain or attend their house without permission. After persistent effort, it was practically impossible to conduct observations with TBAs.

However, before leaving the field, I considered focusing on the observation on midwives, but after careful thought, I realised such observations would not yield the relevant data necessary to reveal the cultural context of maternal mortality. Instead, it would have revealed more about an organisational culture, which is not what I sought to achieve.

Finally, ethnography was not utilised in this current study, and instead an open interpretive qualitative study was conducted using interpretive design. Lambert et al., (2012) stated that instead of a researcher incorrectly naming their research approach as phenomenology, grounded theory, ethnography, it is best to adopt a qualitative descriptive design or even an interpretive design. Therefore, a combination of interview and focus group discussions formed part of the qualitative approach within an interpretative framework in this study.

4.4.0 Sampling

4.4.1 The setting

The researcher is expected to make and justify decisions regarding the research setting (Denzin and Lincoln, 2000). In accordance with the recommendations of Gray (2014), the choice was guided by purposive and snowballing sampling. This implies that my decision was based on the appropriateness, familiarity and accessibility of the research setting to produce data, which is valuable in answering the research questions. It may be relevant to note that Nigeria is a culturally diverse country with six geopolitical zones and over 250 ethnic groups (Gandonu, 1978; Edewor et al., 2014). This study was conducted in the South-Eastern geopolitical zone because evidence from the scoping review (presented in the previous chapter) indicated that the socio-cultural complexities impacting on maternal death are not known in that region.

There are six states in the Southern-Eastern geopolitical zone of Nigeria, but because of its convenience and proximity, this study was conducted in Ebonyi state, and particularly in the Izzi community, as shown in the map in Figure 4.1. I am familiar with this state and was able to use the local language during the data collection activities for those unable to understand English; this enabled the free flow of information and enabled me to grasp tacit meanings. Several scholars have highlighted that convenience, accessibility and proximity influence the choice and selection of study site (Hammersley and Atkinson 2007; Gray 2014).

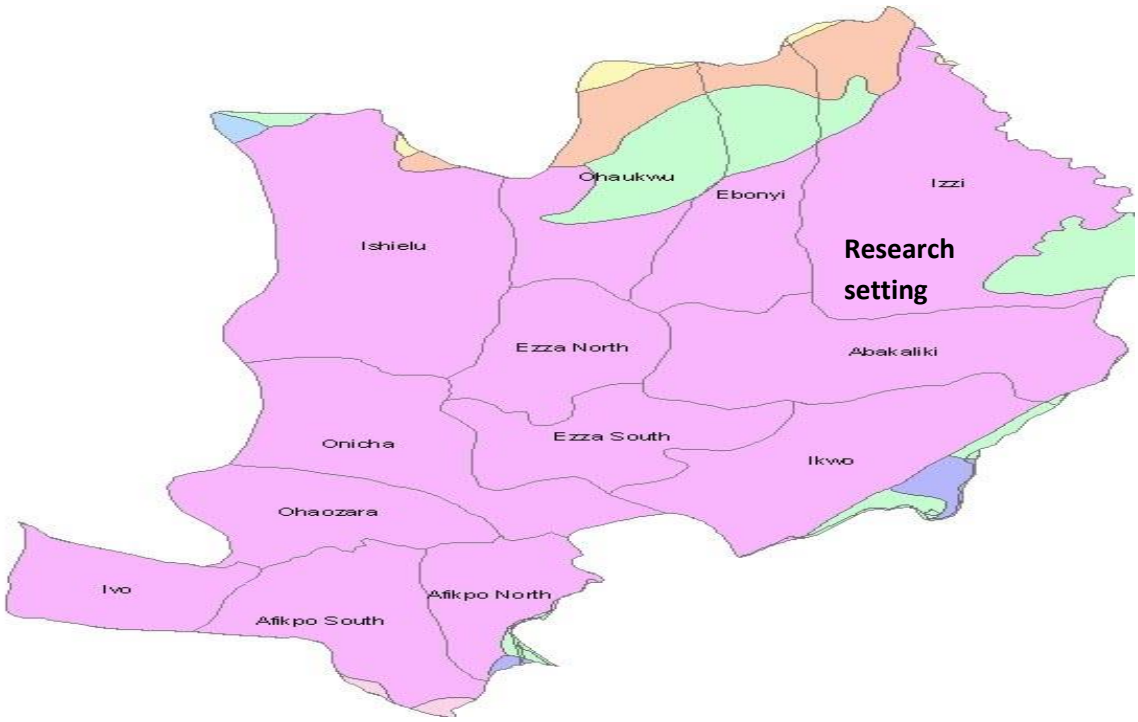


Figure 4.1: The map of Ebonyi state indicating the location of the research setting

Context of the study setting

Onuenyim Agbaja village in the Agbaja community in the Izzi Local Government Area of Ebonyi State in Nigeria provided a context for this study. This state was created in 1996 and is one of the youngest among the 36 states that make up Nigeria as a

country (EON Group International, 2015). The people from this state predominantly face health and social inequalities, unlike many other older states in Nigeria. Notably, Ebonyi state has 13 local governments grouped under three different senatorial zones, which include Ebonyi North, Ebonyi South, and Ebonyi central, respectively (EON Group International, 2015). Izzi Local Government is, therefore, one of the five Local Governments under the Ebonyi North senatorial zones, while Onuenyim Agbaja is one of the villages in the Agbaja community under the Izzi Local Government Area of Ebonyi State.

The Nigerian National Population Commission (NPC) states that one million, sixty-four thousand one hundred and fifty-six (1,064,156) males and one million, one hundred and twelve thousand seven hundred and ninety-one (1,112,791) females reside in Ebonyi state (NPC, 2014). However, no data was found for the population of people who live in Onuenyim Agbaja in the Izzi community, although the area is densely populated. The people of Onuenyim Agbaja, like every other community in Ebonyi state, have occupations, which predominantly include farming, fishing, and trading. As a result of the agricultural activities in this community, they produce crops such as yam, maize, groundnut, and cassava (EON Group International, 2015). The people of this community are predominantly Christians, and this supports the report by the Nigeria Demographic and Health Survey, which states that Nigeria is a deeply religious country (NPC, 2014). Anecdotal and observational evidence also supports that the activities of the women of this community are greatly influenced by their religious leaders, husbands, and social group. Therefore, the religious environment together with the sociocultural and gender pressures on women due to the patriarchal nature of Nigeria society may have some influence on their maternal health (Ugwu and Kok, 2015). The current study explored this assumption.

In terms of the provision of healthcare services in the Ebonyi state, the healthcare services are provided by the government and private health care organizations. The state has one federal healthcare organization, called the Federal Teaching Hospital, at the state capital which serves the specialist healthcare needs of all 13 local governments, as shown on the map of Ebonyi state in Figure 4.1. There are primary health care centres, private and faith-based healthcare organisations that provide for the health needs of the local community members in Ebonyi state. However, most of the rural healthcare organisations in Nigeria lack qualified healthcare personnel and equipment to meet the healthcare needs of the people (Ugwu and Kok, 2015). With reference to the research setting, there is no government health care centre that provides healthcare services to women and general community members. There is only one faith-based organization, called Sudan United Mission Hospital, which renders healthcare services to women during pregnancy and childbirth. Traditional Birth Attendants (TBAs) are also involved in the care of women during pregnancy and childbirth, but statistical evidence of the number of TBAs in this community is unavailable in any known literature.

The people of Onuenyim Agbaja have some cultural beliefs and practices, which are similar to other communities within the South-East geopolitical zones. The people believe that some invisible forces control all human activities and that these are responsible for everything that happens to individuals. The people believe that supreme gods, or a God, keeps watch over his creatures from a distance (Ogba, 1995). The people are generally sociable, live in a scattered settlement and speak Izzi dialect and Igbo Language.

4.4.2 The participants

4.4.2.1 Sample designation and size

In addition to choosing a research topic of interest and research design, choosing appropriate participants, and obtaining an adequate sample size is fundamental in ensuring credible research (Cresswell, 2013). The decision on the participants to participate in this study was grounded on the principle of purposive sampling and snowballing (see the summary of recruitment processes in Table 4.2). Purposive sampling is also known as judgmental sampling and is a deliberate choice of participants in relation to the characteristic or qualities the participants possess which is of interest to the researcher (Cresswell, 2007; Corbin and Strauss, 2008). I was guided by the aim of the study in my decision on suitable participants for this study, and carefully considered individuals with knowledge or experience of the issues under investigation. All women of reproductive age with and without children in Onuenyim Agbaja were considered eligible for this study. Specifically, all women who were able to discuss what they perceive as factors that influence maternal mortality and perceived strategies for its reduction in the rural community were considered eligible for inclusion in the study. In addition, TBAs were chosen for this study because they are perceived to be the custodians of tradition and are involved in childbirth, suggesting they could have good knowledge of the socio-cultural activities within the community that impact on maternal death. Furthermore, doctors, midwives, the religious and youth leader, the village head, and the women's leader, who are representatives or stakeholders of major groups in the community, were also considered part of the sample. Since these participants were representative of the different groups that constitute the community, their opinions and views offered a

robust understanding of the socio-cultural factors that influence maternal mortality. Participants' demographic information is shown in Table 5.1 in Chapter Five.

The participants have been selected purposefully, and it is argued that purposive sampling is not free from bias because participants are selected out of convenience or for their knowledge of the research interest (Smith, 1983; Lopez et al.,1993). However, Bernard, (2002) argued that the data generated from purposive sampling provides useful insights to understand a phenomenon of interest. Furthermore, Morse (2001) made it clear that, despite the inherent bias, purposive sampling can generate credible and robust data. Interestingly, the strength of purposive sampling is based on its intentional bias (Morse, 2001). Thus, instead of choosing participants based on their demographic data, such as their level of education, age, religion, and economic status which may not be useful to achieve the study aim, the sample was identified based on participant's knowledge of the area and purpose of the research (Lewis and Sheppard, 2006).

In accordance with the advice by Johnson et al., (2006) who highlighted that it is always good practice to estimate the sample size for research prior to the data collection, a total sample size of 40 participants was proposed for this study. However, 39 respondents participated in this study. This number fits within the acceptable sample size for a qualitative study and conforms with the recommendation by Onwuegbuzie and Leach (2007) that the sample size in qualitative research should not be too large to avoid difficulties in managing and extracting information. However, I was also mindful that the sample size in qualitative research should not be too small in order to avoid difficulty in gaining robust views and achieving data saturation (Patton, 2015). Finally, a recommendation by Patton (2015) stated the number of participators for this study; this was based on the available resources, allotted time,

and study objectives, which best determined a sample size in qualitative research. Thus, data saturation and time factors were considered in the decision about the sample size for this study.

4.4.2.2 Recruitment of participants

It is well known that accurate participant recruitment is an important aspect of qualitative research and also that understanding the target population is crucial in health qualitative research (Renert et al., 2013; Namageyo-Funa et al., 2014). In relation to this, a familiarization meeting was organised by sending a participant invitation letter (see Appendix 2) to the village head and the leaders of different groups in the study setting. This requested a meeting to explain the purpose of the study and to seek their assistance in recruiting other participants. Women of reproductive age with or without children were initially approached, either face-to-face or by sending them a participant invitation letter (Appendix 2). The next step was to give participant information sheet to each of them (Appendix 3) and offering them an opportunity to clarify any questions they may have about their participation. Finally, each participant was given a consent form (Appendix 4) to sign if they were happy to take part in the study. Notably, most were identified and recruited with the help of the village head in the research setting. Nevertheless, participation was voluntary after a detailed explanation of the purpose of the study to the women. The participants willingly volunteered to participate in the study without any compulsion. Details of the inclusion criteria, sampling and recruitment processes can be seen in Table 4.2

A snowballing technique was employed to identify the TBAs (see Table 4.2 for the sampling processes). This is an approach used in qualitative research where a respondent tells the researcher about someone they know with specified characteristics (Bryman, 2001). Ransom and Yinger (2002) stated that TBAs are

important in rural areas in Nigeria because they handle most of the childbirth that occurs there. TBAs were identified with the help of a respondent and included in the study for the interview after each of them was provided with a participant information sheet and consent form (Appendices 5 and 6). Although the disadvantage with snowballing is that a sample recruited through only this technique is always prone to bias as those who know each other may have similar characteristics and behaviour or can influence each other in relation to the research. However, it can be used as a supplement to other methods (Ritchie and Lewis, 2003). Therefore, snowballing was used as a supplement to recruit TBAs for an interview (see Table 4.2 for a summary of the recruitment process).

As with other group of participants, the healthcare professionals and opinion leaders were recruited by giving them a participant information sheet (see Appendix 5), and by providing them with an opportunity to ask questions about the study. Each were given minimum of 24 hours and up to one week to make a decision about whether to participate in the study. Those who agreed then signed the consent form (Appendix 6). The summary of the recruitment processes for each group of participants is shown in Table 4.2.

Table 4.2: Recruitment process based on the inclusion and exclusion criteria

The participants	Sampling strategy	Inclusion criteria	Exclusion criteria	Recruitment process
Women of reproductive age with children used for the focus group discussion	Purposive and snowballing	The participants were selected because of their personal experiences or knowledge of childbirth Women of reproductive age meeting these criteria - Had given birth with a TBA - Had given birth with midwives - Had given birth at home - Had given birth with other health care professionals - Not pregnant	- Women who are not at a reproductive age. - Women with no experience of childbirth	- Were identified and approached face-to-face or by giving each of them participant invitation letter - These participants were recruited by providing them with participant information sheet (See Appendix 5) - Provided an explanation about the study in English and Igbo Language - Allowed up to 72 hours to make decision about participation - Given informed consent form (See appendix 6)
women of reproductive age without children for focus group discussion	Purposive and snowballing	Women who - Had not given birth - Had knowledge of childbirth - Are in their reproductive age - Not pregnant	- Women who are not in their reproductive age. -women with no experience of childbirth	Followed the same recruitment process as above

5 women of reproductive age for interviews	Purposive Snowballing	Other women who were mentioned as having robust knowledge about childbirth (n=5)	Women who were unwilling to participate in a one-to-one interview	- Women who met these criteria were identified and were recruited then - Provided information about the study (see Appendix 3) - Given a consent form (see Appendix 4)
3 doctors and 4 midwives	Purposive Snowballing	Doctors who work in maternity department of the hospital in the studied community Midwives who currently work in the hospital located in the studied community and possess 15 years or more experience Midwives who previously worked in the studied community	Doctor who has no experience of providing care to women during pregnancy and childbirth Midwives who have no experience of providing care to women during pregnancy and childbirth	- The doctors and Midwives were identified and recruited based on my previous knowledge of healthcare professionals who work in the studied community - They were approached by giving them participant invitation letter 9 (see appendix 2) - The recruited doctors and midwives referred to others who met the inclusion criteria - Both the doctors and midwives were provided with participant information sheet about the study

				- Given opportunity to ask questions and make decision about participation - There were given informed consent form (see appendix 6)
3 Traditional birth attendants	Purposive Snowballing	TBAs who currently provide care to women during pregnancy and childbirth	TBAs who are no longer provide care to women during pregnancy and childbirth	- A TBA was identified with assistance from the community leader - Other TBAs were identified by snowballing technique - TBAs were provided with a participant information sheet (Appendix 5) about the study - Given the opportunity to ask questions and make decision about participation - Given informed consent form (see Appendix 6)
Opinion leaders • A village-head • A religious leader • A youth leader • A women leader	Purposive Snowballing	Lead any group in the community	Not a leader in the community	- Identified through snowballing - Each of the opinion leaders were provided with participant information sheet (appendix 5) about the study - Given opportunity to ask questions and make decision about participation - There were given informed consent form (see appendix 6)

4.5 Data generation methods

In qualitative research, there are different types of methods used in data generation, such as observation, focus group discussion, interviews (individual or group) and textual or visual analysis either from books or videos (Silverman, 2013). The two methods used to generate data for this research were in-depth interviews and focus group discussions, as shown in Figure 4.2. Following the recommendations by Newell and Burnard, (2011), the decision about the choice of these methods was based on a consideration of where and from whom to elicit information as well as what sort of data would help to answer the research question. These data generation methods are shown in Figure 4.2 and this is followed with a discussion of how they were used.

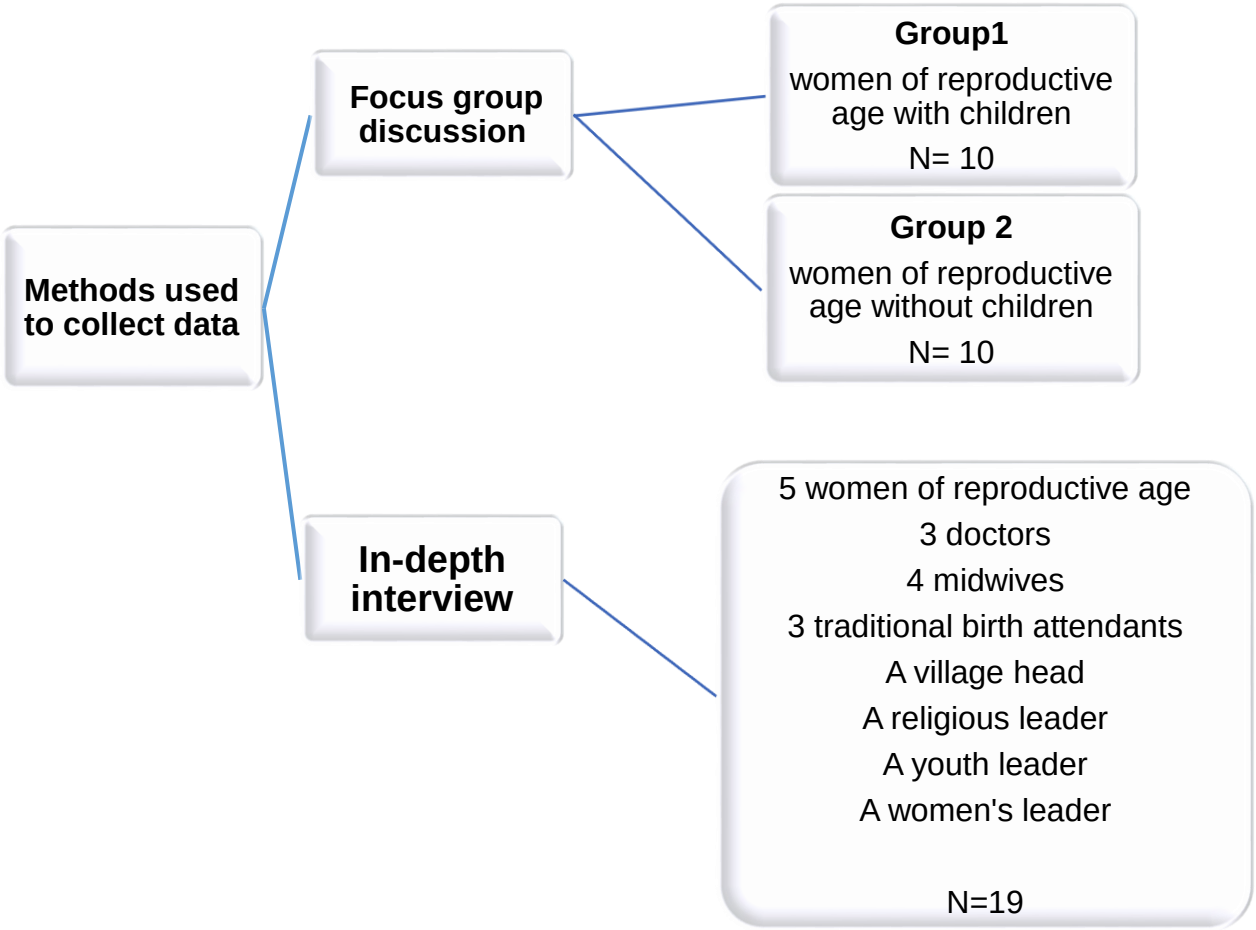


Figure 4.2: Data generation methods

4.5.1 Focus group discussion

There are several definitions of focus groups in the literature, but most influentially Kitzinger (1994) and Morgan (1998) define a focus group discussion as an organised group, that is guided, monitored, and recorded by a researcher with the intention of gathering information on a topic of research interest. Focus groups are also used to obtain data on collective views and can be used in gathering participants' perceptions and beliefs (Morgan, 1998; Wilkinson, 2004). Focus groups have three uses, which include use as a self-contained method of gathering primary data; use as a

supplementary method of data collection when the main interest of the study depends on another method, and lastly as an aspect of multimethod research, which uses two or more methods for data collection (Onwuegbuzie and Collins 2007; Sobresperez, 2008).

In this research, a focus group discussion was combined with one-on-one, in-depth interviews, which generated robust data that considered various perspectives on the topic under investigation. The justification for using focus groups in this study aligned with the statement by Krueger (1995) that focus groups aim to identify and capture attitudes and perceptions in relation to concepts and programmes, leading to interactions with other people. This means that the researcher takes advantage of the interactions among group members to generate rich data (Onwuegbuzie et al., 2009). Thus, the aim of the focus group is to establish an inclusive context where respondents draw from each other in a process of mutual discussion (Berg, 2001; Wong, 2008). Therefore, interaction becomes key to the focus group method, because what a respondent says can be confirmed, or contradicted within the group discussion (Krueger, 1994; Wilkinson, 2004; Wong, 2008), as was experienced in the current study. Interestingly, a focus group discussion can also raise conflicting ideas, which would thus be expected in studies that adopt this method. This can cause participants to reconsider their opinions, which can lead to a change of mind or the upholding of views. This made this process very creative because ideas came up and were introduced by various participants which the researcher might not have considered (O'Reilly, 2005). In addition, George, and Jones (2008) added that group dynamics enable the emergence of different types of ideas from participants, and therefore hearing different views can be an advantage. For instance, participants might have forgotten some information but a discussion with others can enable the recall of such

information. It also helps the researcher to gain an insight into the group dynamics and how to heighten the group involvement.

In the current study, two focus group discussions were organised during the data generation process and a focus group guide (see Appendix 7) was developed to guide the process and discussion. One focus group was comprised of 10 women of reproductive age with children, and the second group consisted of 10 women of reproductive age without children (see Table 5.1 for the participants' characteristics). Due to the homogeneity of the group, the participants were sufficiently relaxed and comfortable to share their thoughts and perceptions of the socio-cultural factors that influence pregnancy and maternal mortality. The meeting took place in a room at the village town hall whereby particiants were solely present during the focus group discussion. The participants sat in a circular form in such a manner that enabled them to see each other when giving their opinion. Refreshments were provided and the ground rules explicitly explained (see Appendix 7). Each focus group discussion lasted for a period of 55 to 70 minutes. The women were asked many questions, such as; what they know about their traditions which have implications during pregnancy; why do some women not seek antenatal care in the hospital during pregnancy; what is the role of the religion in women's health; what do they perceive as the cause of maternal mortality in the community, andwhat do they believe about pregnancy, childbirth and maternal mortality, (Appendix 7 shows the focus group guide). They also discussed and explained the cultural issues that affect women in general in the community. An interpreter was not used during the discussion because the researcher understood the local language used by some of the participants when expressing their opinion.

The discussion was recorded in a tape recorder and the researcher also wrote notes. The focus group effectively revealed insightful information about the views of the

women on the causes of maternal mortality in rural communities. Women effectively discussed the research topic, whilst the researcher asked different questions which focused on eliciting responses to achieve the objective of the research. This proved a useful method to answer the research questions (Stewart et al., 2007). The information, themes and issues generated from the focus group discussion were further explored through one-to-one, in-depth interviews.

4.5.2 In-depth one-to-one interview

An interview remains one of the most widely used methods of data collection in qualitative research. Warren (2002) described interviews as a face-to-face conversation between the researcher and participants, which aims to understand meaning through an explanation of a topic under investigation. Interviews in qualitative studies are categorised in three different ways; structured, unstructured, and semi-structured (DiCicco-Bloom and Crabtree, 2006; Edward and Holland, 2013). A semi-structured interview was adopted in this research because it provided an opportunity to explore in more depth some of the emerging ideas generated during the focus group discussion. It also provided an opportunity for the participants to explain new ideas they considered important. In contrast, a structured interview was not considered because it is often akin to the oral administration of questionnaires where a list of pre-arranged questions is asked with no plans for follow-up questions (Gill et al., 2008). In comparison, unstructured interviews do not reflect any predetermined ideas or theories, therefore unstructured interviews were inappropriate to explore ideas from the focus group discussion.

As done during fieldwork, the semi-structured interviews were scheduled in advance at an agreed time and location (such as an office or town hall), and a set of pre-

planned, open-ended questions (see Appendix 8) were used to allow for dialogue between the interviewer and the interviewee (DiCicco-Bloom and Crabtree 2006; Edward and Holland, 2013). The information generated from the two focus group discussions informed the guide that provided the basis for the in-depth interview. This implies that some of the points raised by the focus group participants were further explored in the interview in order to elicit more clarification and acquire detailed knowledge about the emerging ideas (Appendix 8 shows the interview guide). In-depth semi-structured interviews were used in this study since they allowed the researcher to explore the respondents' perceptions and beliefs about the topic under investigation (Cresswell, 2007; Gill et al., 2008). Also, it gave an opportunity to explore the participant's own views on the socio-cultural influences on maternal health and maternal mortality, without any collective or group influence.

In addition, Gill et al., (2008) highlighted that the flexibility of this method allows for the elaboration of information in a more detailed way by the participant. Data was generated from 19 participants, which consisted of five women of reproductive age, three doctors, four midwives, three traditional birth attendants, and the opinion leaders which included a religious leader, a village head, a youth leader, and a women's leader (Table 5.1 details the participant demographic characteristics). These data offered views on the socio-cultural factors that influence pregnancy and possible solutions to the high rate of maternal mortality. The participants and the researcher agreed on a suitable room in the community town hall. However, the interview for the healthcare professionals took place in different rooms and offices at their workplace where it was quieter and more conducive for an interview; in such cases, the interview was conducted out of office hours based on the participant's availability. Gill et al., (2008) stated that interviews should be undertaken in a place free from distractions and at the

time and setting that is most suitable for the interviewee. Overall, the venues for all interviews were risk assessed to prevent or minimise possible risk. This followed Creswell's (2007) advice that a researcher should create a conducive environment where the interviewee can chat freely and form a good rapport to enable them to disclose their experiences, thoughts, emotions, perceptions, and inner thoughts (Barbour 2005; Creswell, 2007). Although an interview setting was chosen that considered the interviewees' preferences, the researcher was also mindful of the sitting arrangement (face-to-face) and promoted the free flow of information from the interviewee. Moreover, the researcher-maintained professionalism during the interview without conveying any cultural shock about the emerging socio-cultural issues from participants.

Furthermore, interviews were personal, direct, face-to-face, and were recorded with an audio recorder, lasting for an average of 45 minutes to an hour. The advantages of audio recording were explained to the participants; namely, to ensure that accurate opinions were captured, and to allow the researcher to concentrate on the interview questions and responses instead of notetaking (Bailey, 2008). Warren (2002) noted that participants talk more freely when the recorder is turned off than when it is switched on. However, participants in the current study said they wanted their voices to be heard and were happy to be voice recorded. Thus, the interviewees were not constrained by the presence of the recorder but were relaxed and able to express their opinions, experiences, knowledge, and perceptions about the socio-cultural factors that influence maternal mortality. The researcher was able to delve more deeply into the interviewee's personal experiences and perceptions about the topic under investigation without any restriction. This contributed to an in-depth discussion on the concerns raised during the focus group meeting.

Nevertheless, qualitative interviews have been criticised for various flaws, such as their subjection to individual features like class and ethnicity, race, and gender (Denzin and Lincoln, 1994). However, May (2002) and Bryman (2001) stated that this kind of interview offer the opportunity to gather robust data that enables an understanding peoples' perceptions and socio-cultural beliefs. It further encourages a good rapport between the researcher and the participants which helps to generate qualitative data on their beliefs and cultural practices (Chapman and McNeill, 2005). Besides, it allows the interviewer to monitor the discussion, thus obtaining all the relevant information required. Although it consumed a lot of time due to the bulky volume of data generated, this method produced useful data which were used to answer the research questions.

4.6 Data Analysis

Qualitative data analysis is the range of processes and procedures where researchers move from qualitative data, which have been collected into some form of explanation, description and interpretation of the people and situations under investigation (Grbich, 2012). A qualitative data analysis allows researchers to make sense of the raw data in terms of the participants' views and experiences of the situation (De-Casterle et al., 2012; Gray, 2014). However, some level of subjectivity exists during the data analysis (Strauss and Corbin, 1998), as it involves interplay between the researcher and the data, meaning there is some level of subjectivity within the interpretation of the generated data (Rabiae, 2004). Although there is an argument on the extent to which the process of qualitative data analysis can uncover the truth, it is suggested that there should be an audit trail or sufficient explanation of how qualitative data are analysed (Dey, 2003). This allows another researcher to verify the findings, thereby increasing the rigour of the study.

Interestingly, whilst qualitative data analysis is widely known to be an exercise that transforms data into findings, there is no one formula or recipe to guarantee the success of such transformation (Patton, 2015). Grbich, (2012) similarly states that qualitative data analysis is a complex process and no procedure for the analysis will guarantee the success of the data transformation. Therefore, it is argued that there is no one way to work with qualitative data (Casterle et al., 2012. Nevertheless, it is reassuring that each qualitative tradition offers guidance or direction for data analysis (Patton, 2015). This implies that, during the qualitative data analysis, researchers consider which methods or techniques can support this challenging intellectual process (Dey, 2003). There are many approaches or techniques for qualitative data analysis, which include: discourse analysis, thematic analysis, grounded theory approach, conversational analysis, narrative analysis, and framework analysis (Cohen et al., 2011; Patton, 2015). The choice of a particular technique is informed by the purpose and theoretical perspective of the study (Keenan et al., 2015). These choices are also made in relation to the research design and the method used to generate data. Male (2016) acknowledged that qualitative data analysis typically commences concurrently with the data collection. Similarly, Rabiee (2004) supports that qualitative data analysis, and particularly a focus group discussion occurs concurrently with the data collection and this can be undertaken in the form of reflections and preliminary field analysis during the data collection process.

Thematic analysis is widely used in qualitative data analysis and has been chosen for this study. Thematic analysis is a form of pattern recognition within the data (Joffe and Yardley, 2004), and is a method for identifying and analysing patterns (themes) within qualitative data (Braun and Clarke, 2006). This analytic approach is appropriate for the study because the researcher aims to uncover the patterns of socio-cultural

meanings based on participants' perceptions and experiences of the issues that influence maternal mortality. Braun and Clark (2014) acknowledged that thematic analysis aims to capture the perceptions and experiences grounded in the participant's account. Thematic analysis provided the opportunity to gain a detailed and in-depth description, explanation, and interpretation of the participant's perceptions of the socio-cultural issues that influence maternal mortality and on how to reduce maternal death and improve maternal wellbeing. Additionally, focus group discussions and interviews, as methods used to generate data in this study, lend themselves to thematic analysis (Joffe and Yardley, 2004; Rabiee 2004; Krueger and Casey, 2014). The analytical approach was chosen because it supports the theoretical perspective of constructivism that underpins this study.

There are recorded successes in the use of thematic analysis to address questions about people's views, opinions, and practices (Braun and Clark, 2014). Thematic analysis has also been used to analyse transcripts from the interviews and focus groups (Braun and Clark, 2014). However, Antaki et al., (2003) argued that a lack of clear, concise and strict guidelines for thematic analysis could mean that 'anything goes. Tuckett (2005) similarly stated that thematic analysis lacks clear agreement on a rigid process for data analysis. These authors argued that, if there is no prescribed clear data analysis process, it will be difficult to assess the dependability of the research outcome (Antaki et al., 2003; Tuckett 2005). Conversely, Braun and Clark (2014) stated that the thematic analysis process is systematic, sequential, and verifiable and this provides the trail of evidence needed to assess the quality of the analysis. There are six phases of thematic analysis, which involve some degree of iteration between the phases (Braun and Clarke, 2006). This implies that analysis involves the constant backward and forward movement between the entire data set

and the phases of the analysis under construction. A summary of these phases is presented in Table 4.3.

Table 4.3: Summary of the data analysis phases

Phases of data analysis	**Brief description**
Phase one: Familiarising yourself with your data	This phase involves immersing oneself into the research data by reading and re-reading the data to grasp the depth and the breadth of the content. At this stage, I repeatedly listened to the voice recordings of the focus group discussion and the in-depth semi-structured interview, and then commenced the transcription. Bird (2005) argued that this phase is an interpretive act where the initial impression is noted, and the meaning created.
Phase two: generating initial codes	This phase involves a systematic way of organising your data into meaningful groups. Codes were generated to explain chunks of raw data and were assessed in a meaningful way regarding the issue under investigation. Thus, the coding process was used to arrive at themes that emerged from the data (Cresswell, 2014).
Phase three: searching themes	This phase involves looking at the relationship between codes and collating/grouping similar codes to form a broader category that could form themes and sub-themes.
Phase four: reviewing the themes	This involves considering the suitability or appropriateness of the themes with the actual data and reviewing if the theme reflects the set of data by re-reading the transcript again to check and modify the codes or add additional codes if necessary. A visual thematic map aided this process of code review codes within each theme.

Phase five: defining and naming themes	In this phase, I redefined and refined the themes to ensure they capture the full meaning of the themes in relation to the codes labelled for each data set.
Phase six: producing report	This phase involves writing up the analysis using extracts from the data. The report is written under the broad themes generated from the data analysis processes of both the focus group and interview scripts.

The application of these phases in relation to the data analysis is presented next

4.6.1 Summary of the processed used to analyse data

Thematic analysis was chosen as the analytical framework for this research and I followed all the six prescribed phases. I summarised this into a two-stage processes which were data transcription, and coding. These stages are discussed further in the following sub-sections.

4.6.1 Transcribing process

Data transcription is the representation of audible or visual data in a written form (Bailey, 2008). Representing audible talk as the written word requires reduction, interpretation, and representation in order to make the written word meaningful and readable (Burnard et al., 2008). The transcription process is acknowledged as time-consuming and regarded as a meticulous process (Smith and Firth, 2011). Nevertheless, it is a valuable thematic analysis stage because it gives the researcher greater familiarity with the data. In this process, I listened to the focus group discussions and the interview audio recording several times to familiarise myself with

the data before transcription. Then, all the interviews and focus groups discussion were transcribed into English (samples are shown in Appendix 9).

On average, about 12 hours were required to transcribe each one-to-one interview while transcription of the focus groups discussions took a longer period, between 15 to 24 hours, with the transcript length varying from 5 to 13 pages. This was a two steps process; I transcribed the focus group discussion and conducted an initial analysis of the data. I then used this to inform the interviews. At the completion of the entire transcription process, I spent some days listening again to the focus group discussions and interview tapes and went through the interview and focus group transcripts to ensure that no important information had been missed. Subsequently, the data analysis process continued with the data coding.

4.6.2 Coding process

The data coding process involves assigning codes to a segment of data (Bird, 2005). The core idea of coding is that texts containing raw data are indexed (Gläser, and Laudel, 2013). Codes are tags or labels for assigning units of meaning to the descriptive or inferential information compiled during a study (Miles and Huberman, 1994). Gläser, and Laudel (2013) stated that codes are words, phrases or mnemonics that describe a specific segment of transcript (Gläser, and Laudel, 2013). These authors further highlighted that codes aim to indicate what is talked about in a segment of text and thus support the retrieval of text segments, which can be used to support analytical claims (Gläser, and Laudel 2013).

In this research, coding began after all the transcripts were stored in Nvivo 11. This software was used because it supports the coding and organization of qualitative data (Bazeley and Jackson, 2013). An inductive and deductive approach to coding was

used in this project. Inductive coding involves analysing data with little or no predetermined theory, structure or framework and uses the actual data to derive the structure of analysis (Burnard et al., 2008). This approach was chosen because it is comprehensive although time-consuming; it is most suitable where little or nothing is known about the study phenomenon (Thomas, 2006). Furthermore, Holton (2007) added that inductive or open coding prevents the researcher from being constrained or inhibited from the effective generation of conceptual categories. All the transcripts were read line by line and codes were assigned to segments of text. The codes were reviewed, and similar codes grouped into conceptual categories. The conceptual categories were reviewed, and this led to the generation of themes with samples, as shown in Figure 4.3.

It should be noted that the list of nodes shown in Figure 4.3 is not all-inclusive but a sample to demonstrate the processes undertaken to generate the themes. The three themes generated following the thematic analytsis are shown in Figure 5.1 in Chapter 5.

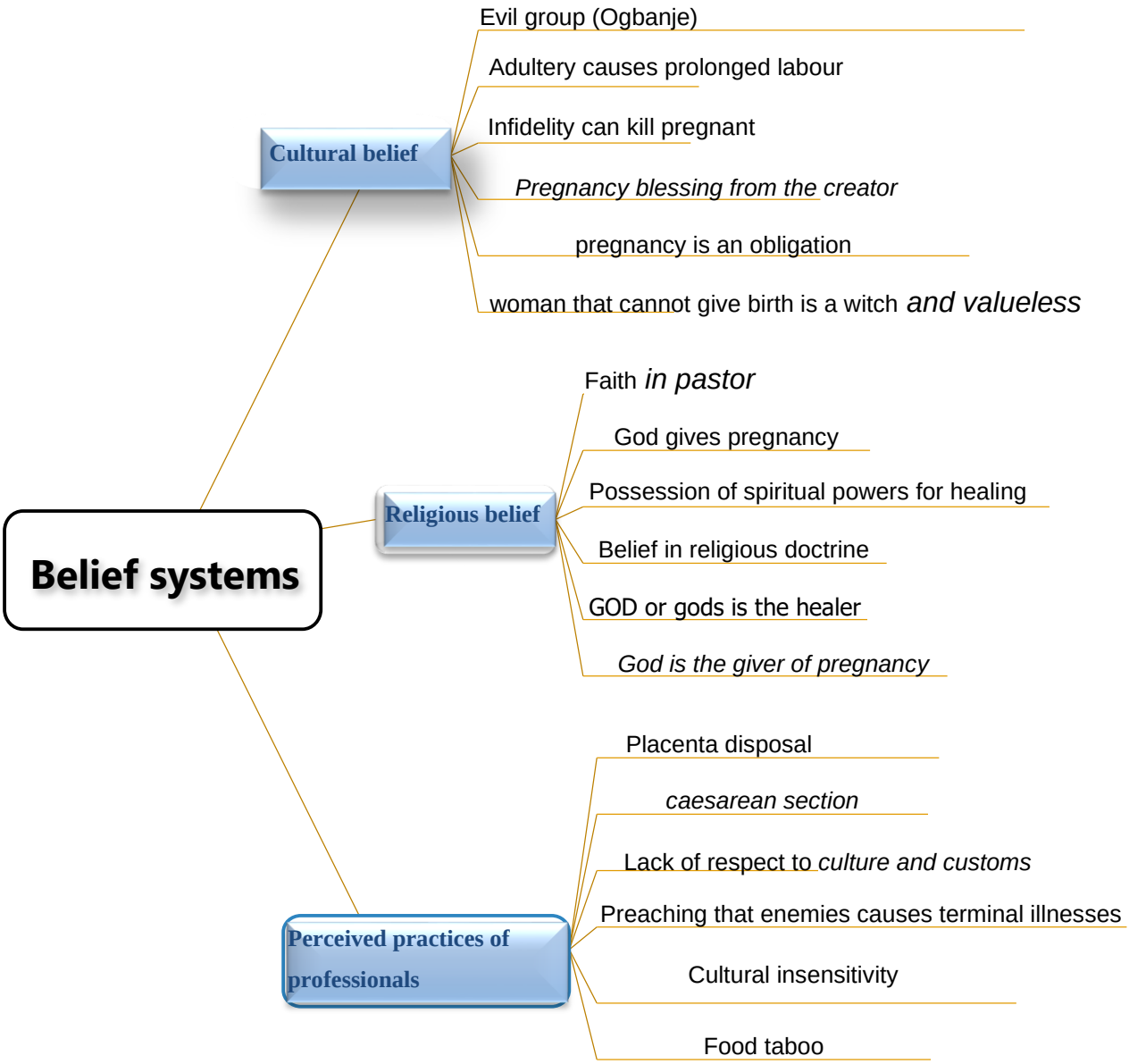


Figure 4.3: Thematic structural processes

4.7 Rigour of the Study: Credibility, Reliability, Generalisation and Reflexivity

Rigour is a concept used in qualitative research to signals the quality of the research process (Given, 2008). Evidence based on the literature suggests that there is a contention on how to assess the quality of qualitative research. Despite an increase in literature addressing the quality of qualitative research, Sandelowski (2015) acknowledged that there is no consensus on how to assess this. Corbin and Strauss

(2008) argued that the quality of research is influenced by the purpose of the research, the methods utilised in its conduct, and by the researchers undertaking the study (Corbin and Strauss 2008). The findings from the systematic review conducted by Cohen and Crabtree (2008) show that the quality of qualitative research can be assessed using seven criteria. These include: the relevance of the research, reflexivity, the use of rigorous and appropriate research methods, credibility, reliability, the clarity and coherence of the research report, and the conduct of ethical research. However, Casey and Murphy (2009) added that the method of triangulation increases the trustworthiness of the research. Method triangulation has been undertaken in this research by constantly comparing the data generated from the focus group discussion and in-depth interview methods. This is one of the methods used to ensure the trustworthiness of the research outcome. Furthermore, an evaluation of the research quality is emphasised by Guba (1990) in terms of its trustworthiness. Evidence from a range of literature agreed that trustworthiness can be assessed by the criteria mentioned by Cohen and Crabtree (2008). Some of these concepts are discussed next in relation to the conduct of this research.

Reliability concerns the reproducibility of the research findings, or whether the result could be applied to other regions (Bryman, 2012). In qualitative research, Silverman (2013) and Seale (1999) acknowledged that complete replication is unrealistic and even unnecessary, although some degree of replication would or could be possible. Differing views of the same events or activities by different researchers and different interpretations of the same phenomenon, behaviour or activities are likely in qualitative research. Social constructionists believe that different perspectives, or accounts, of the social world exist and there is no way of determining the most authentic (O'Reilly, 2012). Most qualitative researchers are rather more interested in the patterns of social

life, such as daily routines or patterns of behaviour and thought, which are replicable in various contexts by various people. In this research, the research finding may be reproducible within the same cultural environment. This is because culture informs people's entire beliefs and practices; therefore, the cultural issues reported by participants are likely to be applicable to other members of the community.

Generalisation is the application of the research findings beyond a particular setting, group, or context. A qualitative study is more concerned with an in-depth understanding of a setting, group, or context rather than generating findings to represent an entire population (Bryman, 2012). However, an awareness of the need to generalise qualitative research finding is increasing, although Brewer (2000) has warned that a qualitative researcher should be cautious in generalizing findings obtained from a small sample size, or from one or two study sites. Similarly, Seale (1999) acknowledged the limitation of generalising qualitative research findings very widely although it can be generalised in various ways, such as in similar settings or similar groups, because the result can be used to draw inferences. The research finding of this study is most likely to be generalizable but only within and to communities with similar cultural contexts. However, it is most likely to be generalised in states within the South-Eastern geopolitical region of Nigeria due to the similarities in cultural beliefs and practices.

Credibility is the confidence that can be placed on the plausibility of the research findings (Macnee and McCabe, 2008). It establishes whether the research findings are plausible based on the data and whether they are a correct interpretation of the participants' views and perceptions (Graneheim and Lundman, 2004). There are some recommended approaches and techniques that can be used to establish the

credibility of a qualitative study, which include triangulation, debriefing, member checking, peer review, and external auditing (Barker and Pistrang, 2005; Cohen and Crabtree, 2008). However, these procedures have been criticised by some authors (Barbour, 2003; Eakin and Mykhalovskiy, 2003; Sandelowski, 2015), who argue that asking members to check their data is unnecessary. To these authors, the participants may not recall what they said or did; therefore, member checking is considered irrelevant (Barbour, 2003; Eakin and Mykhalovskiy, 2003; Sandelowski, 2015). Data triangulation is particularly relevant in this study and was utilised as one of the approaches to ensure its credibility. The different data sources were compared to identify patterns of convergence or divergence and thus develop an overall interpretation. This helps to enhance the quality and credibility of the research by assisting the researcher to reduce bias and examine the integrity of participants' responses (Anney, 2014). Again, feedback from the supervisory team throughout the research processes also contributed to the credibility of the current research. This is because the supervisors' comments challenged my thought processes and approaches, which thus provided an opportunity to become more critical, unbiased travel more in-depth with the data analysis.

4.8.1 Reflexivity

It is clear that there is no agreed meaning of reflexivity, wuch as when and how it can be applied in the study process (D'Cruz et al., 2007; Darawsheh, 2014). Reflexivity is viewed as a theoretical idea and a methodological instrument in qualitative research (Hall and Gallery 2001; Kingdom, 2005). Thus, reflexivity is, therefore, the '*awareness of the influence a researcher has on what is being studied and also how the research process affects the researcher'* (Probst and Berenson, 2013:814). The idea of

reflexivity has been widely acknowledged as a vital tool within the research process (Bott, 2010; Lambert et al., 2010). Probst and Berenson (2013) assert that the quest for its utilization is increasing more in qualitative research than in quantitative studies. In terms of authorising the quality of the research, researchers must also be aware of their own reflexivity when conducting a study (Finlay, 2003). Also, readers are always concerned to find reasons to trust researchers and the products of their study (Pillow, 2003). Finlay (2003) stated that beliefs, perceptions, assumptions, and interest from the researcher can impact the results of the study. Reeves et al., (2013), added that reflexivity is a procedure that encompasses the reflection of the researchers' values, experiences, beliefs, behaviour, background, knowledge, actions, feelings, actions, thoughts, emotions, and position while planning and conducting a study. This is why Chambliss and Schutt (2006) argued that the way researchers handle issues and communicate with participants in the field are expressed as their own reflexivity within the research process.

Therefore, the idea of reflexivity is crucial to qualitative research because qualitative researchers are often represented as having the potential to negatively affect their data collection and analysis (McGhee et al., 2007; Bryman, 2008; Holoway and Biley, 2011). Moreover, Doyle (2013) confirmed that the values and experiences of qualitative researchers can have potential influences on what they see and understand, and thus introduce bias. Reflexivity in a qualitative study is paramount as it enables the researcher to constantly reflect on how their own profession, actions, values, perception, and behaviour can influence both data generation and data analysis (Gerrish and Lacey, 2006). Therefore, reflexivity is used by researchers to uphold transparency in the conduct of research and is used as a technique for the

validation of research practices, to minimize the researcher's influence on the study (Kingdom, 2005; Smith, 2008).

The idea of reflexivity is vague as it is identified with numerous meanings (Ybema et al., 2009; Darawsheh, 2014). Different authors have acknowledged that the practice of reflexivity in a qualitative study is an important strategy in the process of gathering knowledge (Hammersley and Atkinson, 2007; GerstI-Pepin and Patrizo, 2009; Ahmed et al., 2011; Probst and Berenson 2014). Similary, Finlay (2003) added that, for transparency in the data generation and analysis process, reflexivity should be clearly noted in order to clarify the researcher's views. I agreed with Finlay because, to give appropriate detail on how the generation and interpretation of data were achieved, the researcher should report on his/her reflection during the research process. Besides, Chambliss and Schutt (2006) and Reeves et al., (2013) stated that reflexivity empowers readers to determine the findings and conclusion of the study, via the researcher's perspectives. In Section 4.8.1.1, I present my own experiences and reflexive explanation to express how my experiences, personality, values, and emotions may have affected or impacted on the study process during the data generation and analysis. This will guide readers to judge the value of the study by measuring the possible impacts of these influences on the study (Reeves et al., 2013).

4.8.1.1 Researcher's Background and Experiences

Kleinman (1991) recommended that, in qualitative research, the researcher should acknowledge their background, values, bias, beliefs and experiences before conducting the fieldwork. In relation to this recommendation, my personal experiences, educational and cultural background are explained and analysed hein this sub-section.

The researcher was fully aware of her responsibility as a midwife, as well as a researcher, and also the need to be reflexive on how the research is conducted. Prior to the data generation, I tried to identify my personal feelings and perceptions, which exposed my disappointment around maternal death. At this point, I remembered my National Youth Service Corps (NYSC) where I served the country for one year in a federal hospital in Nigeria. I experienced a significant number of maternal deaths as a result of pregnancy. This prompted me to conduct a review of the hospital's records (Federal Medical Centre Lokoja, Kogi State, Nigeria) to ascertain the major cause of maternal mortality during pregnancy. I found out that postpartum haemorrhage was the leading cause of maternal death in the hospital. Based on this, during my master's programme, I decided to conduct a systematic review on the use of misoprostol for the prevention of post-partum haemorrhage as my dissertation (Agom et al., 2015). Despite the efforts to reduce maternal death, it is still high in Nigeria. As a qualified midwife I have worked in different communities, such as Nwaezenyi in Ebonyi State, and Lokongoma in Kogi State, Nigeria. It was during this period that the present study was conceived as, in my community work, I witnessed some unsafe maternal health practices that had injurious health implications. Qualitative researchers frequently assume a reflexive position to overcome the likely problems accounting for their preconceptions about a study. My belief on this subject is that *"no woman should die while giving birth";* a close friend bled and died during pregnancy because there was no good road and transportation system to transport her from the community to town for expert management. This experience left an indelible mark on my memory.

As a midwife with many years' experience, a teacher of midwifery, and being pregnant at the time of this study, it was important for me to reflect on how these might have influenced the research. I also hail from the geopolitical and cultural zone where this

research was conducted. I am familiar with the research setting as I am married to someone from the community. This gave me the advantage of already having some understanding of the socio-cultural factors that influence maternal health. However, this unavoidably means I bring to the study strong views on what constitutes adequate maternal health practices, which include the provision of care during pregnancy and childbirth by a qualified midwife in healthcare centres in the community or tertiary healthcare hospitals. Meanwhile, I was cognisant of my position as a researcher/midwife. I always acknowledge that researchers are part of the social world they study but must cultivate the attitude of reflection on themselves and the activities of that world. Due to my experiences, my profession as a midwife, my cultural background, and my pregnancy during the study, I acknowledge that these impacted and had an influence during the data collection, data interpretation, and knowledge construction. Similarly, Morse (2001) and Lincoln and Guba (1985) accepted this fact and stated that a researcher's experiences, background, and social identity influence the study process. This is why Patton (2015) posits that reflexive practice should include the documentation of the elements of the researcher's professional and personal information that may influence the data generation, interpretation, and analysis. According to Corbin and Strauss (2008), I actively practiced reflexivity throughout the phases of this study and was aware of my responsibility as a midwife, my preconceptions, personal traits, and my pregnant state as I connected with participants about the influence of maternal death during pregnancy, labour and puerperium. My reflective account during the data collection is presented in the next sub-section.

4.8.1.2 During Data Collection

In the data generation phase, reflexivity gave me an opportunity to appraise the subtleties of the researcher and the participants' involvement in the construction of knowledge, continually adjusting these dynamics during the field work to improve the reliability of the research (Bover, 2013). Also, Lofland (1971) stated, as a tradition, when a researcher has requested an understanding of human behaviour within the framework of naturalism, she is required to minimize her effects on the study process. I consciously upheld my responsibility as a midwife and as a researcher; I documented my feelings, emotions, fears, actions and reactions, mistakes, thoughts and decisions in my research journal and it was continuously reviewed which enabled me to adjust some of my actions. This practice accorded with previous researchers, such as McGhee et al., (2007) and Prosbst and Berenson (2014), who develop self-consciousness during the stages of their research data generation.

During the first focus group discussion with women of childbearing age with children, I displayed some emotions, which distracted me for a few seconds from listening to the contributions of the women. I was emotional and compassionate when they shared how pregnant women are subjected to strenuous activities in order to earn money to feed the family, and how their husbands frequently subjected them to domestic abuse while pregnant. After the focus group discussion, I reflected on my performance and noted that I exhibited empathy. This was against what Patton (2015) calls '*empathetic neutrality',* although this was an understanding based on a neutral stance. In addition, during one of the interviews with a traditional birth attendant, I was able to control my feelings and actions as she was pouring the herbal drink in a can for pregnant women who visited her to drink for the nourishment of the foetus and pregnant mother. She tried to persuade me to take the drink, as I was pregnant at the time of this data

generation. She insisted that I would not interview her unless I took the herbal mixture. I maintained calmness and implored diplomacy and told her that I would take the drink as soon as I returned home. It is her belief that the herbal mixture nourishes the foetus in utero and aids normal delivery during labour. Although I am familiar, to some extent, with the cultural practices and beliefs of the people, it was rather difficult to flout what was considered ‘good maternal practice’.

I also experienced unprecedented disappointment from one of the traditional birth attendants; she consented to be interviewed but on arriving at the agreed venue, she kept me waiting for two and half hours. She later showed up to inform me that she could not continue with the interview because she was scared that I could be a spy who came to elicit information in order to arrest her for illegal practice. Also, coupled with my pregnancy, she said she could not disclose any information to me because I was not her client. Although it was really difficult for me, I was able to control my emotions and reactions, as I quickly remembered that any participant could disassociate from the study without any question. Thus, my pregnant state, and my position as a midwife and researcher had an influence on the data collection. Thus, the researcher’s positionality is described next.

4.8.1.3 Researcher’s Positionality: the insider-outsider viewpoints

According to McGarry (2015), positionality is how people are defined in relation to their change of position and identity in a web of relationships. It can also be referred to as where one stands relative to others. Based on this study, positionality is a reflection of who the researcher is as an individual, a member of the community under investigation, and how this position affects the knowledge under construction. I made my position as a midwife and researcher known from the onset of the data collection. This helped me to work in an acceptable social setting.

In accordance, Milligan (2016) stated that the individuality and situation of the researcher in relation to participants can be positioned as an outsider or insider or both. An outsider can be described as a ‘foreigner’ with no common features with the participants or subjects under investigation, whereas an insider is someone who holds an understanding and has some common features with the participants and topic under investigation (Holmes, 2010; Bover, 2013). In addition, Innes (2009) argues that insider researchers conduct studies about communities, such as the researcher’s profession, workplace, culture, and society. Thus, my position in this study is that of an insider/outsider. The theoretical development of the insider-outsider position is due to the fact that some researchers are not completely insiders or outsiders in the conduct of a study (Milligan, 2016). As an insider, I shared a geographical, professional, ethnic, and religious identity with the participants, and I was an outsider because I am an academic researcher and lack the cultural knowledge of providing maternal care services in the community where I have not practiced. Knowing the researcher was a midwife highlighted a commonality in cultural identity between the researcher and the subjects and implied a level of ‘trustworthiness’. Additionally, the socially made meaning of the professional identity offered a convenient way of communicating firm positive researcher characteristics, such as empathy, caring and the capacity to listen (Leslie and McAllister, 2002). This gave me easier access to participants in the community. It also indicated a commonly embodied knowledge of the nature of midwifery care, which also helped the community of women and midwives who participated in the research to develop trust and confidence in me as a researcher, hoping that the research would eventually bring changes to the lives of women in the community. In addition, Borbasi et al., (2005) opined that professional

acculturation and a level of cultural competence enables the acceptance of the researcher in the community.

Furthermore, in terms of geographic and ethnic identities, the insider position removed communication barriers and encouraged an understanding and explanation of unspoken cultural deeds and symbolic language. This would not have been possible if the study had been conducted in different ethnic and geopolitical zone in Nigeria to that of the researcher. Similarly, Geertz (1973) argued that the researcher's 'nativity' would probably lead to more precise descriptions and interpretations of a culture because cultural puzzles and symbols shared by the researcher and participants would expedite an understanding of the unspoken and explicit cultural knowledge that informs cultural practices. Nevertheless, the insider position has some challenges, as Griffith (1998) proposed that the insider position cannot be identified with only shared features, such as gender, race or ethnicity history. Indeed, Lincoln and Guba (1985) agreed that the researcher's 'nativity' might possibly make the researcher 'go native', and thus neglect important issues during the data generation. Similarly, Burns et al., (2012) added that the method of discovering how to work creatively within a familiar place would unavoidably pose some tension. They argued that all qualitative researchers bring a combination of skills when embarking on research studies (Burns et al., 2012). This was not my experience during the data collection as the researcher, I pre-planned the data generation process which was strictly followed. In addition, professional affiliation in a group is just an aspect of commonality and does not denote complete sameness within the group (Dwyer and Buckle, 2009). I agreed with Dwyer and Buckle (2009) because the community women, midwives, doctors, and traditional birth attendants might comprise varying levels of commonality in culture and sub-cultures, as most were not 'native' to the community. It is, therefore, imperative as a

midwife to consider the implications of cultural and professional characteristics on the association with research subjects and colleagues (Leslie and McAllister, 2002). As an insider, I shared multiple commonalities with the participants, such as religious beliefs, culture, profession, and experiences. Sometimes, sharing these similarities led me to experience dilemmas during the data generation process.

My role as a midwife and as an insider conflicted with my role as a researcher in the community during one of my interviews with one of the traditional birth attendants, as stated earlier. I observed the traditional birth attendant giving the pregnant women herbal mixtures to drink; as an insider, I know what constitutes good maternal health practice. Hunt and Symonds (1995) stated that there could be a certain level of anxiety and difficulty concerning the prospect of developing the ability to handle the things we are familiar with as a researcher. This requires the researcher to understand what effects these practices might have and to make sense of the situation. As a midwife, I believe that this herbal mixture can harm the foetus or the mother; this was an ethical dilemma because, as a midwife, I have a professional duty to advocate for what constitutes good maternal health for patients. However, as a researcher my ethical approval does not allow me to intervene with the activities of the TBAs. In order to avoid going against the research rules, I ignored my professional background. However, even as an insider to the culture, there were certain cultural activities in this community that were strange to me; for instance, if a married woman sleeps with another man, unless she confesses to her husband and a cleansing is done on her in the form of beating, it is believed that she will die during childbirth. I was surprised, but I maintained calmness throughout the focus group discussion. My emotion was controlled, and I often reminded myself of my position as a researcher, which was external to the context of the culture.

Conversely, as an outsider, some of the women were able to share their concerns with me one-to-one, because they saw me as a researcher and midwife who had come to help to improve maternal health and reduce maternal mortality in their community. In fact, one of the TBAs said*, "you are my sister because you are married to my brother; I will not conceal anything from you, and I am sure you will not support the government to arrest me or stop my work".* This suggests that my outsider position, as constructed by the participants due to the situation, formed direct communication about participants' perceptions of the culture investigated. Supportively, Ryan et al., (2011) and Ceglowski (2000) assert that the outsider position always disperses concerns of leaking the research data; thus, the participants were confident that the information they provided would be kept confidential. With regard, to the theory of positionality, the researcher makes meaning from diverse aspects of their identity due to overlapping identities (Kezar, 2002; Bourke, 2014). Freire (2000) and Bourke (2014) argued that insider-outsider positionality is a conflicted relationship that signifies a space where objectivism and subjectivism meet. In conclusion, my insider-outsider qualitative position enabled me to improve my perceptions and generate robust data that encouraged quality descriptions and in-depth interpretations of the socio-cultural factors that influence maternal health; however, it was not without challenges.

The theory of positionality highlights that the research relationship between the researcher and the researched is characterised by complex power dynamics and this can affect the outcome of the research. Notably, feminists have also emphasised that reflexivity is a powerful tool for navigating the power dynamics that occur in every stage of the research process (Nencel, 2014; Hesse-Biber, 2007). Feminism which underpins the current research aims to uncover and proffer suggestions that could be used to address oppression faced by women in aspects of pregnancy and childbirth,

therefore reflexivity is an attempt to ensure that no power abuse during the research processes between the researcher and the researched. Feminist researchers favour negotiating the power dynamic in the research relationship and rejection of a hierarchical notion of power, which attempts to apportion power to some individuals at the detriment of others (Hamilton, 2020). Feminists and other scholars recommend that power should be like a fluid, neither seized by the researcher nor the participants (Conti and O'Neil 2007), as is the case of the current PhD research.

It may be relevant to mention that intersectional reflexivity was a tool used to navigate power in the research process because it is in concurrence to differential effects (Collins, 1998: 211), produced by intersections of factors such as class, race, gender, and other aspects of differences that can yield power imbalance during research relationship. The term intersectionality was first coined by Kimberele Crenshaw in 1989 who states that oppressive structures that constraint society are governed by race, gender, and class (Crenshaw, 1989). Thus, intersectionality provides a reflexive space to examine the domain of power in order to understand and acknowledge how power dynamics may have shaped the research outcome but not necessarily to overcome the power inequalities that may have occurred at any stage of the research process.

I perceived myself as a black feminist researcher that researched black women from the same geographic and ethnic background. Engaging in reflexivity enabled me to uncover how power manifested during the research processes. For instance, power dynamics were located within my shifting positionality. Precisely, traditional birth attendants and women with children considered me as a younger woman who has less experience about pregnancy and childbirth, and this constantly shapes the power

discourse in my relationship with them. However, there was an instance whereby one of the TBAs perceived me to be more powerful due to my educational background and that I could report her practice to the law enforcement bodies. This was managed by explaining the purpose of the research and by reminding her that the confidentiality of the data provided will be maintained throughout the research process. I acknowledge that this power imbalance was difficult to mitigate and possibly may have led to potential restrictions of the information shared (selected and shared informed thought would not reflect badly upon them or enable the researcher to judge their actions) during interview. However, no significant difference was notices in her responses compared to other TBAs, an indication that the power imbalance was managed effectively.

The midwives that participated in the study perceived me as their junior colleagues because of some of them playfully made a comment such as ‘You know that I have been practicing for a long time even before you qualified as a midwife’. This suggest that those midwives thought that I am less experienced and therefore may not have sufficient experiences to judge their midwifery practices. This could signify that they considered themselves more powerful and would not worry of withholding information from me. However, being a PhD researcher from a UK university earned me a level of acceptance and a sense of being more powerful than them because they considered me to have more privileged circumstances such as knowledge of international best midwifery practices. Also, the view of these midwives that the outcome of my research could trigger more women to seek midwifery care in the hospital and improve their working condition appeared to be some of the factors that buttressed their involvement and cooperation during the data collection. Therefore, power was like a fluid that flows to the participants and the researcher in their relationship.

4.9 Ethical considerations

The importance of the proper application of ethical principles in qualitative research cannot be over-emphasised as it protects human subjects or participants in the study. Moreover, Batchelor and Briggs (1994) argued that the inability of the researcher to address ethical problems before going to the field can result in researchers being ill prepared to manage the unpredictable nature of qualitative studies. Conducting research with human participants means there is a relationship between the researcher and participants; it might lead to an issue that can cause an undesirable effect, mostly to participants as subjects of the study (Sarantakos, 1998). Therefore, to prevent any physical and emotional hurt to the participants, the researcher followed codes of ethical approval (LoBiondo-Wood and Harber, 2006; Polit and Beck, 2006). The research was given favourable ethical approval by the University of Salford Research Ethics committee (shown in Appendix 10). Also, due to the nature of my research, which involved the use of human subjects to talk about maternal mortality and due to my pregnant state at that time, an approval and support letter was obtained from my sponsor, Ebonyi State University Research and Ethics Committee (shown in Appendix 11). In addition, authorization was sought and achieved from the village head and opinion leaders in the research setting (Onuenyim agbaja). Ethical approval was gained in relation to the following considerations outlined below.

4.9.1 Autonomy

In 1979, the Belmont report on ethical principles and guidelines for the protection of human subjects in research was formed as the basis for conducting human research (National Institute of Health (NIH), 2008). Respect for an individual rest on the ethics that people should be treated as "*autonomous agents*" who are allowed to detect for themselves the possible harm and benefit of a situation. This implies that, she or he

should be allowed to analyse how the risks and benefits relate to her or his personal values regarding the research, and to thereby take action to participate or not based on their analyses. Moreover, a qualitative study aimed at an in-depth understanding of a particular issue, including an exploration of the context of participants' cultural beliefs. This was designed to be probing in nature and respect for research participants' autonomy is the basis for contemporary research (Weindling, 2004; NIH, 2008). According to Corbett et al., (2002) Social research can be intrusive; thus, the participants have the right to evaluate whether they want to join the study or not. Participation in a study should be voluntary; it is therefore the researcher's duty to provide potential participants with adequate information to enable them to make an informed decision (Weindling, 2004). The autonomy of each participant in this study was respected as no one was forced to take part in the research. A consent form and participant information sheet were provided to all potential participants.

4.9.2 Informed consent

Informed consent can be defined as a process which provides more knowledge of the research in order for participants to make an informed decision, either to join the study or not (Burns and Groove, 1997; Denzin and Lincoln, 2011). Christian (2011) stated that participants have the right to autonomy and to be informed about the nature and consequences of the research in which they partake. Thus, participants must voluntarily accept to be involved in a study without physical or psychological coercion; their acceptance has to be based on open information they receive from the researcher (Green Thorogood, 2009; Christian, 2011). In addition, Soble (1978) asserts that participants must know the duration, possible risks, methods, and the aim and objectives of the study.

Thus, the information sheet was translated into Izzi language (shown in Appendix 6) for the participants who could not read the English language and was given to the participants. All participants were given two weeks to study the information sheet, ask questions for more clarity and decide on whether to participate or not in the study. Mostly, the women and traditional birth attendants needed the translated copy of the information sheet, with further explanations of the items listed; this was done orally by the researcher. The researcher did this with reference to Christian (2011) and Bulmer (2008) who agreed that informed consent in health and social science research should be achieved without deceiving participants. Robson (2002) asked a question on how realistic it is for a participant to be asked in advance whether they are prepared to be involved in a study, as it might not be possible to determine this at this stage. However, Bulmer (2008) still maintained that the use of deception in a research study should be condemned and the general principles of a code of conduct should be strictly adhered to. Following, or adopting, Bulmer's position, every participant in this study received proper explanation (without deception) on the information sheet. The researcher also explained to the participants that they could withdraw from the study at any point during the research process, without providing any reason and they would not be punished. Meanwhile, all participants who had read the participant information sheet and agreed to take part in the study were given the consent form, which they signed and returned to the researcher (see Appendix 7).

4.9.3 Confidentiality and Anonymity

Codes of ethics have insisted on safeguards to protect participants' identities and those at the research setting. Confidentiality is the major safeguard against the unwanted exposure of participants to the public (Green and Thorogood, 2009;

Christian, 2011). They explain that all participants' personal information must be secured and only made public if they are anonymous. Also, the researcher is required to be alert to any potential consequences of the study and should try to forestall and guard against damaging consequences for participants (Sin, 2005). Thus, the researcher anonymised the data by assigning pseudonyms to the participants' names, and the data collected was kept strictly confidential to ensure privacy and respect for the participants, as maternal mortality is a sensitive issue on which to share information (Polit and Beck, 2006).

To support the above statements, I uphold that researchers should always maintain their integrity and do their best to protect the fundamental rights of the study participants. Similarly, the BSA (2002) opined that research relationships should be made available by establishing trust and integrity. To ensure appropriate identification, each of the participants, both in the focus group discussion and the interview, were given codes and pseudonyms, which only the researcher could discern. The data generated was transferred from the tape recorder to an encrypted password protected computer folder; only the researcher accessed the code and password. The recordings will be erased as soon as the doctorate thesis is completed; however, the transcripts, which have codes and pseudonyms, will be stored in an encrypted computer (which is password protected) for a further 10 years for reference purposes to clear any future doubt. This is according to the University of Salford guidance on data storage regulations. Confidentiality and anonymity were maintained before, during and after the data collection processes, and all the information collected was used for research purposes only.

4. 10 Summary of the chapter

This chapter started with a description of the research philosophy and paradigm that underpinned this study. The philosophy and theoretical approaches, which underpinned this research are interpretivism informed by feminism and GAD theory. On this basis, a qualitative methodology was appropriate to capture the participant views and perceptions about the sociocultural factors that influence maternal mortality and to capture data about participants' opinions on how to reduce maternal death and improve maternal wellbeing.

The in-depth interviews were conducted with 19 participants comprising five women of reproductive age, three doctors, four midwives, three traditional birth attendants, a village head, a religious leader, a youth leader, and a women's leader. Also, two focus groups were conducted comprising 10 women of reproductive age with children and 10 women of reproductive age without children. The researcher discussed the method of data analysis, namely thematic analysis, which used inductive coding. The reflexive/reflective account of the different stages was discussed, and this chapter concluded with the ethical considerations of the research processes. Next is an overview/ introduction of the finding chapters.

CHAPTER FIVE

OVERVIEW/ INTRODUCTION TO THE FINDING CHAPTER

This short chapter sets the scene to signpost the reader on how the findings chapters have been structured and organised. This chapter begins with information about the characteristics of the participants who took part in the research.

5.1 Characteristics of the participants

Thirty-nine (39) participants took part in this study; focus group discussions were conducted with 20 participants while 19 took part in one-on-one in-depth interviews. As mentioned in the previous chapter, there were women of reproductive age with children and women of reproductive age without children who willingly participated in this study. Other participants included doctors, midwives, TBAs, a village head, a religious leader, a youth leader, and a women's leader. The number of females who participated was 33 while the number of participating males was 6. Table 5.1 shows the demographic information of the participants.

Table 5.1: Demographic information of female participants

S/N	Fictious name	Parity	No of live children	Aware/ witnessed maternal death	Age (yrs)	Marital status	Level of Education	Occupation	Where you had previous babies
Women of childbearing age with children who participated in focus group discussion 1									
1	M1	Gravida 9	7	Yes	43	Married	Primary education	Housewife	TBAs, home, hospital
2	M2	Gravida 12	10	Yes	42	Married	No education	Housewife	Home, TBA

3	M3	Gravida 7	7	Yes	55	Married	Primary education	Trading	TBAs
4	M4	Gravida 10	9	Yes	40	Married	No education	Housewife	Home, TBAs
5	M5	Gravida 6	6	Yes	48	Married	Primary education	Housewife	TBAs
6	M6	Gravida 7	6	Yes	44	Married	Primary education	Housewife	Home, TBAs
7	M7	Gravida 7	7	Yes	42	Married	No education	Housewife	TBAs, home, hospital
8	M8	Gravida 5	5	Yes	54	Married	No education	Trading	Home, TBAs
9	M9	Gravida 4	4	Yes	49	Single mother	Primary education	Trading	TBAs, home
10	M10	Gravida 6	5	Yes	40	Married	Primary education	Cleaner	Home, TBAs
Women of childbearing age without children who participated in focus group discussion 2									
11	P1	0	0	Yes	21	No	College	Student	None
12	P2	0	0	Yes	23	No	College	Student	None
13	P3	0	0	Yes	21	No	Secondary	Student	None
14	P4	0	0	Yes	25	No	University	Student	None
15	P5	0	0	Yes	22	No	College	Student	None
16	P6	0	0	Yes	21	No	Secondary	Student	None
17	P7	0	0	Yes	24	No	University	Student	None

18	P8	0	0	Yes	20	No	College	Student	None
19	P9	0	0	Yes	23	No	College	Student	None
20	P10	0	0	Yes	21	No	College	Student	None
Women who participated in one-on-one interviews The women who participated in one-on-one interview includes other women who were mentioned as having robust knowledge about childbirth and pregnancy and be willing to participate (n=5). Further information about the sampling criteria and recruitment processes is presented earlier in Table 4.2, Chapter Four (Recruitment process based on the inclusion and exclusion criteria). The demographic information of these participants is shown below.									
21	W1	Gravida 4	4	Yes	35	Married	College	Trading	Home, TBA/
22	W2	Gravida 7	6	Yes	38	Married	Primary education	Housewife	TBAs, home
23	W3	Gravida 5	5	Yes	35	Married	No education	Housewife	Home
24	W4	Gravida 7	7	Yes	41	Married	College	Clerk	TBAs, home
25	W5	Gravida 3	3	Yes	28	Single mother	Primary school	Farming	TBAs
26	Woman leader	Gravida 7	7	Yes	45	Married	College	Messenger	Home, hospital

Table 5.2: Demographic information of the Traditional Birth Attendants, Midwives, Doctors and Opinion leaders

S/N	Fictions name	Gender	Age	Level of education	Witnessed maternal death	Length of practice

27	TBA 1	Female	51	Primary education	Yes	16 years
28	TBA 2	Female	48	No education	Yes	15 years
29	TBA 3	Female	49	Primary education	Yes	20 years
Demographic information of the midwives As previously explained in Table 4.1, Chapter 4, Table 4.1 that the midwives who participanted in this study currently work in the hospital located in the studied community and possess 15 years or more experience. The demographic information of these participants, as presented below, showed that these midwives were older, reflecting their years of practice.						
30	Midwife 1	Female	44	Registered midwife	Yes	18 years
31	Midwife 2	Female	55	Registered midwife	Yes	25 years
32	Midwife 3	Female	50	Registered midwife	Yes	21 years
33	Midwife 4	Female	54	Registered midwife	Yes	10 years
Demographic information of the doctors						
34	Doctor 1	Male	47	Degree	Yes	12 years
35	Doctor 2	Male	39	Degree	Yes	8 years
36	Doctor 3	Male	53	Degree	Yes	17 years
Demographic information of opinion leaders						
37	Village head	Male	67	None	Yes	NA
38	Religious leader	Male	50	Degree	Yes	NA
39	Youth leader	Male	38	College	Yes	NA

5.2 Structure of the findings

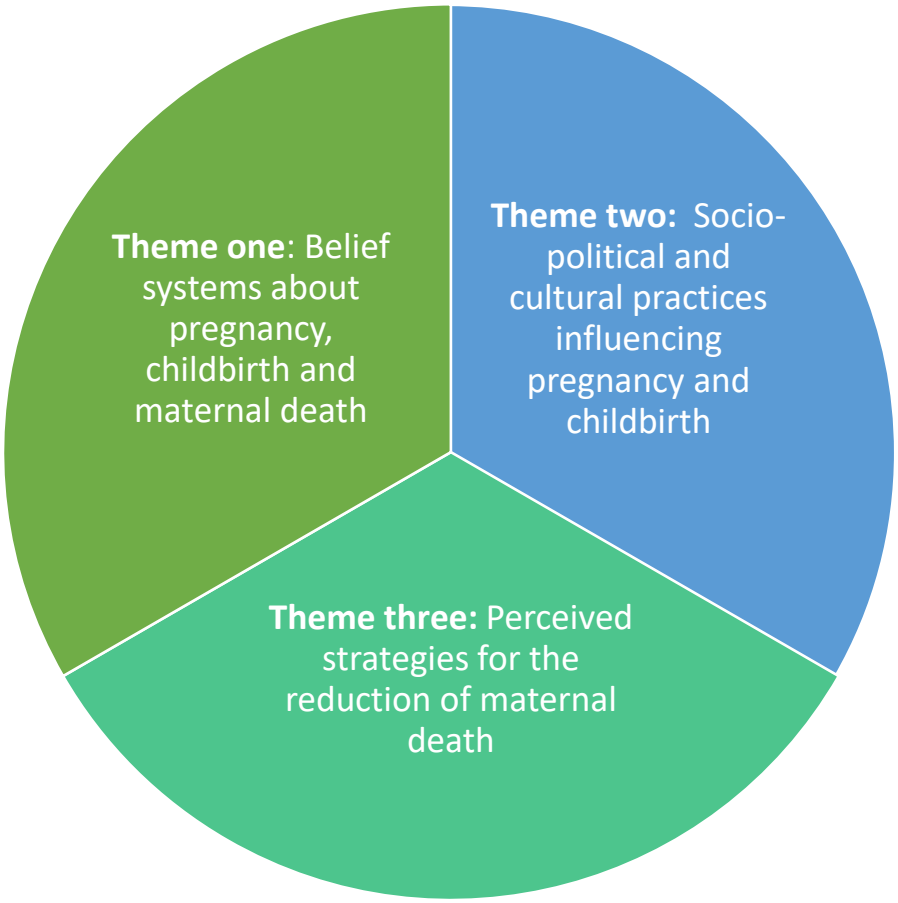


Figure 5.1 Thematic framework

Theme one: The first findings chapter will present the findings from local women (women of reproductive age with and without children), traditional birth attendants, community healthcare professionals (doctors and midwives), and opinion leaders (religious leader, youth leader, village head, the women leader) regarding their belief system about pregnancy, childbirth, and maternal death. The data analysis revealed that the participants used their belief systems (cultural and religious beliefs) to

construct meaning about pregnancy, childbirth and maternal death and engaged in cultural practices which are rooted in their understanding and perception of pregnancy, childbirth, and maternal death.

Theme two: This chapter will explore how these culturally based perceptions and ethno-religious knowledge may have contributed to the socio-political and cultural practices that influence maternal health, thereby leading to maternal mortality. Specifically, the practices of persons in governance, the community healthcare providers (doctors and midwives), the local women and traditional birth attendants that enhanced or contributed to maternal death and maternal health were explored. This theme, 'Socio-political and cultural influence on pregnancy and childbirth', is divided into four subthemes which are: the political influence on pregnancy and childbirth, socio-cultural practices, healthcare system influences on pregnancy and childbirth, and patriarchal system and women's subordination.

Theme three: The local women (women of reproductive age with and without children), traditional birth attendants, community healthcare professionals (doctors and midwives), and opinion leaders (religious leader, youth leader, a village head, women leader) were given an opportunity for the first time to discuss maternal death in Nigeria, and to state their thoughts on how maternal death could be reduced. Following, the data analysis it was found that some participants, mainly local women, reiterated their views that there was no measure to reduce maternal death because the death of a woman during pregnancy was a destiny, as discussed in Chapter eight. However, some of the participants mentioned their perceptions of what could be done to reduce maternal death. The strategies suggested by these participants are presented in three subthemes: compliance to social norms, assimilation of TBAs into

anorthodox healthcare system and free maternal healthcare services during pregnancy and childbirth.

The extracts have been presented to indicate to the reader whether they originated from focus group 1 (M), focus group 2 (P), traditional birth attendants (TBAs), doctors, midwives, village head, youth leader, women's leader and the individual women that participated in this study. For instance

- *(Excerpt from FGD 1, M1) denotes* focus group 1, women number 1
- *(Excerpt from FGD 1, M3) denotes denotes* focus group 1, women number 3
- *(Interview Excerpt, women 4) denotes* interview extract from women number 4
- *Excerpt from FGD 2, P8) denotes* focus group 2, women number 8
- *Interview Excerpt, Religious Leader denotes* interview extract from religious leader
- *(Interview Excerpt, TBA 3) denotes* interview extract from Traditional Birth Attendant number 3

Finally, the findings have been presented, analysed, and discussed in relation to the relevant literature and theories.

CHAPTER SIX

BELIEF SYSTEMS ABOUT PREGNANCY, CHILDBIRTH AND MATERNAL DEATH

6.0 Introduction

The key aim of this research is to understand whether and how social and cultural factors influence maternal mortality and what participants consider to be potential approaches for the reduction of maternal death in a Nigerian South-Eastern community. This first finding chapter will present the findings from the local women (women of reproductive age with and without children), traditional birth attendants, community healthcare professionals (doctors and midwives), and opinion leaders (a religious leader, youth leader, village head, the women's leader) regarding their belief system about pregnancy, childbirth, and maternal death.

The data analysis revealed that the participants used their belief systems (cultural and religious) to construct meaning about pregnancy, childbirth and maternal death and engaged in cultural practices which are rooted in their understanding and perceptions of pregnancy, childbirth, and maternal death.

6.1 Belief systems about pregnancy, childbirth, and maternal death

Belief systems are the sets of beliefs the participants held and used to make sense of and construct meaning about pregnancy, childbirth, and maternal death. These sets of beliefs were found to be deeply rooted in, and related to, cultural and religious beliefs, which provided the social rules for peoples' social and cultural construction of reality about maternal death. In this chapter, I will show how understanding these beliefs was relevant towards grasping how they influence maternal health and its contribution to maternal death. This is important because they provide insights that can be used to develop health and social policy aimed at improving maternal health.

Belief systems will be presented in two sub-themes, namely cultural beliefs, and religious beliefs; firstly, we will look at cultural beliefs.

6.1.1 Cultural beliefs about pregnancy and childbirth

Cultural beliefs are the underlying values, principles and tenets held by the participants. According to Levine (2017), cultural beliefs are the socio-culturally recognised traditions and norms that inform how people interrelate with, and respond to, situations in their world. These cultural beliefs are explored in this section, as well as how these beliefs may have impacted on maternal health and seem to have contributed to the magnitude of maternal death in this community. Cultural beliefs about pregnancy and maternal mortality were found to be part of a societal culture that influenced people's understanding of maternal mortality. Many of the respondents believed that pregnancy and childbirth are associated with supernatural powers and issues that cannot be easily understood. Those in-charge of pregnancy in the community are the traditional birth attendants because of their purported possession of supernatural powers; they are easily accessible by the women and are believed to be more knowledgeable in issues surrounding pregnancy and childbirth than the midwives and doctors (Interview excerpts women 4).

> *It is through divine direction. If I enter a bush or forest, God will direct me on different roots, and leaves to gather. I will gather all according to the divine direction, prepare it and start administering it to pregnant women when they visit me for care (Interview excerpt Traditional Birth Attendant 2).*

Moreover, superstition and cultural beliefs seemed to have an influence on the minds of the people in the community, leading to worrisome fears and anxieties relating to pregnancy and childbirth. Therefore, in this community, pregnancy and childbirth are

perceived to be surrounded by cultural myths and superstitious beliefs, which the women must heed to enable them to have a safe pregnancy and childbirth. Previous research has shown that cultural perceptions about pregnancy and childbirth affects the health of a woman and contributes to maternal deaths (Ajiboye and Adebayo 2012; Morris et al., 2014; Hill et al., 2016). In addition, Geertz (2000) and Thompson (1990) noted that culture is a functional set of beliefs and biases that forms an integral part of human lives, and which influences human behaviour and action. In this chapter, evidence will be provided to show how cultural beliefs held by the participants seemed to strongly influence social rules for the patterns of behaviour and actions in relation to attitudes towards maternal health.

This research revealed that local women, traditional birth attendants and some opinion leaders (village head, women's leader, youth leader, religious leader) held the general belief that pregnancy was not an 'illness' but was believed to be a gift from a supernatural being (God) who possesses supernatural power to control the outcome of the pregnancy without the need for specialised care from health care providers:

> *Pregnancy is a blessing from the creator of this world who has power over everything that exists. When a woman is pregnant, God who gave her the baby will protect the woman and the baby until birth. God determines what will be the outcome of the pregnancy and the people that work in the hospital have no control of it. For me I do encourage my wives to go to hospital for care during pregnancy (Interview Excerpt, Village Head)*

> *I believe that God gives pregnancy and has power to care for the woman throughout the period of pregnancy until childbirth. I do not support pregnant*

women visiting hospital because it is a waste of time and money (Interview excerpt, Women 5)

The white people brought hospitals to deceive our people and encourage them to come to obtain some medication during pregnancy, but this medication causes the baby to grow big and during childbirth, they will say 'operation' (caesarean section) will be the approached to deliver the baby. We tell our people not to go to hospital but to come to us, so we can give them [a] natural herb created by God, so they will feel good and their baby till the baby is ready for birth (Interview excerpt, Traditional Birth Attendant 3).

My wife drinks herbal concoction whenever she is pregnant because almighty God is the giver of pregnancy. He cares for the pregnancy … (Interview Excerpt, Youth Leader).

These extracts suggest that some inhabitants of this community perceived pregnancy to originate from a supernatural being who they believed has power to preserve the woman and unborn baby without obstetric/midwifery intervention from doctors and midwives. Additionally, the opinion leaders (Village Head and Youth Leader) and the local women surprisingly accepted and advocate that pregnant women should instead patronise the services of a traditional birth attendant because they use natural remedies to care for the pregnant woman. As would be expected, the TBAs (as demonstrated in the extract from 'TBA 3') promoted their services and have constructed a reason and rationale that appeared to condemn conventional maternal services. In addition, the extract from 'TBA 3' supported by other participants as evidenced above shows that the TBAs felt they were better positioned to provide culturally acceptable maternal services to pregnant women. Unlike the healthcare

professionals who were perceived to engage in caesarean section that was not consistent with their traditional pattern for childbirth. Life in African culture is often communitarian (Gyekye, 1996; Ezekwonna, 2005), implying that communalism is central to the African ethos. Drawing from the concept of communalism in relation to the context of this current research, it could be argued that opinion leaders who subscribe to these beliefs would be more likely to influence the decisions of their wives and other women to seek care from TBAs, in line with the African communitarian ethos, instead of midwives in hospitals who appeared to lack the social bonds with community members.

Overall, it is plausible to argue that the views of these participants could denote a demonstration of a poor level of biomedical knowledge and understanding about pregnancy, and instead, the participants appeared to have used their cultural lens to construct the meaning of pregnancy in this environment. Previous studies have indicated a conflict between the biomedical model practices and traditional beliefs of women related to pregnancy and childbirth (Harris et al., 2012). For instance, in developed countries, pregnancy is viewed as a medical condition that is largely managed by using a biomedical model and with the focus of applying a scientific explanation of the stages of pregnancy as well as the potential complications (O' Leary et al., 2007). However, in many developing countries, such as Nigeria, and as found in this current study, pregnancy appeared not to be largely perceived as a medical condition among rural dwellers and those who were less educated (Hoang et al., 2009). The opinion leaders and the local women in the current research had little or no education, as grasped from the demographic information gathered during the interviews and focus group discussions (see Table 5.1, Chapter 5). This is different to the healthcare professionals, who were more educated and who did not construct

meaning about pregnancy and childbirth through their cultural lens. It can therefore be construed that the difference in meaning-making between healthcare professionals and local women (including the opinion leaders) could be accounted for by their level of education.

In addition to the belief about pregnancy being perceived as a supernatural gift, some participants also stated that pregnancy and childbirth was an obligation for every woman in their society. This is because it is an identity that gives relevance and social security to protect women in their marriages:

> *Marriage and pregnancy are an obligation for every woman (interview excerpt, TBA 1)*
>
> *In every family, pregnancy and childbirth brings joy. A woman that cannot give birth is a witch and valueless. We send such women away to their parents because they are not needed (Interview excerpt, Village Head)*
>
> *It is a desire of every woman to get married and become pregnant and give birth because that is the only condition that sustains marriages. Men send their wives away for their inability to conceive … it is a bad thing that will happen to any woman (Interview Excerpt, Women 2)*
>
> *Women laugh at their fellow women when they are unable to bear child and it is a serious issue in our place that has made so many women lose their marriages. Pregnancy is a competition among women in this society (Interview Excerpt, Women 5)*
>
> *We value pregnancy and childbirth. If my wife refuses to be pregnant, I will drive her away, then will go to marry another woman because I need children that*

will look after me when am old. I also want my lineage and my name not to be erased… (Interview Excerpt, Youth Leader)

The widely held belief from a range of participants, that pregnancy and childbirth is inevitable for every woman from this cultural background, accords with the issues raised by theories of feminism, which underpin this research. For instance, as previously explored in the methodology chapter, some feminist writers have highlighted that the feminist theoretical perspective is based on the premise that women face multiple oppressions because they are distinctively disadvantaged based on their gender and social status (Ujah et al., 2005). This premise was manifested and revealed in this research as well as in previous research conducted in Akwa-Ibom in Southern-Nigeria (Mboho et al., 2013), in that pregnancy and childbirth are a cultural obligation on all women, whether or not they want it to be. Consequently, any woman who fails to meet the cultural expectation for pregnancy and childbirth is found to face the consequence of being driven away by their husbands and losing their marital rights (sexual relationship), social status and economic support, as demonstrated in the extracts above from the Youth leader, Village head and Women 2.

The cultural norm of blaming women for their inability to conceive, as found in this research, without verifying the possibility of the man having an underlying medical condition that may contribute to a woman's inability to conceive, could suggest either the deliberate or unintentional oppression of women. This appeared to be connected to a lack of biomedical knowledge about pregnancy and childbirth. This finding agreed with that of Ella et al., (2017) and Azuah et al., (2015) who noted from their research that a lack of knowledge about pregnancy and childbirth has a strong influence on gender roles, which in turn impact on maternal health. Again, the cultural labelling of women as '*witch and valueless'*, as depicted in the excerpt from the village head,

above implies that men could be using these unsubstantiated or unscientific reasons to subject women to unnecessary suffering because of their perceived inability to conceive and bear a child. This appeared to demonstrate gender inequality and women's subordination. Previous research has also shown that Nigerian societies have been recognised as being patriarchal in nature; a society where men have unequal rights with women, and which tacitly supports measures that put women in socially disadvantaged situations (Makama, 2013).

Furthermore, it appeared that the cultural norms of assigning value to a woman based on the prerequisite of their reproductive relevance has necessitated women in this cultural environment to consciously strive to conceive and bear children as a measure to uphold their relevance in that society. The excerpt from women 5 above shows how women in this community engaged in pregnancy and childbirth competitions to secure their place in marriages and their value in the society; this was repeatedly echoed by most of the women who participated in this study. A competition among women to be pregnant could suggest that many of these women may be prone to risks, such as haemorrhage, because their uterus is not allowed to recover before another episode of pregnancy. The recent study by Ndiaye et al., (2018) found that social, gender, and religious norms, including competition between co-wives drove women into high parity, which contributed to high maternal death in Nigeria. This supports the claim above that a lack of child spacing may lead to poor maternal health and may contribute to maternal death during or after pregnancy and childbirth. As a midwife-researcher with many years of working experience in this society, it can be deduced that the 'cultural pregnancy-competition', as found in this current study, could explain why the use of contraceptive devices are not generally accepted by most of the women. Perhaps, this

cultural norm may have contributed to why women sought care with TBAs who do not discourage multiparty, unlike midwives who educate pregnant women against it.

Finally, the participants repeatedly mentioned that childbirth should have no restriction in terms of the number of children a woman should give birth to. The women and the opinion leaders, unlike the healthcare professionals, widely professed their belief that pregnancy is a blessing from God, as stated above. However, they added that God has pre-planned the number of children each woman will deliver; thus, a woman will continue to give birth until she has exhausted the number of children that God has placed in her uterus:

> *I can tell you that, even before a girl attain to the age when she is ripe for childbirth, the Creator has already placed how many children she will deliver. Our responsibility is to continue to perform the men job while the women continue to give birth to children. As you can see, I have many children, and this is the joy of fatherhood (Interview excerpt, Village Head)*
>
> *… we are to continue giving birth until we deliver all the children God has blessed us with… (Interview excerpt, women 2)*
>
> *… this has been our culture; a woman must give birth to as many children as possible because you do not know which of your children that will not die. If one has many children, they will look after you during old age … clap (Excerpt, FGD 1 M4)*

These excerpts show that multiparty is a culturally accepted norm and is being practiced by the women because it was believed to be divine and a fulfilment of gods' plan for every woman. It is worthy of note that even women in this community

subscribed to this belief and appeared to be happy with this practice, as demonstrated by the rousing applause from a member of focus group discussion one, when one of the women (Women 4) made a comment to justify that giving birth to many children was a guarantee for being cared for during old age. This could be attributed to a low level, or lack of, women's educational status. Again, this could also imply that the lack of support system for the care of the elderly, particularly women, in Nigeria facilitates societal acceptance for multiparity as a strategy for social survival during old age. A study by Tanyi and colleagues further showed that Nigeria has no functional national policy for the care and welfare of older persons (Tanyi et al., 2018). Thus, this revealed that a lack of social support service provision for old age compelled women to keep giving birth to many children who it is perceived would protect their welfare during old age, but without insight that this practice could facilitate maternal mortality.

Woman 4 during the focus group discussion also mentioned that multiparity is acceptable for reasons related to the likelihood that some of the children will die. This appears interesting because it provides insight that infant mortality is one of the drivers for high pregnancy rate, which adversely contributes to maternal mortality. Surprisingly, this finding is contrary to the findings of Sadiq et al., (2016) who highlighted that a great number of their respondents (women of reproductive age) in Soba LGA of Kaduna State, Nigeria acknowledged that recurrent pregnancy (multiparity), especially amongst women with more than five pregnancies, may increase the risk of miscarriage, bleeding, hypertension, and seizures. The participants in that study appeared to demonstrate some level of biomedical knowledge about pregnancy and childbirth unlike the current research where a greater number of the participants appeared to use their cultural lens to understand pregnancy and childbirth, suggesting a general lack of knowledge.

In conclusion, this current research has revealed that issues concerning the survival of a family member, care in old age, the cultural fulfilment of fatherhood, and cultural beliefs appeared to represent a vicious circle that promoted attitudes related to multiparity which increases the risk of maternal mortality and morbidity. Other research has also identified that grand-multiparity is a contributing factor that leads to maternal death, both in Nigeria and other developing countries (Idowu et al., 2015; Ujah et al., 2017). This section has identified the beliefs held by the women and the opinion leaders associated with pregnancy and childbirth and has also discussed its connections with maternal health. However, the healthcare professionals did not profess any cultural beliefs related to pregnancy and childbirth and did not make meaning by using cultural understanding. This is not unusual because one would expect that a Western lens would replace a cultural lens in meaning-making as the level of education and knowledge advances. The next section will discuss the beliefs related to maternal death as this also appeared to be linked to the identified beliefs about pregnancy and childbirth.

6.1.2 Cultural beliefs about maternal death

Childbearing is explained and understood to be a biological event in society, and all over the world the process is the same in terms of its physiology. Also, childbirth, according to Kanyoro (2002), is the arrival of a new life in a community and in some cultures, there is a belief that it is the return of an ancestor. However, the ways in which women experience the state of pregnancy and childbirth are also socially and culturally influenced. These occurrences are located within a cultural context and informed by the perceptions and practices of that culture. The data analysis indicates that pregnancy and childbirth within the study setting are still masked in superstitious

beliefs. A key aspect of cultural beliefs is the superstitious beliefs held by the community members about maternal death in their environment.

The participants (local women, traditional birth attendants and opinion leaders) shared their perceptions about the causes and their experiences of maternal death, which had occurred in their community. It was evident that their understanding about maternal death appeared to be rooted in their cultural beliefs. For instance, all participants in these categories widely believed that maternal death during childbirth was the result of a woman defiling the traditional marital customs of being sexually faithful to her husband. In this community, it is thought that a married woman who engages in sexual intercourse with a man, other than her husband, will die during childbirth unless she confesses her 'sin'. This 'sin' will then be addressed by traditional cleansing and whipping with sticks by the chief priest or their representatives.

> *…as you (the researcher) are married and pregnant now, if you have sexual intercourse with another man, you will die during childbirth except you confess and rituals [are] perform to cleanse you (Interview Excerpt, TBA 3).*
>
> *In our tradition, if a married woman had sexual intercourse with another man and she refused to confess, during childbirth she will die (Interview Excerpt TBA2).*
>
> *When a married woman has sexual intercourse with another man, she will die during childbirth. If such woman refuses to confess that she had sex with another man, she will experience difficulties during childbirth that will lead to her death. But if the woman confessed to her husband before the time of her childbirth, she may not die during childbirth because traditional cleansing will*

be performed on her, after which she will be flogged (Interview Excerpt, Women 1).

There was a pregnant woman in my neighbourhood; she experienced difficulties during labour and her baby could not be delivered after a long time. She later confessed that she had sex with another man and after few hours, she gave birth to her baby. Many pregnant women die because they are ashamed to confess their sins (Interview Except, Village Head).

Yes, some people in this community believe that if a woman has prolonged labour, it means that such woman committed adultery. The woman will be demanded to confess what she has done. The woman will not be taken to the hospital for management because they believe that she has committed a taboo by having sex with another man (Excerpt from FGD 1, M1).

Izzi women are not allowed to have sexual intercourse with another man. If the woman did not confess, she will die during childbirth (Interview Excerpt, women 4).

These extracts suggest that adultery was perceived as an abomination that could lead to maternal death during childbirth. Remarkably, delayed, or prolonged labour during childbirth was perceived as a sign that a woman had committed adultery in this community; thus, there was a cultural expectation that any woman having trouble during childbirth had to confess, in ccordance with traditional customs, she has defiled. It was also revealed by most of the participants that women are being whipped with sticks as part of the traditional cleansing, as well as being stopped from seeking orthodox midwifery care. This suggests an act of oppression which is consistent with feminist theory (Harding, 2004; Mackay, 2015). Surprisingly, the death of a woman

during childbirth was not culturally considered unacceptable, but it was perceived as a justifying punishment for an offence of adultery, which a woman deserved unless she confessed to her 'sin'. This possibly shows a lack of basic knowledge and understanding about the physiology of pregnancy and childbirth. Previous research concurs that poor education and ignorance was associated with upholding irrational beliefs, which result in a high rate of maternal death in developing countries (Abara, 2012; Wydra and Johnson, 2013).

These cultural beliefs have such power and are so firmly held that the medical reasons for maternal mortality, such as obstructed labour, are discounted. The perception that, if a married woman has sex with another man, she will die during childbirth as mentioned above, appears to be a cultural ideology that is acceptable in this community and inherent in people within this cultural environment. This is further supported by Oduyoye (2002) who stated that a human being is born into a human community and that is what makes them a human. This means that human beings depend on life-in-community for their self-understanding and this has been passed from generation to generation. Arguably, these inaccurate beliefs and misconceptions lead to a misunderstanding of childbirth and maternal death. According to Thompson et al., (1990), each culture holds a set of beliefs, biases, and habits that inform people's preferences and choices in a social situation. In this study, cultural beliefs about the influences on maternal mortality were found to be an area of societal culture that affects peoples' perception of the causes of maternal death. In this cultural environment, the tradition and patriarchal structure demands that a married woman should be faithful to her husband. Difficulties in labour caused by an inadequate pelvis, macrosomia baby, obstructed labour, or placenta abruptio/previa etc, were not considered. Instead, in cases of complications during delivery, the community

members believed that the woman would die if she had committed adultery or sin. This resonates with Oduyoye's (2002) argument that a woman who had given birth was described as someone who had returned safely from the battlefront. But when a woman dies giving birth, it is regarded as defeat and defeat at childbirth indicates the presence of evil (Oduyoye, 2002).

However, this unfortunate act of adultery and the punishment of the woman that follows, was seen by the doctors and midwives who participated in the study as evidence of ignorance amongst community members. They identify that the woman's life could be saved if she were brought to the hospital for expert care:

> *Since I started working here, I have observed that, the pregnant women with preeclampsia or eclampsia are not aware that it is due to their pregnancy. They believe that the condition is caused by spiritual attack or that they stepped on a poison (Interview Excerpt Midwife 3)*
>
> *Because of this belief, they try to manage the condition and pray at home before they finally visit the hospital when their home treatments might have failed" (Interview Excerpts, Midwife 3)*

One of the midwives I interviewed stated that most of the deaths that happened in their hospital were pregnant women who had complications and were referred to the hospital from traditional birth attendants. It is evident that the midwives believe that they occur because of the practices undertaken due to superstitious beliefs. Moreover because of superstitious beliefs, the TBAs allow a pregnant woman to labour for days with a traditional birth attendant before coming to the hospital. However, it may also be interesting to consider how and why these midwives have constructed reasons for maternal death, which instead blaming TBAs for their late referrals of pregnant women

to the hospital. These midwives appeared to have not considered the influence of any of their own organisational cultural practices, as will be discussed in the next section, which are contributing factors to maternal death.

In addition, it was also identified that, participants believed that taking an oath or swearing, especially when a pregnant woman is guilty of committing a crime, was one of the key issues within their culture that could lead to a woman's death during childbirth. Some participants stressed that pregnant women are not allowed to engage in these attitudes, as it was culturally abhorrent:

> *Another thing is that some pregnant women are thieves. If the community suspects that the woman was the person that stole the item, she will be invited for interrogation. She will be made to take an oat; if she refused that, she was not the person that stole the material/item. The elders will mandate her to swear that if she is the person that stole the item, [or] let her die during childbirth. Such women die during childbirth if they truly stole the material (Excerpt from FGD 1, M8)*
>
> *…that is true! Some pregnant women engage in stealing. The inability of some men to provide for the needs of their wives causes them to steal. If a woman is accused of stealing, she will deny it, and swear to die in childbirth if she was the person that stole the item. A pregnant woman that is guilty of stealing and had sworn will die during childbirth (Excerpt from FGD 1, M3)*
>
> *The thing you should note is that, if a woman steals her husband's money or another thing but denied that she was not the person that stole it. This woman will be asked to swear. If the woman had truly stolen, then she will experience*

difficulties that will lead to her death during childbirth (Interview excerpt, Village Head)

All the women of child-bearing age without children who participated in 'Focus Group Discussion Two' emphasised that the behaviour of some women who engaged in stealing was not commendable. As depicted in the extract from the focus group discussion above, most women perceived that a woman denying her action was a cultural reason that compel the elders of the community to mandate such a woman to take a curse inform of an oath upon herself to profess death during her childbirth. This is a measure to prove innocence of committing such offence.

Certainly, attributing oath-taking as a risk factor that could lead to maternal death seems to lack scientific justification, suggesting that participants may lack knowledge about pregnancy and risk factors that could lead to maternal death. On a general level, compelling or subjecting a woman to swear an oath suggests an act of suppression and subjugation by the leaders who are often the elderly men in this society. This supports the findings of Ujah et al., (2005) who highlighted that women in Nigeria are subjected to multiple oppressions, which are deeply rooted in the country's cultural system. This finding perhaps indicates that men in this culture use their patriarchal power and position to supress women into accepting beliefs that seem to lack scientific justification, this is in line with Gender and Development (GAD), theory (Parpart, 2000), which underpins this research. As previously discussed in Chapter four, GAD theory examines how relationships, women's positions, patriarchal authority, and structures at the community and household levels affect both women and men (Moser, 2012). Women seemed to be culturally inferior and powerless while men seemed to be powerful. Thus, men use their authority to compel women, who are suspected to have stolen, even without any evidence about the alleged offence, to engage in a

cultural ritual of swearing. This indicates the gender inequality and power imbalance operational in this cultural environment. The power imbalance appeared more obvious when some participants, surprisingly women, expressed their beliefs that if a woman disobeys or disrespects her husband it could cause difficulties during childbirth that could lead to maternal death. This could imply the system is so patriarchal that women seemed to take on patriarchal views as accepted in this society. Others also reiterated this belief but added that dishonest women, including women that degrade other women, would experience difficulties during childbirth that could lead to maternal death.

> *A woman that disobeys her husband will have difficulties during childbirth. Disobedience to [a] husband is equivalent to having sex with another man (Interview Excerpt, TBA 3)*

> *If a pregnant woman humiliates other woman because of childlessness or if a pregnant woman is disrespectful to her husband, it will lead to difficulties in childbirth that may lead to maternal death (Excerpt from FGD 2, P2)*

These excerpts further support that women are perceived as inferior to men in this community, and that women themselves reinforce and perpetuate these values and beliefs. Thus, men appear to be a dominant group whereas women seemed to be subordinate group. Drawing from radical feminism, which which argues that gender inequality is best understood as men's deliberate attempt to maintain power and privilege to the detriment of women due to the dominant partiarchial sysyem (Crow, 2000), it appeared that men in this community have convinced women to accept a lesser social position and must obey the dictates of their male counterparts. Consequentially, maternal death appeared to be a social and cultural problem that

was facilitated through a power structure where women appeared to depend, or seek approval, from men on all issues, including decisions of where to seek healthcare during pregnancy and childbirth.

Furthermore, another identified cultural belief was that some participants believed that maternal death was either caused by 'evil persons' in their community or as a consequence for a woman who belongs to an evil group:

> *If a woman belongs to evil spiritual group, she may have agreed with her group members that she will die during childbirth to cause shame to their families. These kinds of women must die during pregnancy or childbirth in line with their agreement and destiny (Interview Excerpt, Woman 5)*

> *…. the mother explained that she was aware that her daughter belonged to 'mami water group'. She died during childbirth and her child also died two weeks later. Any woman that belongs to this bad group usually die during childbirth and we do not provide any care to them because they are destined to bring shame to their families (Excerpt from FGD 2, P8)*

> *Another issue is belonging to evil spiritual group called 'Ogbanje'. If a woman belongs to this group, she must die during childbirth…. (Interview Excerpt, TBA 1)*

> *If a woman engages in a quarrel with people around her, those people may witch-hunt her, and may use diabolic power to cause her to die during childbirth. A pregnant woman is not supposed to be arrogant about her pregnancy (Excerpt from FGD 2, P5)*

In these excerpts, the participants attributed maternal death to an ‘evil other’ and belonging to spiritual groups, such as ‘Ogbanje’ and ‘mami water group’. It is thought that people willingly joined these groups to cause adversity and bring shame to their families; thus, any woman perceived to be a member of this group was despised. A previous study conducted in Southern Nigeria by Mboho et al., (2013) similarly found that beliefs about an evil spirit were perceived as the cause of maternal mortality. In this current research, the two explanations for maternal death appeared to fit the personalistic paradigm of the Disease Theory System (Foster and Anderson, 1978). The personalistic paradigm attributes illness causality to the intervention by non-human (evil spirit) forces, and this appeared consistent with the beliefs of participants in this current research about maternal death. However, these participants (women and opinion leaders) did not perceive maternal death as an illness but believed it to be caused by human and non-human agents. This finding, in my view, may not be unsurprising because one would not expect anyone to attribute maternal death to evil persons or to a mere belonging to an evil group as it lacks scientific justification. It appeared that participants used their cultural understanding to make sense of maternal death since they lacked scientific knowledge and understanding about pregnancy and risk factors to maternal death. Notably, all the participants that subscribed to this worldview appeared to lack a formal education. Previous research found that the level of women’s education was associated with maternal death in Nigeria (Ariyo et al., 2017); this further supports the findings of this current study as stated earlier.

Lastly, some of the participants (women, TBAs, and opinion leaders) believed that maternal death was a destiny. Most of these community members recognised that

maternal death during pregnancy and/or childbirth occurred in their community but appeared to accept these deaths as a good fate and already destined:

> *This is true! Some ladies when they get married and during childbirth, they will die because they have been destined to die during childbirth (Excerpt from FGD 2, P4)*

> *Death of a woman during pregnancy is a destiny. Nobody can direct God. A woman destined to die during childbirth will eventually die. It is according to the will of God (Interview Excerpt, Women 8)*

> *A woman that dies during pregnancy or childbirth is already destined to die before her birth. It is not avoidable if a woman has been destined to die during childbirth. Destiny cannot be prevented (Interview Excerpt, TBA 2)*

These participants possibly have perceived maternal death as a "normal event", which they cannot alter or prevent, suggesting their acceptance of maternal death in this community. The power of this belief system in influencing thinking and health behaviour was demonstrated in this research; for instance, some participants attributed maternal death as God's will. This also concurs with Adejor et al., (2018) who reported that some of their participants expressed a strong belief that pregnant women taking medication was against God's will because pregnancy is an event were a destiny is orchestrated by God, and thus did not require medical interventions to improve the health of the woman. The participants in this research who held these beliefs were unable to substantiate how and why maternal death was a destiny, suggesting that using a cultural lens to explain maternal death may possibly be rooted in limited biomedical knowledge about pregnancy and childbirth.

Interestingly, there was a dichotomy in the explanation about the cause of death during pregnancy and childbirth, whilst most of the local women and opinion leaders appeared to have used their cultural beliefs as a lens through which to understand and provide explanations about pregnancy, childbirth and the causes of maternal death, as presented above. A minority of the participants (women and opinion leaders) used a biomedical lens and knowledge to explain pregnancy and construct meaning about childbirth and the causes of maternal death. For instance:

> *What I know that can affect pregnancy and can lead to maternal death is that some pregnant women drink herbal concoction locally called 'ogwu Igbo or Ogwu oke ogba'. The pregnant women take this herbal concoction because they believe that it nourishes the body and helps in foetal wellbeing; the foetus will be small and no difficulty during childbirth, but I don't think so, (Excerpts from FGD2 P9)*

> *Some pregnant women expose themselves to the activities of 'nurse eliza' (untrained and unqualified healthcare workers) and also drink herbal medications during pregnancy; this contributes to the death of most women during childbirth (Interview Excerpt, Religious Leader)*

> *When a pregnant woman does a strenuous job, bleeding may occur, and this condition may lead to maternal death (Interview Excerpt, Women Leader)*

> *The traditional birth attendant does manual manoeuvre to force baby out of the uterus. They also give the labouring women different kinds of herbs to chew or drink to facilitate the birth of the baby. In the process of childbirth, many of the women usually die (Interview Excerpt, Women 1)*

These participants perceived that herbal concoctions, patronising the medical ‘quacks’, (untrained medical professionals) the activities of traditional birth attendants, and haemorrhages due to strenuous activity by pregnant women could pose risks for maternal death in the study setting. The view of these participants supported some of the findings from previous research about the risk factors for maternal death in Nigeria (Omo-Aghoja et al., 2010; Igwegbe et al., 2012; Ezugwu et al., 2014; Oye-Adeniran et al., 2014). This indicates that a few of the women and opinion leaders, had what seems to be a more biomedically informed explanation of maternal death during pregnancy and childbirth. This is because it fits into the widely accepted and scientifically justifiable naturalistic paradigm about the causes of diseases, in accordance with Disease Theory System (Foster and Anderson 1978). Naturalistic disease theory holds a view that a disease, illness, or misfortune is due to impersonal factors, such as enviornmental influences and pathogens (Foster and Anderson, 1978). Notably, local women and the opinion leaders who seemed to be more educated, articulated a more ‘scientific’ knowledge about pregnancy and childbirth unlike most of the illiterate participants who held perceptions that appeared to be rooted in cultural beliefs. It can be deduced that the perception of participants was shaped by their level of knowledge, and the different types of knowledge about pregnancy and childbirth that they had access to.

Finally, it was interesting to note that the views of a minority of local women and the opinion leader who seemed to have some contemporary knowledge about pregnancy and childbirth coincides with some of the views of community healthcare providers (midwives and doctors) about the causes of maternal death in the study setting. For instance, some of the midwives and doctors stated that:

Pregnant women are being advised by their older women to take herbal mixtures during pregnancy. For instance, if a pregnant woman has a swelling on her legs and she continued to drink herbal mixture, the condition that caused the swelling will advance and the woman may experience fits, which may lead to death of a woman and her baby (Interview excerpt, Midwife 1).

Most of the pregnant women do not go to the hospital to ascertain the maternal and foetal wellbeing, positioning and presentation of their baby. They continued to drink concoctions and 'kai kai' or 'akpuruachia' (alcohol), these contribute to the death of women during pregnancy and childbirth (Interview excerpt, Midwife 2)

As I have told you earlier, pregnant women in this community have trust in herbal mixtures. They drink these concoctions, which affect their pregnancy, and contribute to maternal death (Interview Excerpt, Midwife 4)

Some women attend most of their antenatal visits but 70% of them go somewhere for childbirth. Some of them are brought back late to the hospital due to complications they have experienced during childbirth. This contributes to increased maternal death in this community (Interview Excerpt, Doctor 2)

The views of these midwives and the doctor indicates that maternal death was attributed to women drinking excessive alcohol, herbal concoctions from Traditional Birth Attendants (TBAs) and patronising the services of TBAs for childbirth. However, the idea that services of TBAs contribute to maternal death raised controversy and debate among women who participated in the Focus Group one discussion. It was also a source of concern raised by all TBAs themselves during the interviews. While most of the women and opinion leaders appeared to support and encourage the use

of TBAs for childbirth, others considered it inappropriate and discouraged pregnant women from accessing any of the services of non-orthodox maternal healthcare providers for various reasons. We can see these divergent views in the following discussion.

Supporters of the use of TBAs stated thus:

> *Pregnant women need to drink herbal mixtures to prevent disorders of placenta during childbirth. A woman will be well and deliver safely if she drinks this mixture during pregnancy (Interview Excerpt, Youth Leader).*
>
> *…some pregnant women that have pedal oedema get relief after drinking this herbal concoction (Excerpt from FGD 1 M1)*
>
> *When a woman drinks herbal mixtures during pregnancy, it causes a speedy process of childbirth during delivery (Interview Excerpt, Women 2)*

These participants perceived that the herbal concoction treats pregnancy disorders and facilitates the process of childbirth. This finding reflects those of Fakeye et al., (2009) who also found that two-thirds (67.5%) of pregnant women drawn from three geopolitical zones in Nigeria had used herbal medicine for reasons such as perceived better efficacy and effectiveness as well as its lower cost compared to conventional medicine. In this current research, I witnessed one of the TBAs dispensing the herbal concoction to a pregnant woman as part of a traditional antenatal care service. All the TBAs who participated in this study provided a rationale for these treatments; for example, it helped the uterus to descend, eased the process of childbirth, prevented placenta previa and offered a solution to prolonged labour.

Health care workers in the hospital discourage pregnant women from taking herbal concoctions but this herbal mixture is good for pregnant women because it helps to make the uterus to descend in readiness for childbirth. This mixture does not cause swelling of legs unlike the medication they give pregnant women in the hospital (Interview Excerpt, TBA 3)

There is a condition where placenta usually comes down to block the birth canal and the baby will not be delivered. This usually led to surgery. For me, I prepare tea (herbal concoction). I give pregnant women this tea because when they drink it, it dissolves these things that could block the birth canal of a woman during childbirth (Interview Excerpt, TBA 1)

For me, I give herbal concoctions to all the women under my care to drink. When to give these mixtures depends on the condition of the woman during pregnancy (Interview Except TBA 2)

When analysing the contention regarding the use of herbal mixtures from the perspectives of TBAs and midwives, as noted above, it can be interpreted that the orthodox and non-orthodox maternal healthcare providers in this community seemed to be engaged in a struggle over the continued use and existence of their services. Whilst the majority of women and opinion leaders appeared to place higher value, accept and respect the role of TBAs in providing herbal concoctions and other maternity care services. It is possible that the wider acceptability of herbal concoctions and of the services provided by the TBAs in this community were reinforced because of the underlying beliefs held by participants, as presented earlier in this chapter. Elujoba et al., (2005) argued that herbal medicine is intrinsically interwoven with the culture of the people, which explains its high acceptance. Furthermore, the study

conducted by Mboho et al., (2013) in Akwa Ibom, Southern Nigeria supports the idea that pregnant women accepted and preferred TBA services because they believe they possessed skills and a supernatural ability to manage pregnancy and prevent potential adversity. Although most of the participants in this current research supported the service of TBAs, including the use of herbal concoction, there were some who were against it:

> *There are differences between seeking antenatal care in the hospital and taking herbal concoctions from the TBAs. Pregnant women are examined by midwives for maternal and foetal wellbeing, but TBAs and other people that sell herbal concoctions have no instrument to check for the maternal and foetal wellbeing. I believe there are a lot of disadvantages from drinking this herbal concoction (Excerpt from FGD 2, P7)*

> *Some husbands encourage their wives to drink herbal mixtures instead of visiting the hospital for antenatal care and childbirth… (Interview Excerpt, Women Leader)*

> *Pregnant women visit them (TBAs) for care during pregnancy, but I do not encourage this because the constituents of the herbal mixture they usually give to pregnant women are not measured to determine the dose and dosage. TBAs do not conduct any laboratory investigation and cannot perform abdominal scans to assess the condition of the baby and the woman (Interview Excerpt, Women 2)*

Some women in this community do not subscribe to the use of herbal concoctions during pregnancy and childbirth because of the perceived dangers. During the Focus Group discussions and the individual interviews, it became clear that participants who

did not concur with the idea of pregnant women drinking herbal concoctions were more educated (refer to table 5.1 for the biographic data of participants). This indicates that the level of education contributed to the behaviour concerning the use of TBA services, including herbal medicines. This impression was supported by the work of Mothupi (2014) who found that a lower level of education was associated with the use of herbal concoctions among pregnant women from Kenya. Although Louik et al., (2010) provided evidence that women who used herbal concoctions had non-malformed babies, findings about the use of herbal concoctions during pregnancy in this current research indicates that there is a need for further research to establish the claim either for or against its use.

Lastly, this section has shown the uniqueness of a participant's culture in influencing their thoughts about, and decisions to seek, maternal healthcare services. The cultural issues that influence pregnancy and childbirth appeared to have been explored in some parts of Nigeria and other countries (Agus et al., 2012; Mboho et al., 2013; Roudsari et al., 2015), but the findings of this research showed that a belief system is unique to a particular cultural environment. For example, a comparison between this current research with that of research of Mboho et al., (2013) in Nigeria and of Agus et al., (2012), in rural West Java of Indonesia has shown cultural similarities about belief systems. However, significant differences also exist within this research including studies conducted in another cultural region of the same country. This shows the originality of this current research and its unique contribution to knowledge in this field.

6.1.3 Perceptions and experiences of the practices of healthcare providers

Some of the participants professed that healthcare providers (doctors and midwives) refused to comply with the traditions and customs of their community within their practices, such as the disposal of the placenta. For instance, these participants said:

> *In our tradition, there are ways that placenta should be disposed. We believed that if placenta is not disposed in a cultural acceptable way, it could lead to the death of the baby and the mother. I have observed that when placenta is delivered in the hospital, the midwives usually dispose it in the bin instead of giving it to the women to take home for it to be buried in a designated place within the community as it signifies symbol of life (Interview excerpt, women 1)*

> *When women give birth in the hospital, their placenta is thrown carelessly in the bin. This is a taboo; we are not happy! (Interview except, Village Head)*

The community members, particularly three women and four opinion leaders stated that the placenta was a symbol of life and should be buried in a traditional way. For these participants, a violation of the traditional pattern of placenta disposal could bring about death of the mother and the child. This explains why the participants place immense importance on the placenta and appropriate ways to dispose of it. However, healthcare professionals seemed to consider the placenta as biological waste to be disposed of in a bin in accordance with the hospital policy for clinical waste (Calleghan, 2007). There is evidence to suggest that these participants perceived healthcare providers to be insensitive to their cultural beliefs. Moreover, they expressed discontent with the practices of healthcare providers regarding the disposal of the placenta. I noticed during the interview and focus group discussions that most of the participants who expressed concern about the way the placenta was disposed of in

hospitals but never mentioned that they had requested midwives to release their placenta to them, but instead expected them to follow the cultural pattern for placenta disposal. This finding appears to be similar to the study conducted in Canada and United States, where Baergen et al., (2013) found that the majority of perinatal pathologists did not release the placenta to their owners because of a lack of requests, although some reported that hospital policy prevented its release to their owners.

It is perhaps not unusual to find in this research that participants placed a high level of cultural significance on placenta disposal because midwifery literature shows that several other cultures have their own unique cultural or social value attached to the placenta and how it is disposed. For instance, in Australia, pregnant women who were planning a home birth were reported to have planned either to bury their placenta, consume it (placentophygy) or to allow the placenta to dry for possible consumption or burial (Burn, 2014). The practice of placenta burial, as found in this current study, is similar to other cultures, such as Moori customs, Somoan rites and Novajo tradition who bury the placenta after childbirth (Cairns, 2005; Panelli and Tipa, 2007; Avegalio, 2009; and Schwartz, 2009). This negates a widely held biomedical view, especially in western countries such as the United Kingdom and United States, that a placenta is clinical waste (Birdsong, 1998; Hillier, 2003; and Calleghan, 2007). The finding of this research and other studies (Baergen, et al., 2013; Burns, 2014) has shown that various traditions, customs, rituals, beliefs are linked to the placenta and its method of disposal. It is therefore important that healthcare providers should consider the beliefs and culture of pregnant women from different communities as part of the package of antenatal care; this is especially important in African societies when delivering culturally sensitive midwifery care.

Two additional cultural practices identified about the practices of healthcare providers, as perceived by participants in the study community are their alleged high rate of caesarean section (CS) on pregnant women and negligence amongst healthcare professionals in finding the traditional causes of problems faced by women during pregnancy and childbirth:

> *Many people in this community see it as a taboo to perform caesarean sections on pregnant women (Interview except, Midwife 3)*

> *Many pregnant women who went to the hospital for childbirth ended up with a caesarean section. I think the healthcare worker think it is ok to send all the women that come for childbirth for operation. We do not like it because it is against the will of God for us (excerpt from FGD 2 P6)*

> *There was a time I visited the hospital because I was unwell. I saw a pregnant woman that had caesarean section. When this woman came to the hospital because she was unable to deliver her baby, the doctor moved her to the theatre for operation without trying to find out the traditional cause of her prolonged labour (Interview excerpt, Youth leader)*

Caesarean sections appeared to be a cultural taboo in this study community because of the belief that it was contrary to the will of God. It appeared that most participants did not accept the practice of CS even when it was necessary to save the life of a pregnant woman. Members of the community who participated in this research were especially concerned that CS was routine for pregnant women visiting a hospital for childbirth. This claim of participants in this current study about the high rate of CS seemed to contradict evidence available on the rate of CS in Nigeria. For instance, a comparison of the rate of CS between 1999 and 2013 from Nigeria's demographic and

health survey shows a decrease from 2.9% in 1999 to 2.0% in 2013 (Nigeria Demographic and Health Survey 2000/2014). However, participants perceived a high rate of CS in the hospital located in their community, which could be associated with the situations repeatedly described by midwives and doctors, that most pregnant women presented late during childbirth when they had experienced complications, which often led to an emergency CS to save the life of the mother and baby. Thus, CS may most likely have been performed based on the need of the women and perhaps in accordance with WHO recommendation (WHO, 2015). It can be deduced that the participants' view about CS and their expectations that healthcare providers use a traditional lens to explore the cultural cause of prolonged labour could indicate their poor knowledge about the relevance of CS.

Finally, the data analysis showed that these cultural beliefs held by participants about the practices of healthcare providers deter them from seeking the services of midwives during pregnancy and childbirth and instead lead them to seek the services of TBAs who they believed to understand and practice in accordance with their culture:

> *We are more comfortable to tell our women to go to a place where our culture will be respected during pregnancy and childbirth (Interview excerpt, Village Head)*

> *They seek care with them (TBAs) because they felt that those TBAs understand their culture and customs (Interview excerpt, Midwife 2)*

> *The high maternal death in this community and the environs is because pregnant women do not come to hospital, only few of them present as a last resort (interview excerpt, doctor 2)*

These excerpts suggest that consideration of a place where cultural beliefs will be respected is a powerful force and a criterion that shapes the decision about the place where pregnant woman should seek care during pregnancy and childbirth. Arguably, maternal death would be more likely in any community whose members chose not to seek care in the hospital because of the perception that healthcare provider practices were not favourable to their culture or their religion as found in this current research. The connexion of culture and religion in influencing meaning making about pregnancy and childbirth and leading to the behavioural and the reluctant use of midwifery services will be explored next.

6.2 Religious belief on pregnancy, childbirth, and maternal death

Ver Beek (2002) defines religion as an institutionalised set of beliefs and practices regarding the spiritual realm. Religion also influences the way in which people view their world. This means that people's everyday life can be shaped and influenced by religion in a community. Religion affects the daily lives of people, and female sexual and reproductive health are among the issues mostly affected by religion (Ha et al., 2014; Kenneth et al., 2016). It is also known that religion abets culture in the formation of beliefs, attitudes, and practices. Culture and religion are often inseparable; they therefore embrace all aspects of one's entire life (Kanyoro, 2002). According to Cotton et al., (2006), traditional religious practices have been associated with maternal risk. Both religion and culture affect the utilization of maternal health services thereby potentially leading to an increase in maternal mortality. The impact of religion and spirituality on maternal health differs by the type of religion and religious denomination (Ellison and Levin, 1998). In Ebonyi State, Christianity is the predominant religion widely practiced; however different denominations have their own doctrinal rules that guide their fate. The studied community is mostly Christian; they have different

churches and each denomination has laws everyone in the church must adhere to. It was alleged by midwives that pregnant women preferred to adhere to the doctrines of their churches and the words of the prophet purportedly received from God:

> *There are some people that attend some churches that do not believe in blood transfusion even if they are dying. We have had a case when a pregnant woman was brought to the hospital with placenta Previa. This woman needed an urgent blood transfusion, but she rejected it and the woman's relatives also rejected blood transfusion. The relatives of this woman watched her til death, and they did not feel remorse about it (interview excerpts, midwife 4)*

> *Yes, for religion, there is a religion that does not believe in blood transfusion. We had a case where a woman that gave birth somewhere and was brought to the hospital. This woman had cervical laceration and was bleeding profusely. She needed an urgent blood transfusion. We counselled the husband and he accepted, and the woman was transfused. When the woman regained her consciousness, she started screaming because the husband consented for blood transfusion against their religious belief (interview excerpt from midwife 1)*

These two extracts provide evidence that religious beliefs could be influencing decision-making during pregnancy and childbirth. However, whilst some individuals strictly complied with their religious fate, as shown in the first excerpt, others seemed to have used knowledge gained from health education provided by midwives instead of their religious thinking in decision making. For instance, in the second extract, the husband has adjusted his religious beliefs but seemed to have gone against the religious beliefs of his wife. It may not be surprising that individuals who subscribed to

religiosity in decision-making often believed that God would help them in their period of pregnancy; therefore, there is no perceived need to visit the hospital during pregnancy/labour, as depicted by the Midwife 2:

> *These women who are religious fanatics always say that pregnancy is not a disease; therefore, most of them when pregnant do not seek for maternity care in the hospital even if they are sick, and they assume that the sickness is due to offences they might have committed (Interview excerpts, Midwife 2)*

It may be plausible to state that women who believe in their religious leaders or are rigid about their religious beliefs are likely to have higher risks of death due to unattended complications during childbirth. This assumption was reiterated by the Women's leader:

> *Yes, some women die during childbirth because they do not want to go against their church doctrine and beliefs. For instance, Jehovah witness church, do not believe in blood transfusions. If a member of this church is pregnant and requires a blood transfusion, such person will reject and eventually many of them die during childbirth because of haemorrhages. Also, some women visit some prayer houses where they are told that God said they will give birth safely to their babies, that there is no need to continue taking drugs from hospital but instead they rather pray daily from 6am to 12 noon (interview excerpt women leader).*

Hughes (1998) posited that religion should not be undermined, considering its centrality in some people's life. Moreover, there is a belief that the religiosity of women correlates significantly with maternal health, which means religion has a great influence on maternal mortality in some communities. Levin (2010) concluded that the

sphere of religiousness, faith, sacred beliefs, and experiences have been a source of exploration, whatever one's beliefs or preferences about faith or God, it was accepted that these things matter. It is therefore clear that religion influences attitude, knowledge, and the use of healthcare services in the studied community.

Addai, (1999) argued that religion influences attitudes and behaviours in reproductive health. He also stated that the religion's influence on health outcomes cannot be underestimated in Africa, such as a lack of neonatal visits by pregnant mothers and instead a stress on beliefs, teachings, doctrines, healing practices and church regulations. During the focus group discussions with women of a childbearing age with children, the women stressed that some pastors and prophets will always advise their members not to visit the hospital during pregnancy because it is a waste of time and money. Moreover, their religious leaders state that God has already ordained a safe delivery for them. Belonging to a specific denomination may suggest an association with the denominational doctrine; however, Mavalankar and Rosenfield (2005) argued that the realisation of the religious leader that some deaths and injuries to women from pregnancy-related conditions are preventable through early diagnosis and intervention will encourage community members to seek proper care from a hospital during pregnancy and labour. However, if the religious leader does not provide this support, there can be other outcomes, as seen below.

> *Another issue is the belief in church. There was a pregnant woman that went for her antenatal visit in the hospital. After examination, she was advised to return to the hospital for admission two weeks before her expected date of delivery because of the medical condition she had. She went home, explained to the husband but they agreed that they will go and inform their pastor. When they told the pastor, the pastor said, 'God forbid! That she will give birth to her*

baby safely because the Bible said that she will give birth safely like Hebrew women.' That he will pray for her and there are high chances that she will give birth at home even without going to hospital. The woman and the husband believed in what the pastor said and neglected the midwives advised. The woman did not visit the hospital, gave birth to the first baby at home as she was having a twin, but the second baby refused to be delivered. Pastor was invited for prayer, he came and prayed but still the second baby could not be delivered. The woman was later rushed to the hospital but on the way, she died. This woman died because of faith in the pastor (Interview Excerpt, Women's Leader)

I trust and obey my pastor because the Holy Spirit from God empowers them to help people that go to church… (Excerpt from FGD 1 M9)

Also, some women visit some prayer houses where they are told that God said they will give birth safely to their babies, that there is no need to continue taking drugs from hospital but instead they rather pray daily from 6am to 12 noon. Many pregnant women usually believed and abandoned antenatal visit and their medications from the hospital. During their childbirth, most of them die (Interview Excerpt, Women 1).

The members have strong beliefs in the power of the prophets; they believe the Holy Spirit communicates through these religious leaders to foretell impending illness or disease. Members are restricted from patronising modern maternal healthcare services (hospitals) and instead are only allowed to remain in the church to fast and pray, as prayer and fasting serve as coping mechanisms during labour, as depicted by the women's leader. This suggests that there is strict adherence to church doctrines by members of the church. In the extract from the women's leader, it appears that the

couple believed so much in their religious leader they ignored the medical advice. The belief that God controls one's life and can help to deliver their baby safely is comforting and seems to be a psychological strategy by prophets to foster hope and belief. Religious leaders may have convinced women that the outcome of their pregnancies depend on God and not in the hospitals. This finding is consistent with Reeves (2009) study, who stated that beliefs in God or Allah were positively associated with increased maternal and child mortality.

Meanwhile, during the focus group discussion with the women without children, the participants seemed to hold a contrary view about religion and the use of midwifery services, probably because they were more enlightened educationally than the women with children, For instance:

> *For me, I believe in God, but I support that pregnant women should go to the hospital to receive care during pregnancy and childbirth (Excerpt from FGD 2, P3)*

> *O yes, I agree with her…I need to also say that pregnant women should not depend on only praying and fasting without going to the hospital because it could lead to problems during delivery (Excerpt from FGD 2, P7)*

These participants acknowledged that there is God but affirmed that a pregnant woman should visit the hospital and not rely on prayer houses for antenatal care during pregnancy/childbirth. It is insightful that some participants, as depicted in the second excerpt above, recognised that if a woman depended only on the prayers and fasting recommended by prophets and pastors this could lead to complications as a consequence of not seeking midwifery care. The women without children seemed to be younger in age and with higher level of education, unlike women with children. This

suggests that the level of education may account for the differences in their views and meaning making. Laudably, some participants highlighted that every pregnant woman is supposed to eat an adequate diet daily to help nourish her and the baby in-utero, instead of subjecting herself to fasting and prayer.

> *I encourage pregnant women to eat good food, go to the hospital for care and not focus their attention to prayer and fasting as commanded by the men of God (Interview excerpt, women leader)*

> *Yes, there are some religious preachers that will discourage their members not to give birth through caesarean section and not to go for care in the hospitals because God created man to give birth through normal vagina. That caesarean section is not of God. In my own church, we do not preach such messages. Some religion incites fear in pregnant women and other people (Interview excerpts from religious leader).*

However, this religious leader exonerated his own church and alleged that some other religious preachers propagate fear amongst their congregants as an approach to discourage women from seeking care in the hospital, while still despising caesarean section. This could suggest that some religious preachers spread religious values that may identify the seeking of midwifery services by pregnant women as an act of disobedience to God, as well as a demonstration of lack of religious faith in God. Most probably, any pregnant woman who subscribed to these religious teachings may neither visit the hospital for childbirth nor accept services provided by the midwives in this community. This claim seemed plausible because it was repeatedly stated, as shown in the excerpt below, that the participants thought most pregnant women

preferred to visit prayer houses and engage in religious rituals, such as praying and fasting, as an approach to appease God to grant them safe childbirth:

> *… instead, they rather prayed daily from 6am to 12noon (Interview Excerpt, Women Leader)*
>
> *Some women visited prayer houses where they were told that God said they will give birth safely to their babies (Interview Excerpt, Women 1)*
>
> *Some pregnant women keep moving from one prayer house to another. The women engaged in prayer and fasting as recommended by the pastors (Excerpt from FGD 2, P4)*
>
> *Yes, some pregnant women do not go to hospital for the treatment of their diseases but instead they move from one prayer house to another in search of healing (Excerpt from FGD 2, P5)*
>
> *A woman had traces of protein in her urine, we advised her to come to the hospital immediately if at any point she feels unwell while at home because she was at risk of pre-eclampsia. This woman decided to go to prayer house for prayer when she experienced a problem. She was later brought to the hospital at a critical state. She had seizure on arrival to the hospital and later died (Interview Excerpt, Midwife 4)*

These excerpts indicate that participants reported that decision-making about the type of services sought during pregnancy appeared to be influenced by religious beliefs, which are rooted in religious teachings. It can be deduced that some participants believe that faith in God and the activities of some pastors in prayer houses deter women from accepting or seeking midwifery care services during pregnancy and

childbirth. This finding reflects that of Azito et al., (2016) who found that women from Ghana engaged in religious rituals, such as prayer, singing, fellowship and thanksgiving, at the church as measures to prevent complications during childbirth and to achieve safe delivery. Although religiosity has been long recognised to have an impact on health in African societies (Assimeng, 1989), it is somewhat surprising that the power of religion in influencing behaviour, as demonstrated in this current research, was still as active, indicating there could be gaps in participants' biomedical knowledge about pregnancy and childbirth. Arguably, the belief system could be attributed to a long existing cultural pattern inherent in the society which contributes to women's oppression consistent with the views of radical feminists (Harman et al., 2018).

Finally, this section has shown that the participants consistently emphasised that most of pregnant women accepted the instructions, teachings, and advice from their pastors, which resulted in some women refusing the advice from midwives to preserve their life during childbirth even when conditions compelled them to seek care in a hospital. Also, the data analysis showed that participants told stories about some pregnant women who they believed had refused blood transfusions while other women gave accounts of pregnant women who had rejected caesarean sections. It is perhaps shocking that a woman would be unhappy that blood was transfused to her to save her life and that of her baby, indicating that religion seemed to be rooted deep within lives and controlling the decisions that shaped behaviour and actions by some individuals in the studied community. This finding concurs with those by Ugwu and de Kok (2015) in their study within a community in a North-Eastern region of Nigeria. They found that pregnant women refused caesarean sections because of their religious ideologies, and that more than 90% of the C-sections were emergencies

which resulted from the late arrival of pregnant women to hospitals when they have exhausted other measures elsewhere to avoid the procedure (Ugwu and de Kok, 2015). In this current research, it was also revealed, as evidenced in the excerpts from participants, that some pregnant women, due to their religious beliefs, either stopped their medications/antenatal visits or refused to come to the hospital for childbirth, thus leading to maternal death. It can be suggested that, in the views of some of participants, religious beliefs foster a powerful unrealistic hope for a supernatural safe childbirth while denying the possibility that maternal death could occur in the absence of needed midwifery care.

6.3 Summary of the chapter

Perceptions about pregnancy, childbirth and maternal death appeared to be deep-rooted in the participants' belief systems, based on their culture and religion. The sets of identified cultural and religious beliefs held by local women and their opinion leaders about pregnancy, childbirth, and maternal death influence how these participants construct their understanding and meanings, which in turn potentially, shape their behaviour about the use of maternal care services in either the hospital or traditional settings within their community. The opinion leaders, particularly the men, were found to have facilitated and enforced the behaviour of some women about the non-acceptance and use of midwifery services, as rooted in cultural beliefs. Feminism and GAD theory was mainly used as a lens to understand the intricacies surrounding women's behaviour and attitudes regarding the use of midwifery services. It was perceived by some of the participants that religious leaders conveyed religious values and teachings which provided unrealistic expectations that pregnant women would give birth safely through the performance of religious rituals instead of seeking midwifery care in hospitals. This chapter has demonstrated that sets of beliefs held by

the participants revealed that some may possibly have a poor level of understanding about the biomedical view of pregnancy, childbirth and maternal health and mortality.

CHAPTER SEVEN

SOCIO-POLITICAL AND CULTURAL PRACTICES INFLUENCING PREGNANCY AND CHILDBIRTH

7.0 Introduction

The previous chapter suggested that the perceptions of pregnancy, childbirth and maternal death held by the community women, opinion leaders and traditional birth attendants were deeply rooted in their culture and religious beliefs. The various sets of identified beliefs held by participants seemed to have shaped their attitudes, behaviour, and choice of place to seek care during pregnancy and childbirth. In addition, the previous chapter revealed that most pregnant women in the studied community preferred to seek non-orthodox care instead of midwifery care. This was found to be associated with the use of ethno-religious knowledge instead of scientific knowledge in how they constructed meaning about pregnancy, childbirth and maternal health, and death.

This chapter will explore how this cultural-based perceptions and ethno-religious knowledge may have contributed to the socio-political and cultural practices that influenced maternal health, thereby leading to maternal mortality. Specifically, the practices of persons in governance, community healthcare providers, local women and traditional birth attendants who enhanced or contributed to maternal death will be explored. This theme ‘Socio-political and cultural influences on pregnancy and childbirth’ has four subtheme groupings, which are the political influence on pregnancy and childbirth, socio-cultural practices, healthcare system influences on pregnancy and childbirth, and the patriarchal system and women’s subordination. The influence of nationwide governance on pregnancy and childbirth will be presented first.

7.1 Political influence on pregnancy and childbirth

7.1.1 Influence of the national governance

This section will explore how national governance has impacted on pregnancy and childbirth, and potentially contributed to maternal death because it was one of the predominant issues raised by participants. Governance, as used in this section, is defined as the exercise of the political, economic, and administrative authority necessary to manage a nation's affairs (Organisation for Economic Co-operation and Development Governance, 2007). In Nigeria, the three tiers of government (Federal, State and Local Government Authorities) are meant to work in synergy to formulate and implement policies to enhance the welfare of the citizen (Federal Ministry of Health, 1999; Okpani, and Abimbola, 2015). The three-tier structure of government in Nigeria implies that the life and property of citizens are managed at different levels. This makes it possible to share responsibilities and allows the government to manage the country more efficiently. In relation to health, the tertiary and secondary health facilities are mostly found in urban areas, and these are largely managed by the federal government. While in the rural communities, there are only primary healthcare (PHC) services that are rendered, and there are managed by the local government authorities (LGAs). Also, it is argued that the healthcare resource distribution is skewed to benefit the tertiary and the secondary healthcare services rather than the PHC services (Oyedeji and Abimbola, 2014). This is due to the decentralization of health resources and mean that PHC services in rural communities receive little or no attention, making it impossible for LGA leaders to establish many PHC services close to villages, or provide proper instruments, equipment, and human resources to operate in the facility. This invariably denies community members access to good and adequate maternal

services. Moreover, a decision to go to the urban areas to access tertiary or secondary healthcare services becomes too expensive for the poor rural dwellers; this therefore leaves such communities with little or no option other than to patronize the TBAs in their community.

The issues raised by participants suggest that it is the failure of government officials at federal, state, and local government levels to provide adequate social amenities, which thus plays a contributory role in the high levels of maternal mortality. For example, this is seen in the lack of good roads, poor public transport service and infrastructure, a lack of skilled health workers and ambulance services for proper referrals, a lack of equipment for community healthcare centres and few hospitals close to the community members who would benefit.

> *A pregnant woman told me today that her labour started at 7pm but she could not see means to transport herself to the hospital. It was at 3am that she saw someone who used bicycle to transport her and they got to the hospital at 8am in the morning (Interview Excerpt, Midwife 3)*

> *Bad road contributes to the death of women in different communities. Many of the roads in the rural villages where these pregnant women live are not accessible by vehicle. Most of the women are not able to arrive at the hospital early when labour starts as they lived far from the hospital (Interview Excerpt, Midwife 4)*

> *The distance of the healthcare centre to the women is the problem. One of the pregnant women I knew started bleeding while at home. This woman was transported in a wheelbarrow because vehicle cannot access the road from their residence to the hospital (Excerpt FGD 1 M7)*

In these extracts, it can be identified that several issues, as outlined above, could be impacting on maternal health, thereby increasing the risk of maternal death. For instance, it appears that bad road conditions and the limited number of hospitals within the study community seemed to have created difficulties for pregnant women who do not live close to the hospital environs but wished to attend hospital for childbirth. This suggests that the local government may have failed in their responsibility to provide ambulance services to support women in need of transportation to the hospital for childbirth, especially in emergency conditions (Erim et al., 2012). This claim supports the findings of other studies, in which primary healthcare centres located in different states in Nigeria, including Ebonyi State, were found to lack ambulance services to respond to obstetric emergencies (Erim et al., 2012).

However, it was reported that Lagos State in Nigeria has ambulance services (Adewole et al., 2012), although these may not be as effective as those of the United Kingdom. Probably, Lagos State has ambulances because it is one of the biggest cities in Nigeria, so cannot be compared to rural areas without ambulance services. In this current study, the failure of the government to neither build nor maintain the road that leads from the community to the hospital or to provide ambulance services to aid and enhance a prompt response to the needs of pregnant women could suggest insensitivity amongst the persons in governance to the needs of community members, especially pregnant women. This could be regarded as an act of oppression by bureaucrats to pregnant women in this community, which is consistent with theories of feminism, which recognise that women face multiple oppressions because they are disadvantaged in many societies due to their gender and social position (Parpart et al., 2000). Specifically, this appears to fit within liberal feminism, which emphasises

the need for cultural change in relation to laws so that no one should be discriminated against because of their gender (Madsen, 2000).

In addition, a political culture where bureaucrats appear insensitive to the provision of social amenities, as demonstrated in the extracts above, also signifies bad governance, as postulated by Organisation for Economic Co-operation and Development Governance, (OECD, 2007). Using the theory of Gender and Development (Moffat et al., 1991) as a lens to understand the intricacies of the oppression faced by women in the study community, this is rooted in poor governance, and can be interpreted that strategic gender interests (as previously discussed in section 2.13.2) are rooted in political culture. Some of the medically trained participants suggested that those who control political powers (politicians) and their allies (the bureaucrats) either mismanage public resources or may have considered the provision of facilities to improve the wellbeing of pregnant women as a lower priority.

> *The only hospital in this community serves many surrounding villages. Sometimes, pregnant women are unable to come to the hospital for antenatal care or for childbirth due to distance. I think the government do not consider it necessary to build more hospitals and providing other amenities, which could improve the health of the pregnant women (Interview Except, Doctor 2)*

> *The politicians are not providing the facilities and amenities needed to provide high quality care to pregnant women; they are not just interested (Interview excerpts, Midwife 3).*

The behaviour of political actors regarding lack of provision of facilities to improve maternal wellbeing could be attributed to patriarchy, male-based authority or

domination, and power structures that facilitate the oppression of women and inequality in Nigerian society. This explains why maternal health was not given proper attention. It is stated there was fund mismanagement or corruption in the government of Ebonyi state where this current study was conducted (Arowolo, 2010; Nawaz 2012). Consequently, the funding of other government agendas has taken precedence (Okpani and Abimbola, 2015). Okpani and Abimbola (2015) opined that the overprovision to tertiary and secondary health services and the lack of coordination among the three tiers of government contribute to health inequalities. It is therefore plausible to infer that state political culture does not place a high value on improving maternal wellbeing in rural areas, and thereby to reducing maternal death. However, evidence has shown that the government of Nigeria is spending huge funds and has prompted several initiatives, such as Safe Motherhood initiatives, Midwifery Service Scheme, Maternal, Neonatal and Women's Health Services, which have been instituted to improve the health of women and children (Shiffman, 2007; Abimbola et al., 2012; USAID Nigeria, 2012; Cooke and Tahir, 2013). Nevertheless, maternal mortality is still very high in Nigeria, perhaps due to the misappropriation of funds, as participants insinuated in this current research and as also indicated by previous scholars, researchers and international agencies who have documented that governance in Nigeria is challenged by issues such as the misappropriation of funds, nepotism, ethnic loyalty and other forms of corruption (Achebe, 1984; Khan, 2008; Arowolo, 2010; Nwaza, 2012; Okorontah and Odionye, 2015; Transparency International, 2017).

Lastly, women were said to have experienced several difficulties that stemmed from the insensitivity of governance and the failure to provide social facilities:

Some of the women have money and are willing to come to the hospital for childbirth but because of the distance from their home to the hospital and the bad road, they will be discouraged to come to the hospital for care. The government has failed to provide us with good roads (Excerpt from FGD1 M4)

Some pregnant women present with bleeding that commenced after traveling from the hospital to their home because of bad roads (Interview Excerpt, Doctor 1)

Some pregnant women die because there is no hospital close to them to seek care and no means to travel to the hospital nearest to their home. I tell you the government has failed us by not doing these things… (Interview Excerpt, Women Leader)

According to M4, one of the focus group one participants, pregnant women who were discouraged to seek midwifery care due to poor road conditions or a lack of hospitals near their home, would instead seek local alternatives, such as patronising the services of Traditional Birth Attendants. This could lead to the mismanagement of pregnant women and could cause maternal death, as found in the previous chapter. The excerpt earlier from Midwife 4 also shows that pregnant women suffer from preventable conditions, which become more serious because of the lack of transport infrastructure.

7.1.2 Healthcare system influence

The Nigerian healthcare system is pluralistic, consisting of conventional, alternative, traditional, faith-based, and spiritual care (Adefolaju, 2014; Uwakwe et al., 2015; Izugbara et al., 2016; Adeloye et al., 2017; Adekanmbi, 2018). This implies that

maternal health care services are obtained from the above-mentioned sources and even from patent medicine dealers and street medicine hawkers in Nigeria (Izugbara et al., 2016). From the data analysis in this current study, it was identified that the activities of medical “quacks” and the attitude of skilled healthcare providers were some of the issues affecting the healthcare system, which influenced pregnancy and childbirth. The findings pertaining to these issues are presented next as they seemed to contribute to the death of pregnant women.

7.1.2.1 Activities of the Medical Quacks (Unskilled health workers)

The participants, mainly community healthcare providers, perceived that the actions of some individuals who provide care to pregnant women during their period of pregnancy and childbirth contribute to the poor maternal health of women and sometimes leads to the death of pregnant women:

> *Some people work as a doctor or nurse in rural villages but are not licensed to practice; these are quacks that mismanage women during pregnancy and childbirth. These quacks are closer to people in their various homes. When labour starts, most of the pregnant women visit them (interview excerpt, doctor 2)*

> *There are some people in this community and everywhere in this state that manage pregnancy and childbirth, but they do not have sufficient knowledge to do so. Many of these quacks work in maternity centres, traditional settings, private homes, chemists and even in the private or mission hospitals. Their activities contribute to the death of many women in this community and the government is doing nothing to stop this (interview excerpt, doctor 1)*

These excerpts suggest that some individuals provide care to pregnant women as if they were doctors, nurses, or midwives. Some participants labelled these individuals ‘quacks’ (unskilled) because they are perceived as not possessing the necessary knowledge and skills to effectively manage pregnancy and childbirth. The study by Izugbara and Wekesah (2018), who recruited their participants from six states including Ebonyi state, found that the services of maternity care rendered by several providers in the Nigerian healthcare sector was of poor quality rooted in medical quackery, a lack of commitment by providers, and other issues. In agreement with Ndububa, (2007) and Izugbara et al., (2016), the widespread use of medical quackery in Nigeria related to a poor regulatory system and defective policies to curb its proliferation. This shows the failure of the federal government to formulate and implement policies to prevent medical quackery, and thereby make childbirth safer for women.

Unskilled health workers who were referred to as ‘quacks’ and ‘charlatans’ usually provide the women who sought maternity healthcare services from different settings, such as prayer houses, patent medicine shops, chemist’s shops, TBA homes, maternity homes, and private hospitals, care. It was reported by some participants that the practices of these quacks include the prescription of inappropriate drugs to speed up labour, using hand or pestle to pound the waist of a pregnant woman to enable the pelvis to open during childbirth, manual foetal repositioning and the manual pressing of the abdomen of a labouring pregnant woman to force the baby out of the uterus:

> *The traditional birth attendant decided to use her hand to hit the waist of the woman to enable the pelvis to open for the baby to be delivered (Interview Excerpt, Midwife 2)*

… traditional birth attendants do manual manoeuvres like pressing the abdomen to force baby out of the uterus (Interview Excerpt, Women 1)

The unqualified persons which call themselves doctors and nurses from chemists, maternity homes and even private maternity homes sometimes give a push of oxytocin directly to the vein or muscles to hasten the process of labour (Interview Excerpt, Doctor 3)

These excerpts showed that, according to the participants, some individuals who practice as doctors and nurses/midwives in the studied community engaged in activities which seemed to constitute a risk for pregnant women. It could be suggested that this is perhaps because they do not possess adequate knowledge and the skills necessary for the safe management of pregnancy and childbirth. Although, these individuals may be genuinely wanting to assist pregnant women during and after childbirth, their lack of formal training, a lack of funds, limited knowledge, and skills to effectively manage normal pregnancies or obstetric emergencies seemed to have caused harm to pregnant women leading to poor outcomes in childbirth. It could be plausible to postulate that, in the views of the healthcare provider participants interviewed, maternity care seemed to be unsafe, especially in the rural areas of Nigeria because of the activities of the untrained healthcare providers. Previous research has showed that the local government lacked the commitment due to inadequate or the misappropriation of funds to improve maternal healthcare services at the PHC level; moreover, they failed to formulate policies to guide the practices of TBAs and other maternity care providers. Additionally, there has been a lack of political drive to establish educational training for TBAs and other individuals who are involved with maternity care delivery in Nigeria (Sieverding et al., 2015; Abimbola et al., 2016). Summarily, this finding suggests that participants identified the failure of political actors

to effectively coordinate multiple healthcare providers and settings to improve maternal health and reduce maternal death during pregnancy and childbirth.

Furthermore, most of the participants (midwives and doctors) highlighted that medical quacks manage labour for several hours and do not possess the knowledge to determine the appropriate time to refer the pregnant women for expert management. Instead, they wait too long and as such, have repeatedly referred some pregnant women to the hospital when they have caused damage that threatens their lives:

> *During labour, some of the TBAs do manage pregnant women for up to five days; they give them different kind of herbs to chew to hasten labour (Interview Excerpt, Doctor 1 and Doctor 3)*

> *Most of the pregnant women are brought to the hospital at the critical stage. I mean, when they lost much blood during labour being managed by either TBAs or quack nurses that work in chemists and other places (Interview Excerpt, Midwife 2)*

> *These quacks send the labouring pregnant women to the hospital when the uterus has ruptured (Interview Excerpt, Midwife 3)*

The medical quack may have unintentionally mismanaged labour, which endangered the lives of both women and their babies. This indicates that pregnant women in the study community experienced what could be termed as ‘cultural oppression’. Yang et al., (2015) explained that oppression is a structure of power that affects or impacts on individual and communal self-worth. As it appeared that it was permissible in this cultural environment for anybody to manage women in labour. This indicates that, there is a perception that political actors are failing in their responsibility to formulate

policies that will regulate who can manage pregnant women during labour. Several researchers in Nigeria have highlighted that traditional medicine is practiced in Nigeria without enabling legislation; this is due to a lack of political will to either formulate or implement policies, for instance, the National Assembly is yet to pass the Traditional Medicine Council Bill presented in 2007 (Adefolaju, 2014; Izugbara et al., 2016). The current findings confirmed that participants perceived that the government still has a poor attitude towards regulating the practices of medical quacks; this is attributed to a lack of interest to formulate the necessary legislation to reduce or control its proliferation.

Finally, a study conducted in Nigeria found that 60% of TBAs had no formal education, 62.2% of TBAs acquired their skills by learning from a relative or family member and 8.9% had no training at all (Agbo, 2013). This is similar to the current study where all TBAs professed they got their inspiration and knowledge from God on how to deliver pregnant women:

> *I did not learn this work but God teaches me which herbs to gather together and form the mixture that I give to pregnant women when they come here... (Interview Excerpt, TBA 3)*

> *We do not learn this work; it is a gift from the Creator of this world ... (Interview Excerpt, TBA 3)*

A lack of TBA training may have contributed to their inability to recognise when they should refer pregnant women to hospitals. It can also be interpreted that the government seemed to have failed in their responsibility to provide training to this group of individuals and this might have contributed to TBAs and other individuals who possess little to no knowledge about pregnancy and skill assisting women during

childbirth. Their activities were reported to contribute to death, or a near miss of maternal death, during childbirth by several number of participants:

> *I received an injection from a girl that wore a white dress in a private clinic, but I stated feeling dizzy followed by bleeding from my nose. Later, one of our family nurses told me that the injection was wrongly given to me (Excerpt from FGD 1 M6, and Women 2)*
>
> *A pregnant woman was brought unconscious to this hospital; she had bled profusely before arrival. They told us that the woman was being managed by the traditional birth attendant… (Interview Excerpt, Midwife 4).*
>
> *Most of these women die shortly after they arrive to the hospital, because they have lost much blood from the place they had gone for childbirth (Interview Excerpt, Midwife 4)*
>
> *Many pregnant women have been brought to this hospital due to complications encountered during childbirth somewhere. Most of the time, we are unable to assist some of them because of the level of severity, and some of them eventually die shortly on their arrival (Interview Excerpt, Doctor 2).*

This shows that the activities of the medical quacks are rooted in their lack of adequate knowledge and skills to manage pregnancy and childbirth. It is the belief of many of the participants that this led to the mismanagement of pregnant women during childbirth and this increased the risk of maternal mortality. A previous study conducted in Lagos state-Nigeria found that some pregnant women received inadequate or wrong maternity care from TBAs while others were mismanaged in private hospitals (Okonofua et al., 2017). Similar, to this current research, they found that 80% of

women who died from pregnancy or childbirth complications were those who had not received antenatal care but who presented in hospital when complications had occurred. This suggests that the activities of medical quacks appear to be an issue in promoting maternal death; these concerns exist in other parts of Nigeria and fits with Thaddeus' Type 1 in the three delays model that accounts for maternal death in Nigeria (Thaddeus and Maine, 1994). This section has mainly presented the perspectives and experiences of the community healthcare professionals about social issues, which they believe might cause maternal death in the study community. It is remarkable to note how the healthcare professionals blamed maternal death on the consequences of medical quackery, without recognising that they may also contribute to issues that could lead to maternal death. The following section will present the perspectives from community women and their opinion leaders, which alleged that community healthcare workers were a key reason why most pregnant woman in the study community did not seek maternity care in the hospital, thereby potentially contributing to maternal death.

7.1.2.2 Attitude of the healthcare providers

Healthcare providers comprise medical doctors, nurses, midwives, clinical social workers who are authorised or licensed by the appropriate authority to provide direct health services to the people. The community women and their opinion leaders recalled the experiences of their encounters with healthcare providers and professed that this deterred them from seeking maternity care in the hospital during pregnancy and childbirth. The recurrent issues identified from the interviews were: a sense amongst most of the participants that health care providers slap, shout at, abandon, and rebuke pregnant women during antenatal visits and childbirth:

> *Many of the nurses are very wicked to the pregnant women; even some shout and slap them when they come for antenatal care and during childbirth. When*

a young lady becomes pregnant, and then visit hospital for antenatal care or childbirth, the nurses/midwives will start shouting and rebuking her, blaming her for being pregnant instead of focusing on how to care for her (Excerpt from FGD 2 P8).

During my fifth pregnancy, I visited the hospital for childbirth, but the nurse did not attend to me, I felt like defecating, and then went to toilet. I found out the head of my baby was already at the perineum; I gave birth in the hospital toilet. When my baby started crying, … the nurse ran to the toilet, and rebuked me and shouted at me. This was the experience that I can never forget (Interview Excerpt, women 4).

In addition to what she said, my friend went to the hospital to give birth. The nurses/midwives ignored this woman, told her that labour has not started. This woman told the nurse that she was touching the caput of her baby, but the nurse ignored her. She was left alone at night and she later gave birth to her baby before the nurses ran to help her (Excerpt from FGD 2 P3).

Another issue in addition to what others have said, nurses do not take seriously any woman that is not screaming when she is in labour. During one of my childbirth, the nurses ignored me because I was not screaming. These nurses give attention to pregnant women when they are screaming, as they assume it is a sign that labour has started (Excerpt from FGD 1 M5)

The excerpts above show that participants believe that some healthcare workers either abuse or neglect pregnant women during pregnancy and/or childbirth and consequently, some women label them as wicked, aggressive, and unprofessional. There is some previous reported evidence of mistreatment in terms of the physical

and verbal abuse of pregnant women in healthcare facilities in various African countries, such as Tanzania, Ghana, South Africa, and Jordan (Hatamleh et al., 2013; McMohon et al., 2014; Moyer et al., 2014). This perhaps, may appear strange for some individuals, especially those from industrialised countries such as the United Kingdom, who have respect to the rule of law and sanctity of life. As a researcher I have given birth in a hospital in the United Kingdom and I appreciate the high display of professionalism by their healthcare providers in caring for a woman from pregnancy to childbirth. Even though the UK is not totally perfect in issues related to the management of pregnant women, there is still a huge disparity compared to developing countries. Neglecting or abusing women during antenatal visits or labour indicates undignified reproductive care practice and could possibly imply that the healthcare providers may be violating the human rights of pregnant women. Using GAD theory (Moffat et al., 1991) as a lens to understand the attitude of healthcare professionals toward pregnant women, this abuse could be regarded as violence against women because they are perceived as socially inferior to men. This appears to underpin their oppression, as demonstrated by the findings of this current research, due to their gender and perhaps social status. This is congruent with what I perceive to be mixture of socialist and liberal feminism. In Nigeria, the oppression of pregnant women who attend antenatal visits and childbirth in hospitals seems to be a cultural and social norm that is widely accepted and believed by many participants to take place. For instance, a previous study conducted in South-Eastern Nigeria by Okafor et al., (2015) and in North-Eastern Nigeria by Bohren et al., (2017) similarly found that most of the healthcare professionals reported that beating, pinching, slapping, and shouting at women or physically restraining them during childbirth was an acceptable and justifiable practice when done with the intention to make a pregnant woman obey

instructions that will lead to safe childbirth. This was also the case in the current study and could demonstrate the manifestation of a position of power, whereby midwives and other healthcare professional appeared to have greater power within the hospital environment and used it to abuse powerless (pregnant women).

Another compelling finding from this current research was that healthcare professionals were believed to discriminate against some of the pregnant women during childbirth:

> *Some nurses give preference to pregnant women they know or their relatives during childbirth whilst abandoned some that they do not know (interview excerpt, Women 4)*

Discriminating against some women could lead to a lack of adequate attention and care for some women, indicating favouritism family relationship, like in business and politics, in the healthcare facility. This finding is consistent with that of Janevic et al., (2011) and Odhiambo (2011) who similarly found that some women were discriminated against by healthcare providers during pregnancy and labour. Midwives discriminating against some pregnant women can be considered from the perspective of socialist feminism, which identifies classism as an influence on women's oppression. Moreover, this also challenges the idea that men are the sole oppressors of women. However, it provides an insight that women themselves could also oppress each other. In this study, women perceived that midwives and nurses discriminate against them because of their social class; for instance, *"if you are the wife of a politician or well-known wealthy man, the healthcare provider will give you preferential treatment, ignoring other patient that do not have any economic status/class" (Interview Excepts Women 2*)

Remarkably, the midwives who participated in this current research admitted that they sometimes shouted and slapped pregnant women who sought maternity care in their hospital. Furthermore, some of the midwives stated they shouted or slapped their clients in circumstances when they were stressed with their workload. Others echoed this but added that the majority of persons who engaged in these practices were the auxiliary nurses who worked to assist nurses or midwives:

> *Sometimes, when a healthcare worker is over-worked or stressed at work, they shout or slap pregnant women. Our staff are sometimes aggressive due to stress because of heavy workload (Interview Excerpt, Midwife 1)*

> *Yes, the auxiliaries that work to assist us do shout and scold these women when they are in labour… (Interview Excerpt, Midwife 3)*

> *Sometimes, when the ward is busy, as you (the researcher) met us yesterday. The midwives and other healthcare workers are over-worked and because of high numbers of pregnant women and few staff, some of them do not get adequate attention and care. Also, because most of the pregnant women that come for delivery here do not attend antenatal visits, … they missed health education about what to bring for childbirth and how to act during labour. Many of us shout and scold at them when they misbehave. We do not have time then to start teaching them (Interview Excerpt, Midwife 1)*

These extracts show that the participants considered work stress and the lack of adequate skills held by auxiliaries as the cause of abuse to pregnant women during childbirth. This provides an impression that the midwives seemed to consider these attitudes and behaviours as inappropriate, but they unconsciously displayed them because of work stress. The intricacies behind the bullying of pregnant women by

midwives and other healthcare professionals in this study could be grasped using Frustration-Aggression theory (Dollard et al., 1939). This theory highlights that *'the occurrence of aggression always presupposes the existence of frustration and, inversely, that the existence of frustration always leads to some form of aggression'* (Dollard et al., 1939; Miller, 1941). Using this theory as a lens, the environmental stressor experienced by the midwives and other healthcare professionals (such as working in a hot environment without air conditioning and with poor ventilation) and physical stressors related to high workloads (such as tiredness, heat, overwork) seems to have led to their frustration, which seemed to cause anger and aggression and therefore violence against pregnant women. I agree with Dollard and Miller because, as a native of the state where this research was conducted in and as a trained midwife in the same state, I have witnessed the dilapidated state of the healthcare facilities both in Ebonyi state and other parts of Nigeria. I have practiced in different hospitals both in and outside the state; sometimes there are no scan machines, no fans, and no electricity. Also, staff shortages make it highly likely that the available staff are overworked. The healthcare providers though were found to be aggressive and either neglected or abused some of the pregnant women, as witnessed by the researcher. In rural areas there is no conducive environment for trained healthcare workers to perform their duty. Consequently, pregnant women seem to experience social and physical stressors, such as being ignored, bullied, shouted at, and threatened, leading to their negative attitude towards the use of hospitals for antenatal care and childbirth.

However, the findings of this research seemed contrary to that of Okafor et al., (2015) and Bohren et al., (2017) who found that the majority of healthcare providers and even women considered the use of force to control women's behaviour during pregnancy

and childbirth not as abuse but as an acceptable strategy to facilitate women's co-operation for a positive outcome in pregnancy. Coercing pregnant women for any reason would be generally regarded as abuse, especially in industrialised countries such as UK, but the findings from this current research and other previous studies conducted in Nigeria show that social norms, and societal and personal values underpinned the interpretation and reaction to the use of force to control women's behaviour during pregnancy and childbirth.

In addition, some of the local women further emphasised that most of the healthcare providers were not respectful, while others lamented that some pregnant women who had come for childbirth at the hospital were sent back home, especially when they were not accompanied by any of their relatives, or when they had not booked, had no money to pay, or attended antenatal visits. The midwives and doctors who participated in this research admitted these allegations:

> *One of the pregnant women who collapsed in the market was taken to the hospital. This woman died with her twins without any healthcare worker attending to her because she was unable to pay money requested for her care, as she did not book nor attended antenatal visits. I witnessed this painful death (Except from FGD 1 M9)*
>
> *We do send a pregnant woman back home because she did not come with any of her relatives. Yes, we do not attend to such person even if she was in labour (Interview Excerpt, Midwife, 4)*
>
> *A woman gave birth at TBA house, after a week developed abdominal discomfort, which becomes serious. She was taken to the hospital but on arrival, the healthcare worker sent her back home, said that she should go to*

the place she gave birth. This woman was taken to her home and she died after few days (Interview Excerpt, Women Leader).

Rejecting and not being friendly to pregnant women who were unaccompanied by their relatives, or not providing care due to an inability to pay suggests that healthcare providers seemed to place a higher priority and value on money than on saving lives. The out-of-pocket or fee for services, which is the financial mechanism in operation in Nigeria's healthcare system (Aregbeshola, 2016), seemed to have prevented pregnant women from accessing maternity care and this could be contributory to the death of some women during childbirth. In addition, Izugbara and Wekesah (2018) highlighted that private and public hospitals are mainly concerned with profitmaking. This provided insight into why pregnant women who were not accompanied by relatives were rejected because no person would take responsibility for the payment of bills for their care.

However, a few of the participants narrated their positive encounters with midwives during childbirth:

The midwives and the doctors were good to me, they attended to me very well, and I am happy with the services that I received (Interview Excerpt, Woman, 3)

The midwives were friendly to me when I went for childbirth; they took good care of me and with God on my side, I gave birth safely (Interview Excerpt, Woman, 2)

These excerpts show that some midwives in the study community practiced in accordance with international codes of ethics for midwives (ICM), namely, to protect, respect and promote women and new-borns (ICM, 2018), indicating that not all

midwives and doctors neglected or abused pregnant women during antennal care or/and childbirth. However, ill-practices, such as violence against women by some of the healthcare professionals in the study community, discouraged many of the local women from seeking midwifery care during pregnancy and childbirth:

> *Some nurses are quarrelsome; the way they shout at pregnant women discourages some of them from attending antenatal clinic or going to the hospital for childbirth (Interview Excerpt, Women Leader)*

> *Some pregnant women preferred to go somewhere for childbirth because of the attitude or what they heard regarding the attitude of the healthcare workers (Interview Excerpt, Midwife, 4)*

The attitude of some midwives and doctors seems to have contributed to deterring many pregnant women from accessing or seeking midwifery care, implying that these pregnant women would have sought an alternative during pregnancy and childbirth. Consistent with this finding, some previous studies conducted in Southern and Northern Nigeria, highlighted that the majority of pregnant women who did not give birth in hospital cited the poor or negative attitudes of healthcare workers as a reason for their use of traditional providers (Osubor et al., 2006; Idris et al., 2013). It can be reasonable to construe that pregnant women who sought care with non-orthodox providers due to the negative attitude of midwives and other healthcare providers were likely to be mismanaged and this, in turn, is one of the key risk factors that may have an impact on maternal mortality.

7.2 Socio-cultural practices and economic influence on pregnancy and childbirth

This section will explore the identified socio-cultural practices and economic intricacies that influence pregnancy and childbirth with a focus on how it contributes to maternal death.

7.2.1 Socio-cultural practices

Socio-cultural influences on maternal health have been highlighted as a problem, especially in the rural areas of developing countries (Shole, 2015). In this current research, naming practices, food taboos and the value placed on male children were identified as the key socio-cultural practices that appeared to have contributory effects on poor maternal health, thereby abetting maternal death. The women in the study community highlighted their eagerness for frequent pregnancies, which was ingrained in the cultural naming system and locally regarded as 'Ogbo', whereby a family is expected to fulfil an obligation of naming their children after all their maternal and paternal relatives as a demonstration of respect, love, and value for the relatives:

> *We strive to give birth to as many children as God has placed in our tummy and to name them after our family members both dead and alive; it is something of joy to have achieved naming your children to the most of your relatives. It demonstrates love and respect for the relatives (Interview Except, Women 5)*
>
> *There is a valued cultural practice of naming a baby after the maternal or paternal family members. It is expected that a woman should give birth to as many children as possible to name them after their family members. Women continually give birth to children to be able to name them after both parents and grandparents (Interview Excerpt, Doctor 1)*
>
> *Our people valued naming their children after their maternal and paternal grandparents and other relatives. A woman is expected to give birth to as many*

as possible just to name them after grandparents and other relatives. Every woman competes with another woman on who will give birth to highest number of children. When a child is born, grandparents and other relatives compete for the baby to be named after them (Interview Excerpt, Women 1)

Traditional naming is an ancient practice that exists in all human groups (Alford, 1988); mostly these follow a distinct geographical and ethno-cultural pattern, even in todays' modern societies (Mateos et al., 2011). It is argued that personal naming serves to differentiate individuals from each other and to assign to a category within the social context (Alford, 1988; Lieberson, 2000). However, cultural naming practice in this current research appeared to reflect a social norm and the cultural customs used to respect elders of the family, which is rooted in the predominant belief of Igbo people. It is believed in the cultural environment of Nigeria that, even if the family members are dead, they will continue to live on through their grandchildren, and there is an obligation to recognise this through naming practices (Ujah et al., 2005). This cultural obligation places a responsibility on women to continually give birth to children to fulfil family value for the grandparents and other relatives. Without a corresponding obligation from the community or family, or measures that improve the health of women during pregnancy and childbirth, this suggests that women are culturally disadvantaged in this society. This is consistent with a theory of liberal feminism, which perceived that women are subjected to multiple oppressions, which are deeply rooted in the country's cultural system (Ujah et al., 2005). Because of the oppression related to an obligation to frequent childbirth, women are more likely to suffer risks from multiparity that could lead to their poor health, which may lead to maternal death in some circumstances. It has been shown that high parity is associated with complications in pregnancy and childbirth, which could lead to maternal death (Chukuezi, 2010; Ndiaye et al., 2018).

Furthermore, the value placed on male children in this society is also a cultural practice in the study community that may have facilitated women's subordination and appears to have contributed to the poor health condition of women in this society, especially during pregnancy and childbirth. Participants highlighted that pregnant women are faced with the pressure of giving birth to male children to secure their husband's lineage and access to inheritance:

> *There is special value and regards for male children in our society; traditionally, only males can inherit properties of their father. Men are worried if they do not have a male child that will inherit their property after death (Excerpt from FGD 1, M4)*

> *Sometimes, the fault is not from the husbands but their family members. My mother-in-law visited me, told me, oh, you gave birth to another baby girl. She started scolding me and blaming me for not giving birth to a baby boy (Excerpt from FGD 1, M9, and Interview except Women 3).*

> *The society placed higher value on males than females; if a woman gives birth to all female children, it is considered that such woman has no child (Interview Excerpt, Doctor 1)*

Male children seemed to be preferred in this community because of the socially constructed role given to men that empowers and gives males rights over females to inherit family possessions, thus indicating gender discrimination. Consistent with this current research, the findings from previous studies conducted in Nigeria showed that inheritance rights, the preservation of the family name, the source of social prestige and deference to parents, and the provision of old-age security were reasons for male child preference (Eguavoen et al. 2007; Chukuezie, 2010; Olubayo, 2013; Abdullateef

et al., 2016). In addition, and in support of this current research, various cultures in Nigeria have been identified as encouraging male dominance and patriarchal value (Chukuezie, 2010; Abdullateef et al., 2016). In this current research, most of the participants held a general view that male children receive better care and attention from their parents:

> *…because of the high regard for male children starting from birth, they are cared for better than females (Interview experts, Doctor 1)*

> *We pamper male children in this society and empower them to have control over females, even when they are still kids (Interview excerpt, Women 1)*

These excerpts suggest a cultural acceptance of female discrimination based on gender, which is rooted in the perceived benefits of male children. Remarkably, a woman who gives birth to only female children is considered as being culturally childless, suggesting the injustice and oppression of women. Abdullateef et al., (2016) highlighted that male children in various Nigerian cultures are socialized into acquiring a mindset of gender superiority over girls and women and that they feel they need to be listened to and to exert authority over women. It is perhaps necessary to state that the belief system, particularly religious beliefs as previously explored in Chapter six, seemed to be a foundation to encourage the continual subordination of women in this area of Nigeria, even in the 21st Century. Consistent with this claim, Onwutuebe (2013) argued that religious instruction from the Bible, a Christian Holy Book, insists that women must be submissive to men and this facilitates their belief of men's superiority over women. Additionally, Abara (2012) further stated that religious teaching leads to the development of the belief that husbands are the heads of the families and that their

decisions are ultimate, while women must respect men and obey the decisions and instructions of their husbands.

In this current research, it was stated that, by giving birth to a female child especially if a male child were desired, the participants believed that some women could experience cultural oppression that may lead to poor health and in some cases death:

> *The wife of my neighbour gave birth to female children, the husband kept complaining, and said that the wife was wicked, that she wants to damage his family reputation. That he had no need for female children but need a male child. The wife was worried and disturbed until she became sick (Excerpt from FGD2, P3)*

> *…As the woman gave birth to her baby, she requested to know the sex of her baby. When the woman heard that her baby was a girl, she fainted and died. The neighbour of this woman narrated that her husband has been beating her because she had no male child (Interview Excerpt, Women 2)*

> *Last year, a barrister I know left his wife because she gave birth to another female baby (Excerpt from FGD 2, P4)*

> *The husband came to the hospital with another woman he wants to marry, showed her to his wife who gave birth to a baby girl, and said, I found another woman that will give birth to a male child for me (Excerpts from FGD 1, W5)*

According to the participants, women appeared to have suffered physical abuse, emotional distress, abandonment, divorce and even death because of the perceived failure of their inability to give birth to a male child. Husbands and other family members, such as mothers-in-law, apportioning blame for no male child is suggestive

of culturally based interpretations or inadequate biomedical knowledge, of pregnancy and childbirth.

Lastly, the participants repeatedly stated that women while pregnant were restricted from consuming certain food and meat, which was associated with some underlying beliefs that seemed to be unscientific:

> *In some families, pregnant women are restricted from eating some food, such as ice fish, snails, mushrooms; instead, they are encouraged to eat 'Nzu' (a stone excavated from soils). A pregnant woman will give birth to a sluggish baby drooling saliva if she eats snails and would give birth to a dull baby if she eats ice fish during pregnancy (Excerpt from FGD1, M 7)*

> *Yes, in this community, pregnant women are not allowed to eat some food, like eggs, snails. For instance, a pregnant woman will give birth to a gluttonous baby if she eats eeg during pregnancy (Interview Excepts, Midwife 4)*

> *It is believed that a pregnant woman that eats egg during pregnancy, she will give birth to a baby that would start stealing eggs and other things in … later adulthood (Interview Excerpt, Women Leader)*

> *In this community, it is believed that pregnant women are not allowed to eat bush meat, but if she mistakenly eats this meat, she must insert a bone from bush meat into her mouth during childbirth. Because that was the only measure, she would get well whenever she became sick during the period of her pregnancy and labour (Interview Excepts, Midwife 1)*

It appears that the eating practices of pregnant women are guided by the local cultural food taboos, which placed restrictions on the consumption of certain food and meat.

Whilst this finding may be surprising, especially for individuals from a Western culture such as the UK, food restriction practice seemed widely evident not only in the Eastern part of Nigeria but across several Nigerian communities in Northern, Western and Southern Nigeria. However, there are restrictions of different kind of food for different parts of Nigeria. For instance, previous research findings showed that some communities in western Nigeria prohibited pregnant women from the consumption of beans, okra, fish, plantain, and eggs (Sholeye et al., 2014). While in some communities in Enugu and Imo state of Eastern Nigeria, pregnant women reported that they boycotted some food, such as catfish, egg, beans, tea, wheat, okpa, fatty meat, oranges, fried food, noodles, and pap (Madiforo, 2010; Ekwochi et al., 2016). Remarkably, across previous literature and findings from this current research on food taboos in Nigeria, it was noticed that a particular food that is unaccepted in one culture was accepted in another culture, suggesting that a poor level of knowledge or economic status may be rooted in people's beliefs about eating habits and food taboos. This assumption is consistent with the finding by Oni and Tukur (2012), that a lack of formal education and low household income were associated with the practice of food taboos among pregnant women.

It is an established fact that pregnancy places a lot of physiological and additional nutritional demands on women; unfortunately, the food pregnant women avoided in this current research and other previous research are mainly types of food that would contribute to the protein requirements for maternal health and fetal growth during pregnancy. It seems possible that eating restrictions related to cultural food taboos may have contributed to pregnant women suffering malnutrition due to deficiencies in essential nutrients. This may be a reason for the high occurrence of anaemia in pregnancy that is widely suffered by women from this community, as previously

reported by the community midwives 1 and 4. In Nigeria, evidence showed that anaemia occurred in the majority (35-75%) of pregnant women as a consequence of nutritional deficiencies during pregnancy (Bukar et al., 2018). Most likely, this would contribute to poor maternal health and lead to maternal death during pregnancy and childbirth.

Lastly, these findings further provided insight that women during pregnancy were not only made subordinate to men, and suffered physical and emotional abuse, but were further restricted from food that could improve their wellbeing during pregnancy and childbirth, indicating a clear gender inequality and women's subordination in this society. Drawing from Gender and Development theory, and particularly 'tool 5' of the GAD analysis, condition, and position, which depicts women's state and position, makes her vulnerable and subordinate to men. It can be deduced that being of the female gender automatically places women at a disadvantaged position in this society, which is facilitated by inequality related to the nature of patriarchal power and position in Nigerian societies, both at the community and household levels (Moser, 2012). Because of the patriarchal nature of this society, women appeared not to have a voice and lacked power to make decisions about their own health during pregnancy and childbirth, thereby relying on men for their social support. This will be explored in the next subtheme.

7.2.2 The influence of social networks on pregnancy and childbirth

Social networks, in the context of this finding, are defined as a social structure that comprises social actors consisting of pregnant women, husbands, religious preachers, friends and other family members who are closely tied to and engaged in a social relationship with each other (LeGrand et al., 2016). Data analysis suggests that maternal health and death is embedded in a complex social network of relationships

among people of the same social circle in this community. This section will explicate the intricacies and impacts of the social network and identify how the network of relationships influences maternal health, which in turn, impacts on the occurrence of maternal death during pregnancy and childbirth. The data analysis revealed that pregnant women receive informational support in terms of advice and recommendations that appeared to have negative impacts on their health:

> *Most of the pregnant women receive advice from the elderly women and act based on the advice given to them by these older women in this community. These older women encourage them to take herbal mixture[s] for treatment of any condition they may be suffering during pregnancy (Interview excerpt, Midwife 1)*

> *When my sister was pregnant, her friend advised her to visit prayer house when she was sick… (Excerpt from FGD 2, P2)*

> *Most women grew up to see that their mothers and grandmothers usually gave birth with traditional birth attendants. This practice has formed an acceptable way of life in most of the families; pregnant women are advised to follow the same pattern of practice as their mothers and grandmothers (Interview excerpt, Religious Leader)*

The network members appeared to be supportive in providing information about where to seek maternity care, but their cultural-based knowledge appeared to have defeated their good intentions. As found in Chapter Six, belief systems seemed to underpin the misleading advice and recommendations provided to pregnant women by members of their social network, as well as a lack of formal education for most of the women in this community, which could also be attributed to poor knowledge of appropriate places for

maternity care. Previous studies found that the use of maternal services and preferences for a place for maternity care were influnced by the level of formal education (Adewoye et al., 2013; Alenoghena et al., 2015; Ibrahim, 2016; Egharevba et al., 2017), and decreases with age (Mpembeni et al., 2007). However, some studies found no statistically significant relationship between their respondents' level of educational attainment and their use of maternal healthcare services (Oyetunde and Eleri, 2014; Azuh et al., 2015; Onwurah et al., 2015), suggesting that the social rules for behaviour regarding the use of maternity care can transcend beyond the level of education and age, and appeared to be rooted in cultural beliefs, as found in this current study.

In addition, to support the information above, it was also found that pregnant women lacked financial and practical support from the members with whom they had social ties:

> *If a pregnant woman asks for money from their husband, they will reply 'go away idiot'; what happened to the money I previously gave to you (excerpt from FGD 1, M8)*
>
> *Men do not care for their wives, and do not give them money to buy food stuffs and other things. If they complain, men will ask them to keep quiet. Some men tell their wives that 'aluru m gi alu' meaning that they are subordinate to men; they do not have a right to complain (Excerpt from FGD 1, M5)*
>
> *Let me start by telling you that our people are polygamous in nature. Men can marry up to ten wives. Men have the responsibility to impregnate their wives while women have the responsibility to care for themselves during pregnancy*

until delivery. Most of the men do not give money to their wife to go for antenatal care (Interview Excerpt, Women Leader)

My sister gave birth to seven children, but her husband never accepted to give her money to visit hospital. The husband said that her mother gave birth to nine children without visiting the hospital; as such, his wife should not visit hospital. He threatens that if she attends hospital, he will not be responsible for any payment (Interview excerpt, Women 3)

It appeared that most husbands of the pregnant women do not provide practical assistance, such as financial and other social support to their wives that would encourage the use of maternal services during pregnancy and childbirth. It can be construed that a lack of financial support to pregnant women compelled them not to seek maternity care and thus go against their husband wishes. The excerpts above also suggest that men in this community seemed to consider pregnancy and childbirth as the sole responsibility of women and that they were not expected to provide any support to women. This assumption is consistent with Mullick et al., (2005) who highlighted that pregnancy and childbirth in many African countries are regarded as women's affairs, where men are generally have no obligation to provide social and economic support to women in this period. However, in Lagos-Nigeria, Adejoh et al., (2018) found that a lack of support from men to their wives during pregnancy was due to the high cost of maternity care, financial constraints, and time pressure due to job demands. Because of a lack of support from members of their social network (husband, in-laws, extended families), participants in this study talked about how pregnant women engaged in stressful work to meet their basic needs:

My mother was pregnant, continued doing stressful jobs, such as farm work, carrying loads on her head. She became sick, asked the husband to give her money to seek for care in the hospital but the man refused, advised her to visit traditional birth attendant to collect herbal mixture. The illness became more severe; she died in pregnancy (Interview Excerpt, Women 1)

I saw with my eyes that pregnant women do a job that involved carrying concrete and sand on their head to serve those that are laying blocks in a building site to earn money to buy food for themselves and children. This can lead to early rupture of membrane, abortion, and other complications (Interview Excerpt, Midwife 3)

Many of the pregnant women do farm jobs daily for the whole day, trek long from farm to their homes, carrying concrete for builders, carrying water on their head. They do these jobs to get money for their upkeep (Interview Excerpt, Women 4)

According to participants, menial jobs seemed mainly to be perfomed by most of the pregant women in this community and they perccieved that this contributed to complications during pregancy, leading to deaths. Drawing from the tools for analysis of GAD theory, particularly 'Tool 1' (see 2.13.2.1), Parpart et al., (2000) highlighted that societal norms, values and other cultural processes determine the responsibilities or type of work in which men and women engage in society. In this current research, women continued to perform stressful and unskilled jobs when they were pregnant due to the failure of their husbands to provide for their basic needs. The lack of opportunity for pregnant women to do skilled jobs that would constitute less risk to their pregnancy could be associated with the societal value placed on gender, whereby

women are perceived to be of less value, as explored in the previous section of this chapter. As such, women seemed to be deprived of education and other opportunities to secure a good job and earn income that could be used to enhance their wellbeing during pregnancy and childbirth. This therefore meant dependance on members of their social network (husbands) for instrumental support, which demonstrates patriarchal culture and women's subordination.

The patriarchal tradition that operated in this community appeared to have compelled most of the pregnant women to be completely dependent on members of their social circle for decisions related to pregnancy and childbirth. For instance, most of the participants repeatedly mentioned that pregnant women were under a cultural obligation to obey the instructions and decisions of the husbands/in-laws: this meant that the wider social network of relatives and in-laws reinforced these cultural beliefs and the patriarchal system.

> *I will tell you that in this community and others, women are required by the tradition to seek approval from their husbands, fathers, in-laws before they engage in any action (Interview Excerpt, Religious Leader)*
>
> *A pregnant woman was asked to sign a consent form for the caesarean section, the husband said that we should wait for him to go seek for permission from the in-laws (Interview Excerpt, Midwife 3)*
>
> *A pregnant woman is required to seek approval from her husband to attend antenatal visist in the hospital (Interview Excerpt, Doctor 1)*

Some pregnant women in this community seemed unempowered to independently make decisions about their own health but relied on approval from members of their

social network. This suggests a lack of freedom in pregnancy-related decisions and is an indication of subordination and oppression against women in line with the concept of patriarchy, which is viewed by some feminist writers as a system of the social structures and practices in which men dominate, oppress and exploit women (Millett 1977; Jagger and Rosenberg 1984; Walby 1990). However, this is not a surprising phenomenon in developing countries, especially in the context of African culture where gender inequality is rooted in a patriarchal culture that hinder the rights of women for reproductive health decision-making. For instance, women from Kenya, Namibia, India, and Nepal were found to have been restricted in their ability to make decisions about pregnancy, family planning and antenatal care in a population-based study conducted by Namasivayam et al., (2012), and a study by Mattebo et al., (2016). This restriction, in turn, negatively affected the health of pregnant women, as found in this current study and in agreement with previous feminist work, such as Dhakal et al., (2008) who found that the health of women and their children was affected by the patriarchal tradition. What seemed surprising within this current study is that women's oppression is still evident, even in the 21st Century, and that there is no government policy and laws to protect women from subordination and abuse, indicating the Government's lack of responsiveness to maternal healthcare needs, thus representing an index of poor governance, as found previously in Chapter Six.

Remarkably, the participants in this current research revealed that most of the pregnant women endured oppression from their husbands and other members of their social networks to avoid cultural punishment, divorce, the denial of sexual intercourse, and to prevent the perceived difficulty in childbirth, which might lead to maternal death:

> *The pregnant women obey the decision of their husbands and other family members because they are afraid of losing their marriage. If a woman refused*

to obey, she can be divorced. Many women had to endure the suffering to protect the marriage (Interview Excerpt, Midwife 4)

A woman that disobeyed her husband will have difficulty during childbirth (Interview Excerpt, Women 2)

If a woman refused to work in the husband's farm, the husband will punish her by not having sexual intercourse with her or may send her to her parent. Many pregnant women obey their husbands to avoid punishments and quarrels (Interview Excerpt, Women 1)

This suggests that men in this society have tacitly formulated strategies or used rules to compel women to remain subordinate to them. Moreover, some women seemed to choose to endure such oppression instead of confronting the issues causing the oppression.

Lastly, this section revealed that participants believed that pregnant women lacked instrumental and emotional support which led them to perform menial jobs that increased risks to their health. Men tacitly formulated social rules for behaviour, which they used to control the actions of pregnant women. Despite these oppressions, it was particularly remarkable that some men, and some women due to the patriarchal tradition inherent in the community, further prevented some pregnant women from seeking care in hospital during pregnancy and childbirth:

Some mother-in-laws refused their son's wife to be taken to the hospital during pregnancy or childbirth because they considered it as a waste of money (Interview Excerpt, Midwife 1)

On her arrival, she was weak. She was examined, was taken for emergency C-section. When we interviewed the woman, she told us that her husband did not want her to come to the hospital for childbirth. This woman said that she had given birth to eight children at home (Interview Excerpt, Midwife 1)

I repeatedly tried to understand why many of the pregnant women do not come to the hospital, when I ask some of the women, they usually told me that their husband did not allow them to come for antenatal care because they have no money (Interview Excerpt, Midwife 2)

Some men do not allow their wives to attend antenatal visits (Interview Except, Women Leader)

These excerpts show that individuals from the same social network as the pregnant women appeared to pose an obstacle to pregnant women, hindering their desire to seek maternity care in hospital. This interference appeared to be rooted in social and financial constraints and is explored in greater depth in the next section. It is possible that some pregnant women who were prevented from accessing maternal care in the hospital would have experienced poor maternal health, which could increase the risk of maternal death during childbirth. The study conducted by Okafor (2015) in Nigeria showed that woman who did not attend maternity care were at greater risk of a preventable death related to pregnancy and childbirth. The next section will explore the socio-economic complexities that participants perceived contributed to pregnant women's restriction from seeking maternity care.

7.2.3 Socio-economic influence

This section will present the economic status and cost of care, which are the two identified socio-economic issues that seemed to impact on maternal health, and

thereby potentially contribute to maternal death. Firstly, the economic status of women in this community appeared to have contributed to their behaviour regarding the use of maternity care services during pregnancy and childbirth, which seemed to be a contributory factor for maternal death. As previously reported in Chapter Six as well as this chapter, most of the women do not seek maternity care in hospital, partly due to their poor economic status:

> *For me, I gave birth to my children both in the hospital and at home. I gave birth to some of my children at home because I had no money to visit the hospital (Interview Excerpt, Women Leader)*

> *Most of us are poor, lacked money to seek care during pregnancy or to give birth in the hospital (Interview Excerpt, Women 2)*

> *Some pregnant women do not seek antenatal care or go for childbirth in the hospital because their husband does not give them money to pay in the hospital. As you know that pregnant women are required to visit hospital many times for antenatal care, they are required to pay for laboratory investigations and abdominal scan. These involves a lot of money, women do not have money to pay for these services (Interview Excerpt, Women 3)*

Poverty is a socio-economic issue that appeared to be widespread among women in this community because participants (women) repeatedly mentioned that their economic status restricted them from accessing maternity care during pregnancy and childbirth. Women's poor level of economic status thus controls their behaviour regarding the use of midwifery services. The Theory of Planned Behaviour by Ajzen (1985) highlights that the extent to which people have requisite resources and consider that they can manage any obstacle they may encounter will boost their confidence in

performing the action or behaviour. This theoretical idea is aligned with evidence from this research that showed women's poor economic status impeded the performance of their behaviour to seek maternal services. In addition, and in support, the National Bureau of Statistics (NBS) shows that women in Nigeria experienced a higher poverty rate in 2016 compared to men due to underemployment and unemployment (NBS, 2018). Women in this current research seemed to belong to a lower socio-economic group, which increased their vulnerability and risk of death during the pregnancy period. As discussed in the previous section, the poor economic status suffered by most of the women could be linked to the patriarchal system that operated in this community, whereby society placed high value and provided better conditions for the development of men unlike women.

The study conducted by Adebogun, (2004), which drew participants from five major cities in different parts of Nigeria, including Lagos, Port Harcourt, Enugu, Gombe and Jos, found that the poor socio-economic status of women meant they lacked voice, power, and autonomy which meant they were subjected to exploitation aggravated by a lack of economic opportunities. Although this research was conducted more than a decade ago, it points out that women had suffered oppression in Nigeria over a long time and were still experiencing similar oppressions as demonstrated in this current research. However, some midwives and a religious leader offered a contrary view, and highlighted that, although poverty hinders the use of midwifery services, some wealthy women also do not attend hospital during pregnancy and childbirth because they considered it a waste of resources:

> *Some people believed that paying for maternity care during pregnancy or delivery is a waste of money. These women go to traditional birth attendants because they do not pay money (Interview Excerpt, Midwife 2)*

Some pregnant women do not visit hospital because they don't deem it necessary (Interview Excerpt, Religious Leader)

These excerpts show that some women may not necessarily be limited by their poor economic status but by their perceptions of the importance of seeking midwifery care during pregnancy and childbirth. In addition, it also revealed that behaviour regarding the use of maternity services was also conditioned by the perception that midwifery services should be free, yet women were asked to pay money when they went to the hospital:

One of my friends did not attend antenatal clinic because she said that hospital charge money for antenatal care, but government said that pregnant women should not pay for maternity care. She instead goes to TBAs for childbirth (Interview Excerpt, Women 2)

We do require pregnant women that come for their childbirth to pay for soap, Dettol, jik, sanitary pad but they complain that they were not charged for anything when they go for childbirth with traditional birth attendants (Interview excerpt, Midwife 4)

The fee for healthcare services that operates in the Nigerian healthcare system could be a key reason hampering pregnant women from accessing the services required to reduce maternal death. Literature has consistently highlighted that the healthcare system in Nigeria is challenged with a high rate of out-of-pocket payment, a lack of a public social safety net and/or poor social health insurance coverage and poor funding (Onoka et al., 2011; Olakunde, 2012; Riman and Akpan, 2012; Obansa, 2013). As highlighted by some participants and revealed in the quote from 'women 2' above, in 2003 the government of Ebonyi State introduced a Free Maternal and Child Care

Programme (FMCHCP) under the leadership of Governor Samuel Egwu to encourage pregnant women to access maternity care, but the services were limited to the state teaching hospital located in the town centre. In 2008, the following Governor extended this programme to six rural healthcare hospitals including the community of this current study (Uneke et al., 2014). The evaluation of the programme by previous researchers showed that it was helpful to reduce maternal death because most pregnant women reduced care-seeking with TBAs and other non-qualified practitioners, and instead sought care in the hospital (Ndukwe, 2017). However, this programme was stopped with the change of government when a new Governor took over government in 2015; this suggested that maternal health is a lower priority for this current government and meant that the FMCHCP programme came to an end. However, some of the pregnant women in this current research still believed that the programme of free maternal services was still ongoing, as demonstrated in the excerpts by women 2 and Midwife 4 above.

When the healthcare providers asked them to pay for maternity care, some of the women (see excerpt by women 2) decided to seek care with traditional birth attendants. Pregnant women's inability to pay for care was connected to preventable death by the participants:

> *The hospital will demand that money should be paid as a deposit before the pregnant woman will be provided with care. Sometimes, before the relatives of the woman would go to seek for money, the woman may die. Most of the pregnant women seek for care with TBAs because they cannot afford the cost of care in the hospital (Interview excerpt, Women Leader)*

If a pregnant woman needed to give birth through operation, the hospital charge fifty thousand naira; most of the women do not have money to pay. The family of this woman will go to look for where to borrow money; sometimes, the woman would die before the family comes back (Excerpt from FGD 2, P6)

A pregnant woman was brought to me; the man that brought her to me left, abandoned the woman in my house with a little girl. I found out that they had gone to the hospital, but they were unable to pay the money for maternity care (Interview Excerpt, TBA 1)

One of the pregnant women who collapsed in the market was taken to the hospital. This woman died with her twins without any healthcare worker attending to her because she was unable to pay money requested for her care, as she did not book nor have attended antenatal visits. I witnessed this painful death (Except from FGD 1 M9)

The provision of healthcare services, including maternal healthcare services, belonged to the concurrent legislative list in the 1999 constitution of Nigeria, meaning that it is the responsibility of all government levels to fund, provide and make healthcare accessible to the people that requires it. However, concerns were raised in this study about the apparent lack of incentives for providers to set up healthcare facilities in rural areas to improve accessibility for women. In addition, concerns arose regarding the potential exclusion of those unable to pay for healthcare schemes (NHIS) or benefits for poorer people in rural communities, such as the research setting. These excerpts show that pregnant women experienced financial barriers to accessing the maternity care they required, suggesting a failure of the government to formulate and sustain policy to enhance access to, and the utilisation of, midwifery services. As

shown in the excerpt above, the financial mechanisms that operate in the Nigerian healthcare system and poor economic status contributes to preventable maternal mortality.

7.2.4 Summary of the chapter

According to the participants, national governance was found to have failed in their responsibility to provide social services and amenities to facilitate pregnant women's access to the midwifery care they require to improve their health, and thereby reduce maternal death. In addition, because of the government's failure to formulate, implement and sustain policies to improve maternal health and reduce maternal death, medical quackery thrives, and this negatively impacts women during pregnancy and childbirth. The behaviour of some of the healthcare providers was also found to have influenced the development of negative perceptions and attitudes towards maternity care, meaning that women preferred to seek care from medical quacks.

Lastly, various socio-cultural practices, such as naming practice, male-child value, and food restriction, were noted as rooted in the societal patriarchal and cultural system, which favoured male dominance and women's subornation. This exposed pregnant women to risks that increased maternal mortality in line with the theory of feminism and Gender and Development. It was also found that social network members further formulated tacit social rules for behaviour, which were directed at women's oppression, thereby potentially causing women to suffer preventable death during pregnancy and childbirth. These were worsened by the poor socio-economic status of most of the women, fortified by social inequality and a patriarchal system that offered women fewer economic opportunities, thereby meaning they lacked voice, power and autonomy to make decisions about their own health during pregnancy and childbirth, and potentially leading to preventable maternal death.

CHAPTER EIGHT

PERCEIVED STRATEGIES FOR THE REDUCTION OF MATERNAL DEATH

8.0 Introduction

The findings presented in the previous two chapters revealed participants' views on belief systems, and socio-political and cultural practices that influence maternal wellbeing, and potentially contribute to maternal death during pregnancy, childbirth, and puerperium. This chapter presents participants' perceptions on the approach to improve maternal health and reduce maternal death, and it draws connections between all the findings.

The local women (women of reproductive age with and without children), traditional birth attendants, community healthcare professionals (doctors and midwives), and opinion leaders (religious leader, youth leader, a village head, women's leader) were given an opportunity for the first time in the literature to discuss maternal death in Nigeria, and to state their thoughts on how maternal death could be reduced. Following, the data analysis it was found that some local women reiterated their views that there was no measure to reduce maternal death because the death of a woman during pregnancy was a destiny, as discussed in Chapter Six. However, some of the participants gave their ideas on what could be done to reduce maternal death. The strategies suggested by these participants are presented in three subthemes: compliance to social norms, assimilation of TBAs into an orthodox healthcare system, and free maternal healthcare services during pregnancy and childbirth. Compliance to social norms is presented first.

8.1 Compliance to social norms

Social norms in the context of this chapter are the specified cultural codes for behaviour that are viewed as legitimate, and which bind members of the society. The violation or insensitivity to these codes of behaviour attracts disaproval and are believed to contribute to maternal death. Most of the local women, traditional birth attendants and some of the opinion leaders remarked that married women remaining faithful to their husbands would reduce the occurrence of maternal mortality.

> *Women should obey our culture of not having sex with another man (excerpt from FGD1, M2)*

> *I want to add that our tradition requires that a married woman should be faithful to her husband. Women should stop having sexual intercourse with another man to avoid problems that will lead to death during childbirth (Excerpt from FGD 1, M6)*

> *I will recommend that women should never have sex with a man that is not their husband (Excerpt from FGD 2, M9)*

These excerpts demonstrate a thought process whereby some women consider that submission and compliance to perceived societal rules for behaviour and conduct would reduce maternal death. This strategy, as perceived by some women, may appear unreasonable when viewed through a scientific lens, reflecting poor biomedical knowledge. Moreover, feminist stance known as radical feminism provides compelling insight that could help to understand why women perceive that compliance with cultural norms would reduce maternal death. This theory postulates that co-creation processes between culture and the mind arise from a dominating patriachial system, implying that daily rituals rooted in belief systems are used to construct cultural

realities. The individual who subscribes to the shared cultural values and assumptions inherent in their society pursue standards that are consistent with their beliefs (Cavalli-Sforza and Feldman, 1981; Kitayama et al., 1997). It is therefore not surprising that women in the study think that compliance with the cultural norm of not having sexual intercourse with another man would reduce maternal death because pregnant women and TBAs attributed maternal death to sexual infidelity in other research conducted in South Eastern Nigeria (Okafor, 2000) as well as in this current research. In comparison to the current research and the study by Okafor (2000) in which participants believe that, unless a woman confessed her infidelity, she would not be able to deliver her baby, it can be deduced that the cultural values appeared to shape the cognitive and behavioural psychological processes of some people from South Eastern Nigeria which, in turn, were used to construct cultural realities. This shows that gaps in biomedical knowledge about pregnancy and childbirth, especially among rural dwellers in this part of Nigeria, needs to be addressed as it could improve maternal wellbeing and reduce maternal death.

Another strategy perceived by participants as a measure to reduce maternal death in relation to compliance with social norms concerns healthcare professionals' sensitivity to the cultural norms of society. Both the women and healthcare providers, particularly, some of the midwives, think that a midwifery practice that is sensitive to cultural values would motivate and encourage pregnant women to seek midwifery care, and would thus reduce maternal death.

> *The midwives and the doctors should recognise our tradition and obey it, such as the way the placenta is disposed. When they do it correctly, more women can come to the hospital for delivery, which will reduce maternal death (Interview excerpt, women 1)*

Throwing of placenta in the bin should stop. Our tradition should be respected so that we can allow our women to come for delivery in the hospital (Interview excerpt, village head).

The midwives should try to understand the culture of the people, so that they can avoid what the women do not want but which does not conflict with medical knowledge (Interview except, Midwife 2)

Most of the local women and opinion leaders who participated in this study appeared unimpressed with midwifery practice because they perceived that their cultural values were not respected by healthcare providers. These excepts could be explained in terms of culturally sensitive care, which Doorenbos et al., (2005) highlighted occurs when client expectations are aligned with healthcare professionals' knowledge, attitude, and behaviour. The concerns raised by participants about the insensitivity of healthcare providers to their cultural values seems to require consideration because the code of conduct for nurses and midwives in Nigeria stipulates that they should 'consider the views, culture and beliefs of the client/patients and their family in the design and implementation of his care/treatment regimen' (Nigeria NMC, 2019). This could imply that culturally sensitive care is a fundamental requirement for midwives in Nigeria as well as the UK and across the world. For example, it could be recommended that healthcare providers (midwives and doctors) should plan a measure to dispose of the placenta in a manner that aligns with the cultural values of participants, because it would inspire pregnant women to seek care and give birth in the hospital, thereby potentially reducing maternal death. However, it should also be noted some cultural values and norms, such as those discussed in Chapter Six do not coincide with biomedical knowledge and would not be expected to be implemented. Overall, it could be deduced that compliance by women and health care providers to the cultural norms

that are consistent with biomedical knowledge about pregnancy and childbirth could represent a necessary step to reduce maternal death.

8.2 Assimilation of TBAs into the orthodox healthcare system

Another key strategy perceived by participants, particularly some of the women, opinion leaders and Traditional Birth Attendants (TBAs), was the integration of TBAs into the conventional Nigerian healthcare system as part of the medical team who could be employed to work in hospitals.

> *… traditional birth attendants should be allowed to work with midwives and doctors in the hospitals as this will encourage women to attend antenatal care and feel comfortable to deliver their babies in the hospitals (Interview excerpt, Youth leader)*

> *The government should stop discouraging the traditional birth attendant practices; our services are helpful and should be recommended. The government should employ us to work in the hospitals because it will make all pregnant women receive care in the hospital. We know how to manage pregnancy and childbirth to avoid performing caesarean sections which most of the women do not want (Interview excerpt, TBA 3)*

> *The government can build birth stations in the hospitals for us, and then employ us to work with doctors in the hospital whereby women can have a choice to receive our services right inside the hospital (Interview excerpt, TBA 1)*

These extracts suggest that some opinion leaders and TBAs perceive that it is necessary for the government to employ TBAs to work with other healthcare professionals in the hospitals, as they believe that this approach will motivate all pregnant women to seek for care from hospitals during pregnancy and childbirth.

Whilst some of the women who participated in this research seemed to concur with this idea, some suggested that the government should build a designated place within the hospital for use by the TBAs who would provide their services to women during pregnancy and childbirth.

> *I believe that, if the government employs traditional birth attendants to work in the health centres, it will make all the women to seek for care in the hospital during pregnancy and childbirth and this will make it possible for the activities of the TBAs to be monitored and controlled (Interview excerpt, Women 5).*

> *My view is that, if the government build a place for the TBAs in the hospitals and compulsorily made them to practice in this special location, then all pregnant women will automatically seek for care in the hospital. It will be easy to monitor the activities of the TBAs and refer to the nurses and doctors for help when necessary. This will reduce most of the maternal death during pregnancy and delivery (Interview excerpt, Women leader)*

The idea of employing TBAs to work with midwives and doctors in the hospital seemed unrealistic and could cause role confusion in the healthcare system, because the TBAs have no organised training program and are not a recognised member of the healthcare system across the globe. However, it may be useful for the government to consider building what could be termed as a 'centre for traditional birth attendant practice' as suggested by some of the women but not necessarily located within the hospital. A pilot study conducted in 1975 in a suburb of Benin City, in Western Nigeria was reported to provide useful insights to strategies for the integration of TBAs into a formal healthcare system in Nigeria. Here, the TBAs favoured collaboration with orthodox healthcare professionals, and showed interest in training for effective

maternal healthcare practice (Isenalumbe, 1990), although to the best of my knowledge, this was not implemented in Benin or any other part of Nigeria. More recently, evidence from research conducted in Kaduna, North-West, Nigeria about the integration of TBAs in the prevention of mother-to-child transmission of HIV showed an increase from an average of 200 women per month prior to the program to an average of 1500 women per month across the 25 health facilities who were counselled and tested. This led to a higher number of women who were identified and placed on prophylaxis which in, turn, helped to reduce the mother-to-child transmission of HIV (Nsirim et al., 2015). This showed that the involvement of TBAs in this program improved the outcome, despite the short period of engagement.

In this current research, the perceived strategy (assimilation of TBAs into an orthodox healthcare system) appeared reasonable because it would provide an organised system that would make quality control feasible terms by monitoring the activities and practices of TBAs across different rural communities. In addition, it would also provide an opportunity for a coordinated referral system where each centre for traditional birth practice would be equipped with a functional ambulance system to refer pregnant women for expert management by healthcare professionals in hospitals to avert maternal death. Although this strategy seemsd feasible there are controversies surrounding the involvement of TBAs in the health care system; for instance, Ana (2011) argued in favour of the use of TBAs in the healthcare system due to the shortage of skilled maternal care providers, whereas Harrison (2011) believed that use of TBAs does more harm than good. Furthermore, pre-existing rivalries between TBAs and orthodox healthcare professionals, as found in this current research as well as in previous studies (Inegbenebor, 2013; Nsirim et al., 2015), would constitute a major

challenge for the assimilation of TBAs into an orthodox healthcare system if not harnessed.

The perceived strategy related to the integration of TBAs into the formal healthcare system may potentially be unrealistic in the Nigerian health care system because of rivalries, even among healthcare professionals, have contributed to frequent work stoppages (strikes) currently experienced across different parts of Nigeria. However, this strategy could be modified to engage TBAs in special duties via role modification in order to reduce maternal death. This approach yielded successful outcomes in Somaliland where, after engaging them in training, the TBAs were motivated through payment incentives of US $5 for each pregnant woman brought to the healthcare facilities in Maroodi Jeex, Somaliland (Pyone et al., 2014). Instead of providing care to pregnant women during pregnancy and childbirth, the TBAs were rather made to engage happily in their new role of identifying pregnant women and accompanying them to a nearby hospitals for antenatal care, delivery, and post-natal care (Pyone et al., 2014). It would be possible to replicate this approach in Nigeria as a measure to reduce maternal death if there was a collective willingness by the government, and healthcare professionals to provide an enabling environment and incentives for TBAs to adopt a change of roles. Overall, instead of engaging in efforts to alienate the practices of TBAs from the healthcare delivery system, such as in Malawi, where they later had to revise the ban due to the unprecedented increase in maternal death (Ngozo, 2011), the government can harness and modify the activities of TBAs within areas where they have the capacity to contribute towards the reduction of maternal death. Evidence has shown that TBAs could play a vital role in improving maternal service utilisation.

8.3 Re-establishment of free maternal healthcare services

Medical professionals, opinion leaders, Traditional Birth Attendants and community women who participated in this research consistently stated the need for the re-establishment of free maternal healthcare services. These participants believed that it was necessary to re-introduce free maternal healthcare services for pregnant women.

> *The government should make antenatal care and care during childbirth free for all pregnant women even if it is restricted for certain number of births (Interview excerpt, Women leader)*

> *The government should re-start free maternal care services, which would cover all the medical bills from antenatal care to post-natal care because it will really help (Interview excerpt, Midwife 2)*

> *The antenatal care should be made free to all pregnant women so that they will not be excuse of no money for payment of bills (Interview excerpt, Midwife 1)*

> *The cost of care during pregnancy and childbirth should be reduced so that the poor women in the community can afford it (Interview excerpt, Youth Leader)*

> *I will recommend that government should make antenatal care, free for all the women especially for people in rural communities (Interview excerpt, TBA 1)*

> *Antenatal care should be made free by the government because some women don't seek for care in the hospital because they don't have money to pay for the services (Interview excerpt, Women 5)*

> *The government should reduce the cost of antenatal care because the high cost of care made some women not to seek for care in the hospital during pregnancy (Interview excerpt, Village head)*

These excerpts show that some participants recommended the government to reduce the cost of maternal care, while others suggested that maternal care for pregnant women should be free of charge. Financial barriers were noted in Chapter Seven (see 7.2.3) as one of the constraints to access and use midwifery services; thus, participants presumed that 'no-fee-for maternal care' would encourage pregnant women to use midwifery services which will in turn, would reduce maternal death. All the midwives particularly stressed that this strategy, if implemented, would reduce maternal death because of the large numbers of pregnant women who accessed midwifery care before the termination of free maternal healthcare services.

> *Previously, baby clothes were given to women after childbirth; this motivated many of the pregnant women to give birth in this hospital (Interview excerpt, Midwife 4)*

> *We recorded more than one thousand live births per month when antenatal care and delivery was free, but the number of women that give birth in this hospital has reduced so much (Interview excerpt, Midwife 2)*

> *There were so many women that came for antenatal care in this hospital and across other hospitals in this state, antenatal clinics usually resembled markets because of the population of women that come for care, because the women were not asked to pay for anything including the cost of caesarean sections. There is low attendance now because this new government stopped the free maternal care (Interview except Doctor 2)*

These excerpts show the possibility of behavioural change in terms of the use of midwifery services due to a no fee-for-service financial mechanism that operated in the Nigerian healthcare system. The Social-Ecological Model (Moos, 1979; McLeroy

et al., 1988) is a behavioural theory that would provide insight to understand changes in midwifery healthcare services seeking attitudes by pregnant women. This theoretical model was based on the fundamental assumption that human behaviour is due to the interaction between individuals and the context to which they are exposed (McLeroy et al., 1988). Thus, this model seeks to answer questions about the context, how it influences, and is influenced by group or individual factors, implying that interactions between persons and their environments are reciprocal. McLeroy et al., (1988) argued that individual behaviour is shaped by multiple level factors that overlap with each other, and are not linear but interlinked (McLeroy et al., 1988). This argument was supported by other proponents of this model who added that human behaviour or activity is intricately situated within a socio-political and cultural context of meanings and relationships (Trickett, 1996), indicating that behaviour does not develop in a social space or vacuum. Drawing from the Social-Ecological Model, which has been systematically categorised into five multi-level accounts for behaviour such as individual/intrapersonal, interpersonal, organisational, community and policy levels factors (McLeroy et al., 1988), the change of policy regarding Free Maternal and Child Care Programme (FMCHCP) in Ebonyi state resulted in the decreased utilisation of midwifery services, which, it is claimed, in turn, contributed to greater maternal death.

Finally, as previously discussed in Chapter Seven, the government of Ebonyi state introduced a Free Maternal and Child Care Programme (FMCHCP) in 2003 but this programme was unfortunately stopped at the inception of the new government in 2015. Due to the positive impact of this programme on the reduction of maternal death (Uneke et al., 2014; Ndukwe, 2017), participants in this current research suggested that this programme should be re-introduced as a strategy to reduce maternal death. Douglas (1971) highlighted the individual elements, such as belief, value, attitude and

intention, exist and are constructed, maintained or changed in interaction with the social environment. Thus, the attitudes of pregnant women about the non-use of midwifery services exist and are maintained in line with their interaction with their social environment. It is therefore possible for pregnant women to re-construct and change their attitude towards the use of midwifery services if public policies regarding the cost of care are modified; this would have an impact on access to maternal services, which could reduce maternal mortality.

8.5 Summary of the chapter

In this chapter, strategies to reduce maternal death were discussed, as perceived by the community members and the community health care providers. The strategies suggested by the community further revealed that they lacked basic biomedical knowledge and understanding about pregnancy, childbirth and maternal mortality. However, the strategies suggested by the midwives and the doctors appeared relevant and would be considered further as recommendations in the next chapter. This chapter also draws the findings together, providing an explanation of the intricacies and interplay between the perceptions and socio-political and cultural context and practices that informed decision-making about the utilisation of midwifery services, which in turn, influenced maternal health, thereby leading to maternal mortality.

CHAPTER NINE

SUMMARY OF FINDINGS AND ORIGINAL CONTRIBUTIONS

9.0 Introduction

This chapter presents an additional discussion and summary of the key findings of the cultural themes, which provide an understanding of the perceived socio-cultural factors impacting on maternal mortality and the strategies for its reduction in South-Eastern Nigeria. The key findings have been grouped into three sections to disentangle the cultural elements connected to healthcare professionals, TBAs and women as well as opinion leaders whilst focusing on the four questions explored in this study: what are the experiences of women regarding the socio-cultural factors impacting maternal mortality; what are the socio-cultural factors impacting maternal mortality as perceived by healthcare professionals on the basis of their experiences; what are community leaders' and traditional birth attendants' perceptions about the socio-cultural factors impacting on maternal mortality, and in what ways do these participants consider that maternal mortality could be reduced.

Furthermore, this chapter draws all the cultural elements together, presented in the form of a conceptual framework explaining the socio-cultural factors impacting on maternal mortality and strategies for its reduction. This chapter also discusses the theoretical and practical implications of the findings with specific emphasis on the original contributions to knowledge of this study. This is followed by recommendations for midwifery practice, policy and education with a concluding section on the limitations of the study.

9.1 Main findings related to healthcare professionals

The healthcare professionals comprised of doctors and midwives who participated in this study; in the main, they were found either not to possess or to use their cultural beliefs about pregnancy, childbirth, and maternal death to inform their practices. Although they used their biomedical knowledge as an explanatory framework regarding the issues related to the cause of maternal death during or after pregnancy and childbirth, they still seem to be influenced by cultural beliefs to some degree. This could imply that, although the sense of reality used by healthcare professionals was rooted in their biomedical knowledge, they were implicitly influenced by cultural and religious worldviews. This finding could imply that scientific reasoning has replaced cultural meaning-making or lay understanding due to modernisation. Although cultural and religious beliefs preceded scientific training, the healthcare professional appeared to predominantly replace the power of culture over their thinking by the power of biomedical knowledge. However, some aspects of their cultural worldviews were not replaced but sat alongside biomedical knowledge and were reactivated and used in some of their clinical practice, such as the maltreatment of pregnant women.

Furthermore, most participants, mainly women and opinion leaders, perceived the non-application or utilisation of cultural beliefs by healthcare professionals to inform their clinical practice as unacceptable. For instance, these groups of participants, as previously presented in Chapter Seven (see section 7.1.3) widely alleged that healthcare professionals were insensitive to their norms in terms of placenta disposal and disregarding of traditional obligation as causes of maternal death. This suggests either a conflict or dichotomy between biomedical knowledge and cultural worldviews in shaping informal societal rules upon which behaviour and practices depend. The professionals think that medical knowledge should guide the care of women during

pregnancy, childbirth, and puerperium; however, some of the local women and opinion leaders considered their cultural codes were undermined and superseded by western midwifery practice norms. Thus, dissension exists which meant that most women did not seek maternity services, which they considered to violate their cultural standards. Instead, TBAs were preferred because their practices aligned with the cultural explanatory models. This discourse could be explained drawing from the view of Durkheim (1965), who argued that every culture has a system of self-referential logic embedded in their respective social framework that forms legitimate realities. This implies that using scientific knowledge to negotiate meaning among the healthcare professionals was a predominant discourse that informed their way of thinking and practice.

Finally, the perceived disregard of traditional/cultural belief systems was further complicated by the negative attitude of healthcare providers. For instance, many women said that they have either heard or experienced situations whereby healthcare providers have slapped, shouted at, abandoned, or rebuked pregnant women during antenatal visits and childbirth, as previously presented in Chapter Seven (see 7.1.2.2). A wealth of literature from the Nigerian context reported that the negative or unfriendly attitudes of maternal healthcare providers were one of the key impediments to access the maternity care (Adewemimo et al., 2013; Utoo and Utoo, 2013; Akinwaare and Adejumo, 2015; Okonofua and Ogu, 2017). In addition, physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, false imprisonment, neglect, and the abandonment of women during pregnancy, childbirth and puerperium are common practices in several other African contexts (Igboanugo et al., 2011; Hatamleh et al., 2013; Grotegut et al., 2014; Moyer et al., 2014; Okafor et al., 2015). This demonstrates that the oppression of women is still evident and appears

to be implicitly accepted, as found in this current study and in many African or other societies rooted in a patriarchal system (Hatamleh et al., 2013; Grotegut et al., 2014; McMohon et al., 2014; Moyer et al., 2014). Therefore, this underscores the need for a cultural shift whereby women will be treated with respect and dignity because doing so could motivate their utilisation of maternity services, thereby reducing maternal deaths.

Remarkably, midwives in the current study admitted that some women were bullied by the healthcare providers in health facilities, but blamed work stress and a lack of adequate skills held by auxiliaries as reasons for this practice. Although it may sound reasonable that work stress and other environmental issues contributed to the bad attitude and practices of professionals, it is unjustifiable as such practice does not conform to the Nigerian and international midwifery codes of practice.

In summary, this section has shown the complex interaction among key cultural elements particular to the healthcare professionals that impact on maternal mortality. Thus, it has provided insights that could be used by health policy makers to plan interventions to improve maternal health, and thereby reduce maternal mortality. The next section discusses and summarises the key cultural elements particular to the women, opinion leaders, and TBAs.

9.1.2 Main findings related to the women, opinion leaders and traditional birth attendants

Most of the women, opinion leaders and traditional birth attendants in this research consistently used their cultural and religious beliefs in a similar pattern to make meaning about pregnancy, childbirth, and maternal death. Precisely, this group of

participants reported that pregnancy and childbirth was a gift from a supernatural being who possesses power to decide its outcome. This suggests lay theorising about pregnancy and childbirth within a term of reference rooted in ethnoreligious understandings. In addition, pregnancy was perceived as a source of social security for families as well as offering relevance to women's role in the community. For instance, a woman without biological children was considered '*a witch and valueless'* because of their perceived inability to give birth to children who could provide financial and other support to their parents during old age. This reveals that, in some modern African societies, women still go through many obstacles, problems and challenges to become an important member of society. Thus, this finding exposed the need to change the stereotypical image of women and provide them with the opportunities and power to make decisions regarding their reproductive health in Nigerian societies, reflective of the goal of feminism. Again, the findings show that, due to the level of importance this society attached to pregnancy and childbirth, women engaged in childbirth competitions to secure their place in marriage and their value in a society without insight into the risks associated with such practice. Notably, all participants in this group who adopted this cultural system of explanation argued for and held strong support for women who sought care with traditional obstetric care providers, such as TBAs. This is because TBAs used natural remedies and they were seen as better situated to provide care that aligned with cultural and traditional beliefs. Remarkably, TBAs defended their practices and activities, claiming that it was beneficial to women in terms of aiding the uterus to descend, easing the process of childbirth, preventing placenta previa, and offering solutions for prolonged labour. Thus, this could signify a lack of understanding by TBAs of the benefit that could be gained from modern obstetric and midwifery care.

In line with a cultural explanatory model about pregnancy and childbirth, this group of participants (women, opinion leaders and TBAs) also provided traditional lay explanations about the causes of maternal death. For instance, they identified two causal explanations for maternal death. Firstly, that maternal death was due to supernatural causes, such as a woman belonging to a spiritual group (‘Ogbanje and mami water group), destiny, and activities of the ‘evil other’. Secondly, that the activities of women, such as infidelity, stealing, oath-taking, or dishonesty, caused maternal death. This group of participants appeared to hold and use a shared cultural understanding to negotiate meaning about maternal death that was embedded in their dominating patriarchal culture. It is plausible that the meaning-making system which arose from the cultural pattern in the Nigerian society in line with radical feminism, influenced the actions of some participants that participated in the current study. Therefore, the cultural shared meanings held by TBAs, women and opinion leaders about maternal death have not been reconstructed to align with scientific understanding, an evidence that a cultural renegotiation is required. This could be possibly if these participants are provided with adequate information to modify their defining processes or alter their lay understanding. However, a few of the women and a religious leader did not subscribe to the cultural construction of meaning regarding maternal death. Instead, these individuals provided explanations that aligned with the scientific causes of maternal death, as previously presented in Chapter Six.

As a result of the predominantly lay understandings of pregnancy, childbirth and maternal death, conditions such as prolonged labour and haemorrhage were considered the consequences of pregnant women defiling traditional customs. Thus, women are coerced to engage in practices, such as traditional cleansing and religious rituals. This could be regarded as the suppression of women and echoes the ideas of

a Nigerian feminist writer who highlighted that women face multiple oppressions because they are distinctively disadvantaged based on their gender and social status (Ujah et al., 2005). In addition, some pregnant women were disallowed from using midwifery care based on the belief that God would help them in their period of pregnancy and grant them safe childbirth. In the circumstance of maternal death, it was accepted as normal because it was perceived as God's will or destiny. I, therefore, argue that women were culturally constrained, and lacked reproductive knowledge to benefit from reproductive justice due to the predominant discourse concerning beliefs that promote the likely occurrence of maternal death during pregnancy and childbirth.

Furthermore, a predominant cultural discourse was found, whereby participants reported that women were socially influenced by members of their social networks, such as their grandmothers, other women, husbands, friends, and family, regarding their decision-making about where to seek care during pregnancy and childbirth. The informational support, in terms of the advice and recommendations given to pregnant women by friends and families, was based on culturally rooted knowledge. As such, this often-had negative impacts on women's health and the potentially lead to maternal death. Several previous cross-sectional studies, as presented in the scoping review chapter, showed that the majority of women in Nigeria depended on their husbands, other family members and friends' decisions about where and when to seek maternity care (Doctor et al., 2012; Yar'zever and Said et al., 2013; Azuh et al., 2014; Akinwaare and Adejumo, 2015; Odetola, 2015; Anastasi et al., 2017; Azuh et al., 2017; Ndikom et al., 2017). Ajzen's (1985) Theory of Planned Behaviour states that individual behaviour or action is determined by an individual's intentions and is influenced by the value they place on the behaviour, the effort required to perform such behaviour, the views of significant others, and the perception that the said behaviour is within the

individual's control. Using this theory, as a lens to understand this cultural discourse, it can be interpreted that the actions of women in the current study were based on whether members of social circle approved or disapproved of them seeking midwifery care. This shows how the power of a social circle can influence the uptake of midwifery services in a Nigerian society. However, some women professed that they were willing to seek midwifery care against the advice of the family members but were often mandated not to take such recommendations to avoid cultural punishment, divorce, or denial of sexual intercourse. These are acts suggestive of women's subordination, oppression, and violation of their autonomy.

Although participants believed that their social network impacted on women's attitudes about the non-utilisation of midwifery services, leading to a high risk of maternal death, it was also identified by participants that women's poor economic status, leading to an inability to pay for the cost of midwifery services, impacted negatively on their access to care. Several previous studies from a Nigerian context showed that women's poor economic status was one of the fundamental reasons why many did not seek maternal healthcare services (Envuladu et al., 2013; Yar'zever and Said, 2013; Adewemimo et al., 2014; Okafor et al., 2014; Ibrahim, 2016; Okonofua et al., 2017). As professed by some women participants who had been pregnant, poverty compelled some of them to seek care with TBAs and other medical quacks, even when midwifery services were preferred. This exposed them to persons whose activities could lead to avoidable death during pregnancy and childbirth. This finding underscores the need to make access to maternal healthcare services free in Nigeria, as doing so would encourage utilisation, thereby helping to curtail maternal death.

Lastly, several cultural practices engaged in by women and other individuals in the studied community, such as naming practices, food taboos and the value placed on male children, were perceived to have an indirect impact on maternal death. Women were found to be obliged to have as many children (particularly males) as they could to fulfil the cultural naming system, to secure perceived social security and to preserve the family linage. This neglects the consequences such practices could have on women, such as postpartum haemorrhage or other childbirth complications that can lead to maternal death. This could signify an unconscious act of oppression, but women participants often appeared to lack insight into the consequences. This indicates the need to sensitize people of this community to the need to abolish these practices because of their potential to lead to the death of women during pregnancy and childbirth.

9.1.3 Main Findings Related to Governance

The midwives, doctors and some women perceived that government officials have failed women regarding their lack of political will to construct good roads, provide efficient public transport services/ambulances and skilled health workers, equipping community healthcare centres and building hospitals closer to community members. The insensitiveness of those in governance in providing social amenities that would promote the welfare of women during pregnancy and childbirth could signify bad governance, as highlighted by Organisation for Economic Co-operation and Development Governance, (OECD, 2007). This further demonstrates the ways in which society has indirectly continued to oppress and facilitate the suffering of women during pregnancy and childbirth. Importantly, this finding revealed issues that increased the chance of maternal death during pregnancy and childbirth, and therefore

has provided evidence that could be used to plan for the better health of women, especially during reproduction.

Government insensitivity and the failure to provide social facilities was reported by participants to have caused difficulties for women during pregnancy and childbirth, as previously analysed in Chapter Seven (section 7.11). These difficulties included preventable complications, or sometimes death, due to either the unregulated activities of medical quacks, poor road conditions and the lack of hospitals within the community. The outcome of these challenges leads to avoidable maternal death, as previously discussed in Chapter Seven (section 7.1.2.1). A more disconcerting finding about government insensitivity was the lack of policy and a conspiracy of silence regarding obstetric and midwifery quackery in Nigeria, which was repeatedly stated by midwives and doctors in this study. This may not be surprising for individuals who are familiar with the Nigerian healthcare system because several scholars have highlighted the medical quackery in many aspects of medical practice in Nigeria without the corresponding governmental action to minimise such practices (Ndububa, 2007; Adeleke et al., 2019; Awolude et al., 2019).

9.1.4 Main findings related to perceived strategies for reduction of maternal death

Women who participated in this study had polarised opinions regarding the strategies required to reduce maternal death. Some held strong views that maternal death during pregnancy and childbirth was a destiny and emphasised that there were no measures to avoid such death. This illustrates how powerful cultural codes and knowledge can be in shaping a lay construction of meaning. However, a significant number of women, traditional birth attendants and some opinion leaders who used their cultural lens to construct meaning that women's extramarital sex leads to maternal death during

pregnancy and childbirth, strongly stated that such death can be reduced when women are sexually faithful to their partners. Interestingly, a study conducted in Oyo state, South Western Nigeria, found that men and women perceived that the discouragement of pre-marital sex and the moral training of teenage girls reduced promiscuity and thus would reduce maternal death (Adegooke et al., 2010). This is broadly similar to the suggestions offered by participants in the current study and could imply shared meaning-making among individuals from Western and Eastern parts of Nigeria, which may have been negotiated over time based on cultural understandings.

There was a convergence of ideas about the perceived strategies to reduce maternal death between local women and midwives. For instance, both groups of participants suggested that culturally sensitive midwifery practice would inspire pregnant women to seek care in the hospital, thereby reducing the chances of maternal death. This reinforces the relevance of cultural understanding, and the weight individuals give to their customs and traditions. Moreover, it underscores the need to integrate such traditions into midwifery practice, particularly in an African context. Another way to ensure culturally sensitive care, as perceived by some women, opinion leaders and TBAs, was to launch the services of TBAs within a hospital environment, with a level of freedom that would allow them to provide care that aligns with the traditional beliefs of women during pregnancy and childbirth. In my view, building traditional birth centres within a hospital that are staffed by midwives could be a useful strategy that could offer choice to women, either to access care provided by TBAs, or by midwives in an environment that would permit quality assurance, and thereby reducing preventable deaths.

9.2 Summary

This research revealed that the members of the community comprising women with or without children, traditional birth attendants, a religious leader, and community opinion leaders use their cultural and religious beliefs to construct meaning about pregnancy, childbirth, and maternal death. This informed their perceptions, which shapes their attitude towards the use of midwifery services. As a result of the perceptions rooted in this belief system, members of the community engaged in cultural practices, which contributed to increased maternal death. The support that the members of the community provide to individuals within their social circle as well as their poor economic status negatively influenced their decision on midwifery services, which, in turn, contributed to maternal deaths. The findings show that lay perceptions embedded within culture and religion were reinforced by the inadequate political and socio-economic commitment of the persons in governance, which participants suggested also resulted in inadequacies in the healthcare systems that contributed to the occurrence of preventable maternal death. Finally, members of the community perceived that compliance to their social norms within the community and the assimilation of TBAs within the orthodox healthcare system could reduce maternal death, exposing participants' perceived strategies to reduce maternal deaths. The healthcare providers, on the other hand, suggested that free maternal healthcare services could encourage women to seek midwifery care, thereby potentially reducing maternal death. This deeper and authentic story of the complexities of maternal death has made tacit knowledge more explicit and it is hoped will encourage innovation and stimulate change that could lead to better maternal health and reduce maternal death in Nigeria.

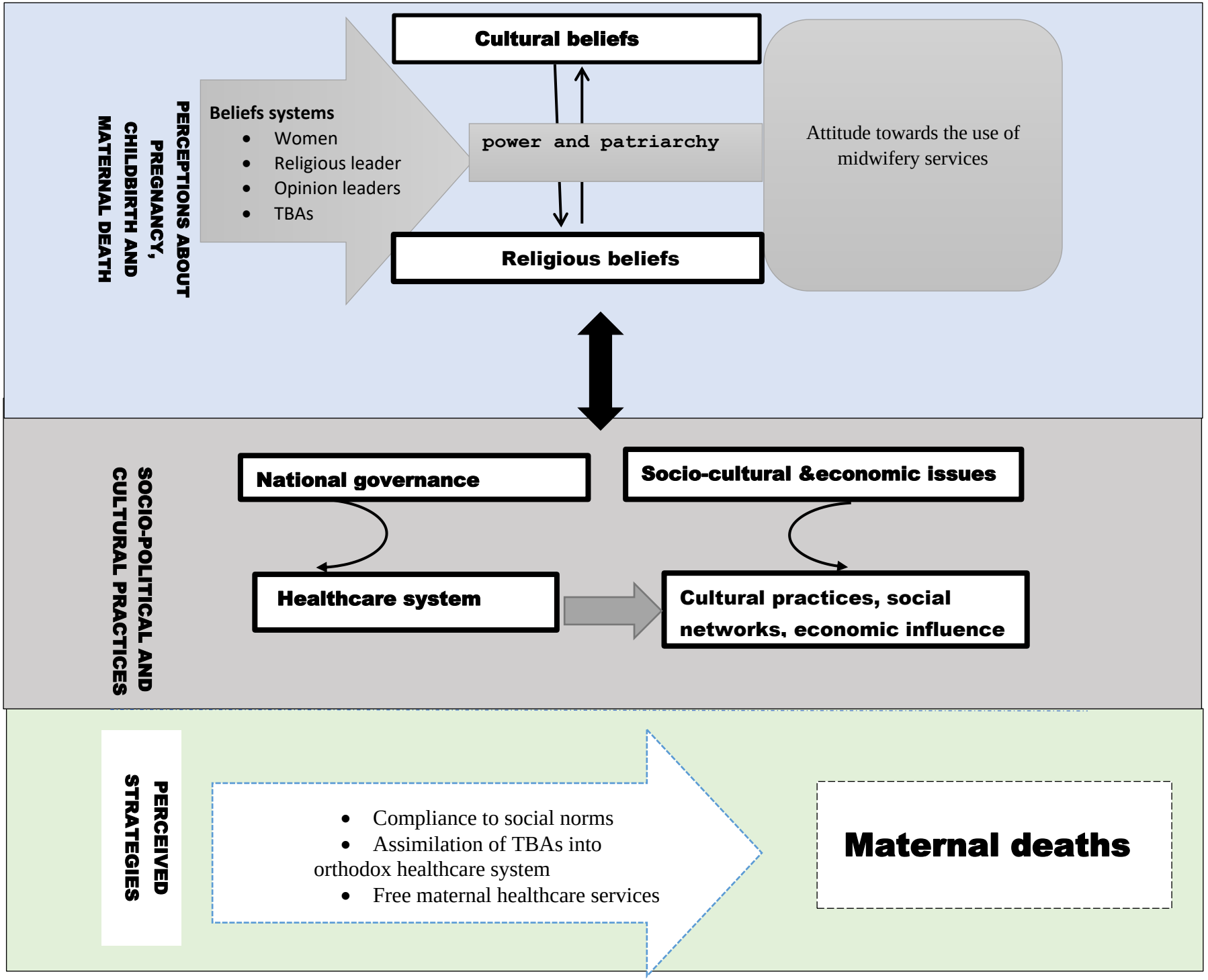

PERCEPTIONS ABOUT PREGNANCY, CHILDBIRTH AND MATERNAL DEATH
Beliefs systems
Women
Religious leader
Opinion leaders
TBAs
Cultural beliefs
power and patriarchy
Religious beliefs
Attitude towards the use of midwifery services
SOCIO-POLITICAL AND CULTURAL PRACTICES
National governance
Socio-cultural &economic issues
Healthcare system
Cultural practices, social networks, economic influence
PERCEIVED STRATEGIES
Compliance to social norms
Assimilation of TBAs into orthodox healthcare system
Free maternal healthcare services
Maternal deaths

Figure 9.1: Conceptual Framework

9.3 Original Contributions to the existing knowledge: theoretical implications

Several aspects of the findings presented in this chapter are broadly aligned with many findings of the previous research on the issues that influence maternal mortality. However, four components of the findings in the current study offered novel contributions to knowledge in the field of maternal health and are discussed in this section. Firstly, the cultural and religious meaning-making of pregnancy, childbirth, and maternal mortality, whereby professionals' behavioural complexities shape the uptake of midwifery services and, lastly the socio-political complexities shaping maternal mortality. The cultural and religion meaning making of pregnancy, childbirth and maternal death will be discussed next in relation to their contribution to knowledge in this field.

9.3.1 Cultural and Religious Meaning-making about Pregnancy, Childbirth and Maternal Death

Cultural and religious meaning making were predominately utilised by women, traditional birth attendants, and community leaders to inform their understanding or worldview of pregnancy, childbirth, and maternal mortality. Baumeister (1991:15) has defined meaning making as the '*shared mental representation of possible relationships among things, events, and relationship*'. In comparison, Rao et al., (2008) referred to culture as beliefs, values, and customs in the form of ritual practices, diets, dressing patterns, and ways of thinking that make up a race or community. In Chapter Six of the current study, the findings clearly show some specific cultural-religious belief systems, which were utilised by some participants in meaning-making about pregnancy, childbirth, and maternal death. Findings from the scoping review, as presented in Chapter Three, indicated that other research found that cultural and

religious beliefs shaped the attitudes and decision-making on the uptake of maternal healthcare services. The findings of the current study have clearly contributed to advancing ethnoreligious knowledge and its perceived impact on maternal health as well as to maternal mortality. Precisely, the current study provided in-depth knowledge to enhance an understanding of the findings from eight studies (Ona et al., 2006; Iyaniwura and Yussuf, 2009; Dairo and Owoyokun, 2010; Ibor et al., 2011; Yar'zever and Said, 2013; Akinwaare and Adejumo 2015; Anastasi et al., 2017; Ndikom et al., 2017) that mention culture and religion as relevant in influencing maternal mortality. As mentioned in the scoping review chapter, these studies utilised questionnaires for the data collection, which limited the opportunity for their participants to provide information about their specific belief systems and how this impacted maternal health. Commendably, the current study utilised a multi-method that provided an apportunity for participants to tell their stories, thus facilitating our understanding of the cultural complexities in relation to maternal health and maternal mortality in the Nigerian context.

Nevertheless, other studies originated from Nigeria which used methods that enabled their participants to express their views about their religious and cultural beliefs as well as how these impacted maternal health (Okolocha et al., 1998; Ejidokun, 2000; Doctor et al., 2012; Mboho et al., 2013; Okafor et al., 2014; Okonofua et al., 2017). These and some other studies (Adamu and Salihi, 2002; Osubor et al., 2006; Adegooke et al., 2010) provided specific information about ethnoreligious issues that impact on maternal death. All these studies were conducted in states within Northern (Kastina, Yobe and Zamfara states), South-Western (Lagos State) and South-South (Edo State) Nigeria. Although the findings of these studies are somewhat similar to this research, the novelty lies in the ethnoreligious meaning-making about the current study, which

is based on the fact that no such knowledge has been uncovered in South-Eastern Nigeria. In order words, this is the first study conducted in the South-East geopolitical zone of Nigeria that examined both religious and cultural meaning-making and how these impact on maternal mortality from the perspectives of community members. The novelty of the meaning-making within this research is supported by the argument that elements of a cultural system must be analysed as an ecological framework as well as in the context in which individual lives as it reflects on their ability to perceive the world (Kagawa-Singer et al., 2015). Therefore, this study provided insight into how individuals from the South-Eastern cultural context of Nigeria make meaning of their misfortune, albeit maternal death. It showed how religion and culture are significant and how they are perceived to contribute to the high maternal death rate in Nigeria; this knowledge is relevant and can be used for policy intervention to ensure that pregnancy and childbirth are safer.

9.3.2 Professionals' behavioural complexities shaping uptake of midwifery services

It may be shocking that numerous women have continued to experience oppression and subordination in various societies, especially in Africa. The tendencies to oppress women during pregnancy and childbirth are alarming considering that would be unexpected in any society in the 21st Century. Studies originating from Tanzania, Ghana, South Africa, and Jordan clearly showed a sustained and brutal attack or the abuse of women in healthcare facilities by healthcare professionals (Hatamleh et al., 2013; Grotegut et al., 2014; McMohon et al., 2014; Moyer et al., 2014). Evidence from the reviewed papers presented in the scoping review chapter further showed that pregnant women sought maternity care services in various healthcare facilities across many states in Nigeria but highlighted that the unfriendly attitude of healthcare workers

discouraged them from continuing with the uptake of midwifery services (Adegooke et al., 2010; Dairo and Owoyokun, 2010; Moore et al., 2011; Adewemimo et al., 2013; Envuladu et al., 2013; Utoo and Utoo, 2013; Akinwaare and Adejumo, 2015; Okonofua and Ogu, 2017). These papers utilised questionnaires for data collection and this implies that there is limited knowledge about what is known regarding the attitude of maternal healthcare professionals in relation to its impact on maternal mortality.

However, qualitative studies by Okonofua and Ogu (2017) and Adegooke et al., (2010) enhanced the understanding and knowledge regarding women's oppression by healthcare workers during pregnancy and childbirth in Nigeria. They provided an account that outlined that women perceived midwives and nurses to be wicked, abusive, unfriendly, disrespectful, and uncaring. Empirically, the current study corroborates the findings of these studies, in that there was evidence from participants that health care providers slapped, shouted, abandoned, and rebuked pregnant women during antenatal visits and childbirth. It also extended this knowledge about women's oppression and provided an additional perspective that some healthcare professionals often discriminated against pregnant women on the basis of individual preferences for some women on the basis of their economic status. Finally, this is the first study conducted in southeast Nigeria to uncover healthcare providers' oppressive and abusive behaviour towards pregnant women and revealed that work stress as a result of unmanageable workloads was the central influence on this behaviour.

9.3.3 Socio-political Complexities shaping maternal mortality

I have argued that meaning making and professionals' behaviour towards pregnant women were elements of the thesis that have made new contributions to knowledge in this field within a Nigerian context. This study also found a complex interrelationship

concerning the socio-political, socio-economic and health system influences, and the socio-cultural practices, social networks, and their impact on maternal mortality. The findings of the current study that pertained to these issues supported findings from other papers, as shown in the scoping literature review chapter. However, the methodology adopted in the current study enhanced the understanding of the complex network of these issues and how they contribute to maternal death. For instance, it distinctly and distinctively, to the best of my knowledge concerning literature of this field, showed that the bureaucratic system in Nigeria was auto inhibitory to maternal health, and thereby contributed towards maternal death during pregnancy and childbirth. It was found that the political class, or bureaucrats, in Nigeria were perceived to lack the commitment and thus have failed in their responsibility to provide social services as well as an enabling environment to encourage pregnant women to patronise midwifery care.

It is evident that, medical quackery thrives in Nigeria, which is linked to a lack of drive by the political actors to implement and ensure the monitoring of policies to improve maternal health. Arguably, this finding contributes to a new understanding, that maternal mortality may not significantly reduce in Nigeria or any other countries whereby corrupt practices in relation to a lack of transparency, irresponsiveness and the unaccountability of the political leaders remain unchallenged and/or tacitly accepted as a norm.

9.3.4 Cultural acceptance of maternal death as a punishment for women who have transgressed social norms

This PhD study adopted a feminist approach and revealed issues of power subjugation and dominance of women by men, a viewpoint that women were marginalised in their

reproductive roles by the men through the structure that operates in the local community and the wider Nigeria system. This aligns with the core feminist idea as stated in section 4.2.1 of the thesis that in most societies' women have been systematically oppressed and thus, they suffer injustices in several aspects of life such as reproduction. The insights from the thesis about women oppression as presented in the sections above contribute to the literature on the underlying factors of maternity care that contribute to poor maternal health and maternal morality as well the feminist goal of valuing women's experience in their reproductive journey (Rich,1994), however, an additional and striking revelation was uncovered in this thesis.

This was the first study to uncover the cultural acceptance of maternal death as a punishment for women who are perceived to have transgressed social norms. As reported in chapter six, there were a dominant discourse of cultural meaning making about pregnancy, childbirth, and maternal death. This lay understanding explains the reasons for the views of women themselves about the inevitability and/or desirability of maternal death. This is a paradox, thus challenging the radical feminism idea that holds a view that societies are inherently oppressive to women because of the dominating male patriarchal system (Crow, 2000). This implies that issues surrounding maternal mortality is more complex and deeper than oppression and subjugation of women in this patriarchal society. The use of GAD theory was particularly useful to underpin and orient this study because it enabled the data not only to be interpreted within the theoretical domains of feminism. It offered a theoretical construct to view the data from a perspective of how both genders may have contributed to maternal morality, thus provided more holistic standpoint that helps uncover the root inequalities that lead to the injustice women experience and show how this is due to convolutions in social relationships between women and men (Moser, 2012).

The view of women themselves about the inevitability and/or desirability of maternal death was rooted in a cultural acceptance of maternal death as a punishment for women who have transgressed social norms, and this is a novel contribution. An indication that men cannot solely be blamed for the high maternal mortality but that women themselves also contributed to this menace. This also indicates the power of the patriarchal system, and how both women and men are incorprated into its beliefs and practices. It also evident that the intersection of patriarchy and traditional cultural beliefs reinforces and reproduces these views. These findings also highlight how relying on only public health education about biomedical aspects of pregnancy and birth, or creation of new roads, or addition of more resources and midwives as solutions to address high maternal mortality, are unlikely to be able to make any substantial difference to maternal mortality, if the cultural norm is that such deaths are an inevitable or even desirable result of women transgressing patriarchal norms.

9.4 Practical implications/relevance and recommendations

The section above discussed the theoretical and empirical contribution of the findings in relation to existing knowledge. This thesis also has practical implications that will be discussed in relation to their relevance to maternal healthcare practice, policy, and education. I will conclude this section by providing specific recommendations that could improve practice and may contribute to the achievement of Sustainable Development Goal 3, with its target to reduce global maternal death from 216 per 100,000 live births in 2015 to less than 70% per 100,000 live births in 2030 (UN, 2019).

9.4.1 Health care practice: cultural competence towards improving maternal health practice

Evidence from the scoping review chapter revealed that the uptake of maternal healthcare services has generally improved in Nigeria, but in the current study

numerous social and cultural impediments were found to have impacted on the attitude of community members towards maternity services. Therefore, there is an urgent need to improve maternal health practices, specifically those aimed at encouraging the utilisation of maternal healthcare services by both rural and urban dwellers regardless of their cultural background and social circumstance. Arguably, this might not be achieved if the healthcare professionals who render care to pregnant women lack the required cultural competence. This research identified a set of cultural and religious beliefs utilised by women and other community members to construct a meaning system regarding pregnancy, childbirth, and maternal mortality. This provided evidence which midwives and other healthcare professionals who work in Nigerian communities can use to improve their cultural competence, so as to provide culturally sensitive maternity support that will trigger positive attitudes to the uptake of services, and potentially reduce needless maternal death during pregnancy, childbirth and puerperium.

The findings from this thesis also provided healthcare professionals around the world with theoretical knowledge of meaning making in maternal care from the perspective of Nigerian culture. Due to immigration, the world population continues to grow in its diversity of language, country of origin, religion, and culture. This means that clinicians who provide maternal healthcare services to women from diverse cultures should have a broad knowledge about the values and beliefs of various ethnic groups, as doing so will promote cultural competences which supports the provision of culturally appropriate maternity care. The current study contributed to an extension of the limited knowledge of meaning-making in maternal care with the aim of enhancing the cultural competence of professionals when providing maternity services to Nigerian communities as well as pregnant women from Nigeria who live in foreign countries.

However, I recognise that findings about meaning systems may not be generalised to all women and individuals from Nigeria due to the differences in beliefs that exist within the same culture. Nevertheless, this finding is still clinically relevant in providing general knowledge of how people from a Nigerian culture could construct meaning about issues related to maternal care.

Midwifery services should be culturally sensitive to the needs of service-users. Therefore, I recommend that midwives and other clinicians, both in Nigeria and abroad, should be prepared to enrich themselves with cultural knowledge about the values and beliefs of individuals from various ethnic groups. However, they should avoid stereotyping by understanding individual perspectives, as doing so may boost the utilisation of maternal services, and thereby reduce preventable maternal death.

9.4.2 Health care policy

Through the Federal Ministry of Health, the Federal Government of Nigeria has been making efforts since early 1990s to reduce preventable maternal death (Kana et al., 2015). The formulation and implementation of policies, guidelines and strategies have been part of these efforts, but have not been effective when considered against the WHO and UN standards and expectations to reduce the number of women who die during pregnancy and childbirth (as previously discussed in Chapter Two, section 2.3). This implies that policy interventions (in terms of formulating new or reviewing existing policies), guidelines and frameworks for the care of the women during pregnancy and childbirth in communities are required to reduce maternal death in Nigeria.

In the current research, it was found that the poor socio-economic status of women compelled them to utilise the services of unskilled birth attendants. Nigeria is enriched with resources that, if well managed, could promote free access to healthcare

services, including maternal services, irrespective of the social circumstance of citizens. Thus, I recommend that the bureaucrats at governmental and hospital levels in Nigeria to develop specific policies that will mandate the allocation of a specific amount of annual funds to improve maternal health care services, especially for rural dwellers. These funds should be utilised to build more hospitals in communities, develop human resources, construct roads, and procure equipment and facilities for midwifery services. Funding should also be made available for the conduct and dissemination of research into maternal and child health.

Furthermore, I recommend there should be policy that enables a comprehensive health insurance scheme or free maternal healthcare services at all levels of healthcare in Nigeria. This policy will encourage a cultural shift whereby women and their households develop positive attitudes towards the use of midwifery services; this is currently not possible because they are worried about the financial implications of choosing to use such services. To contribute to this development, I will negotiate engagements with policy makers, such as the Federal and State Ministry of Health in Nigeria, the Nigeria Budget Office, and Hospital Management Board by presenting policy briefs and conferences that aim to trigger discussion that may lead to policy formulation and implementation.

9.4.3 Education

This current research revealed that the cultural and religious beliefs held by community members about the factors that influence maternal mortality were informed by their lay meaning-making and limited knowledge of the biomedical influences of maternal death. This is probably due to a lack of educational programmes on maternal and child health in the rural areas of Nigeria. I admit that the issues of cultural and religious

beliefs may not be instantly changed by a one-off educational intervention. However, the change would be gradual over time through cultural transformation and the deculturalisation of beliefs that are not based on scientific reasoning. This could be accomplished with the proper dissemination of information and by encouraging people to interact with other cultures with biomedical perspectives about pregnancy, childbirth, and the causes of maternal death.

Mekonnen and Mekonnen, (2003) in a study about the utilization of maternal healthcare services in Ethiopia, revealed that education had a great impact on women's use of maternal healthcare services. Based on this, I argue that developing information leaflets, and using appropriate media can be an effective approach to inculcate some basic knowledge of maternal health to community members, which will enable them to develop insights regarding the need for maternal healthcare services in Nigeria. Specifically, based on my research findings, I recommend that educational programmes should be targeted towards women of a reproductive age, mother's in-law, and male opinion leaders in the community.

In a patriarchal society, such as Nigeria, the inclusion of men in maternal health/ reproductive health education will be of great benefit. For instance, educating men on the health needs of women of reproductive age through maternity-focused-programmes which are delivered face-to-face or in the media could enhance their understanding and their readiness to support women during pregnancy, childbirth, and puerperium.

Integrating cultural awareness courses into a continuing education programme for healthcare professionals involved with the provision of midwifery services is crucial. It was noted that some women complained that the midwives disposed of their placenta

after childbirth in a manner that showed little understanding of, and a lack of respect for their cultural beliefs. Also, the inclusion of cultural awareness and competence courses within the midwifery pre-registration curriculum will be relevant to ensure that student midwives understand the need for culturally sensitive midwifery practice, such as supporting women to adopt their preferred cultural way of disposing of their placenta after childbirth.

Lastly, I recommend that the healthcare professionals should be encouraged and educated to be friendly and approachable towards women during childbirth. The current study showed that women's negative experiences with midwives also deterred them from taking up midwifery services. Accessing maternal healthcare services in a hospital should not be an undignified encounter; women should be treated with respect and compassion.

9.5 Summary of the original contribution

This thesis has contributed towards an understanding of the neglected areas within maternal health care in Nigeria. Specifically, it revealed that there were complex interactions among social and cultural issues that contributed to perceptions of either the poor or non-utilisation of maternity services, which increased needless maternal death during pregnancy and childbirth in Nigeria. Firstly, this thesis extends the current knowledge from existing papers originating from Nigeria on the unfriendly attitudes of healthcare workers (Adegooke et al., 2010; Dairo and Owoyokun, 2010; Moore et al., 2011; Adewemimo et al., 2013; Envuladu et al., 2013; Utoo and Utoo, 2013; Akinwaare and Adejumo, 2015; Okonofua and Ogu, 2017), by demonstrating the underlying reasons for this behaviour and how this discouraged women from utilising midwifery services. Secondly, this is the first study conducted in South-East Nigeria that

uncovered healthcare providers' oppressive and abusive behaviour towards pregnant women and revealed that work because of unmanageable workloads was the central reason for this behaviour.

Thirdly, this thesis found evidence pertaining to the use of cultural or lay knowledge in constructing meaning about the issues related to maternity care and maternal mortality. It exposed that culture and religion were utilised as a lens through which individuals form their perspectives or viewpoints, which informed their decisions regarding uptake of maternal care services. No other study in South-Eastern Nigeria has yet uncovered this knowledge.

Fourthly, this thesis found that behaviour regarding the inadequate, or non-utilisation, of maternity services were conditioned not only by cultural meaning-making but also by economic and social situations rooted in the government's failure to meet their responsibilities. Thus, it was revealed that political culture in Nigeria was not supportive of maternal health because political leaders lacked commitment to the provision of an enabling environment and adequate resources; consequently, maternity services were not used as they should have been.

Lastly, it uncovers the knowledge that women themselves view maternal mortality as a certainty and that the power of patriarchy was such that there was cultural acceptance of maternal death by both men and women as a chastisement for women who have contravened social and cultural norms.

CHAPTER TEN

SUMMARY AND CONCLUSIONS

This research emerged from many years of personal midwifery experiences, and from witnessing the needless death of women during pregnancy and childbirth alongside the continued unacceptably high rate of maternal death in Nigeria. I embarked on this PhD journey because I am a proponent of those who hold the view that no woman should die while giving life. By conducting this study, I have generated evidence that could contribute and help to improve the wellbeing of women in Nigeria especially during pregnancy and childbirth. This study also contributed to knowledge within this field by filling some of the gaps identified in the existing literature. I focused on women of reproductive age with children and without children, doctors, midwives, traditional birth attendants and opinion leaders comprising a village head, a religious leader, a women's leader, and a youth leader. This research aimed to explore the community's perceptions of the socio-cultural factors impacting on maternal mortality and their perspectives regarding its reduction in South-Eastern Nigeria.

I attempted to construct the knowledge presented in this thesis based on participants' views and experiences about the socio-cultural factors impacting on maternal death and strategies for its reduction. This was rooted in an ontological stance which believes that reality is multiple based on context and culture (Guba and Lincoln, 1994; Crotty, 1998). Thus, the readers of this thesis should be aware that the knowledge claims herein are based on the belief that individuals offered multiple social constructions of the subject under investigation in relation to their context and culture. Epistemologically, this thesis was firmly rooted in a stance that knowledge is built or constructed through a social interpretation of the world, implying that human life and activities exits because of their social, cultural, and interpersonal influences. By

conducting this research, I have learnt about specific constructions of reality that are rooted in various perspectives and situated in the social and cultural context of maternal health and the causes of maternal mortality amongst my participants. Firstly, focus group discussions were conducted with women of a child-bearing age with and without children, which helped to uncover intricacies regarding their beliefs and perceptions about maternal death and strategies for its reduction. This was followed by face-to-face and one-on-one interviews with healthcare professionals, some women and opinion leaders to further explore and clarify emerging issues following the focus group discussions. This facilitated a deeper understanding of the themes, which were generated by conducting thematic analysis.

The findings of this thesis showed that exploring the social and cultural factors that impact on maternal mortality from the perspectives of community members and healthcare professionals, revealed knowledge and provided understanding of the strategies that can be adopted to improve maternal health and make pregnancy and childbirth safer. Evidence from the scoping review showed a lack of research that explored the socio-cultural factors impacting on maternal mortality in South-Eastern Nigeria, yet this knowledge could contribute to evidence that can be utilised to improve maternal health. The thesis uncovered evidence of this neglected area and showed that there was a dichotomy among community members concerning the use of cultural worldviews in the construction of meaning; this impacted on their uptake of maternity services. Explicitly, most of the community members hold and construct a system of beliefs rooted in culture and religion; this provided them with an understanding about pregnancy, childbirth, and maternal mortality. These individuals appeared to firmly hold these beliefs because it provided them with a sense of security and because they

aligned with their cultural understandings, which shaped their attitude or decision-making regarding acceptable practice norms concerning the use of maternity services.

The study also uncovers the knwledge that women themselves view maternal mortality as unavoidable and thus, there was cultural acceptance of maternal death by both men and women as a punishment for women who have disobeyed and transgressed social norms. However, a few of the community members and the healthcare professionals did not use their cultural or religious knowledge in meaning-making about pregnancy and childbirth. This contributed to an understanding that differences in individuals' social metrics, such as level of education and socio-economic circumstance, may account for differences in the use of culture and religion by individuals in their meaning-making system. Further study may be required to test whether there is a correlation between social metrics and the use of cultural viewpoints in meaning-making among the larger population in Nigeria.

This thesis also uncovered knowledge beyond cultural meaning-making, and revealed that social complexities, such as economic status, the attitude of healthcare workers and social networks, interplayed and contributed to the high rate of needless maternal deaths. Specifically, it found that the poor economic status of some pregnant women, the unfriendly attitude of healthcare professionals and negative advice from members of their social networks influenced women's maternity healthcare seeking behaviour, thereby potentially increasing the rate of maternal death. Again, it was revealed that those in government appeared to contribute to avoidable maternal deaths deliberately or unintentionally through their lack of will to formulate policies and provide resources to encourage women to utilise maternity services, as well as motivate professionals to deliver effective maternal health services. For instance, women suffered from the

activities of medical quacks, due to the perceived failure of political actors to formulate policies that will monitor their practice. These findings revealed that the contribution of women's behaviour to maternal death stemmed from cultural, social, and contextual factors.

Drawn from these findings, several conclusions were made. Firstly, that meaning making rooted in culture and religion was widespread amongst community members who lacked a biomedical knowledge of pregnancy and childbirth. Thus, these individuals resorted to their cultural or lay understandings to protect or promote their indigenous beliefs and societal patriarchal system. Due to this lay understanding, women themselves view maternal mortality as a destiny that can not be altered and thus, there was an acceptance of maternal death by both men and women as a punishment for women who have transgressed societal norms. This dominant discourse prevails due to the failure of the bureaucratic system to launch campaigns for a cultural shift in meaning-making related to pregnancy and childbirth. I argue that a failure to formulate and implement interventions to discourage the use of cultural or religious lenses in meaning-making related to pregnancy and childbirth will increase already high maternal death rate in Nigeria and other countries with a similar context.

Secondly, this thesis complements knowledge from previous literature that socio-economic circumstances and inadequate knowledge impacts on the uptake of maternal services, thereby resulting in maternal death. This current research shows that the issues that engender maternal death were deeper than these socio-economic complexities but were underlined by a political and medical culture that does not value maternal health. Specifically, medical culture related to healthcare providers' oppressive and abusive behaviour towards pregnant women is fundamental to why

some women are not keen to utilise maternal healthcare services. Again, a political culture that does not provide an enabling environment and resources that allow maternal healthcare services to thrive in Nigeria is key to maternal death during pregnancy and childbirth. This seemed to be rooted in an inadequate understanding of the benefits as to why no woman should die during pregnancy and childbirth. Thus, the sensitization of healthcare workers and a positive attitudinal change in midwifery practice are required as well as the development of a political culture that values the health of women and strives to ensure that all resources are available to encourage the use of maternity services and ensure safe childbirth.

Lastly, I feel that the aim of this research has been achieved by providing both knowledge of the socio-cultural factors that impact on maternal mortality and strategies for its reduction in Nigeria. The qualitative methodology facilitated these understandings and was therefore appropriate for this research. I hold strong a view that this research has made original theoretical, empirical, and practical contributions to knowledge in this field, which, if adopted, could be used to plan, or strengthen existing policies to reduce maternal death. Regardless of the perceived relevance and strength of this study, it has some limitations as would be expected in this kind of research, and this provides direction for future study. The limitations of this thesis are discussed next, followed by the direction for future study.

10.1 Limitations of the Study

This study used a qualitative approach and aimed to uncover the socio-cultural factors that impact on maternal mortality and perceived strategies for its reduction in South-East Nigeria. Although this thesis provided an in-depth description and expounded knowledge about the ethno-religious factors and other intricacies affecting maternal

death in a Nigerian context including the perceived strategies to reduce maternal death, it is not without limitations, as would be expected in a qualitative study.

Firstly, the quality of qualitative research is widely believed to be deeply dependent on the individual skills of the researchers and is prone to influence by the researcher's personal biases and idiosyncrasies (Anderson, 2010). This could mean that, as a qualitative study, the current thesis was subject to the researcher's processes and interpretations, which may have been influenced by her research knowledge and experiences. Being a novice researcher and midwife there is a possibility that evidence generated from this thesis may have been influenced by personal biases. For instance, my position as a woman and as a member of the researched community may have caused an unconscious bias that, to some extent, played a role in the knowledge construction of this research. However, this limitation was minimised through constant supervision of the research processes by academic members of University of Salford and by passing through the University's internal quality processes, such as the interim assessment (IA) and internal evaluation (IE). In addition, I engaged in reflexive and reflective practices at every stage of the research process to ensure that personal biases and idiosyncrasies were minimised.

Secondly, given that the study was conducted in a single community within South-East Nigeria, due to individual demographic differences the sample size may not adequately represent the population of all individuals across South-East Nigeria. This implies that caution should be taken in generalising the findings from this study. However, due to cultural and contextual similarities amongst communities within South-East Nigeria, the findings may be generalisable to similar contexts.

Finally, despite the limitations of this thesis, I have argued that knowledge generated by conducting this research remains valuable because it theoretically advanced knowledge in this field and provided practical contributions, which could be used for the improvement of maternal health in Nigeria and another similar context.

10.2 Direction for future research

The thesis was conceived to fill a gap that was generated by conducting a scoping review, as presented in Chapter Three of this thesis. Other research gaps were generated by conducting the current study whilst other gaps remained from the scoping review, which will be discussed in this section by providing suggestions for future research.

The current research provided findings related to governance. It specifically showed the participants perceived that the Nigerian bureaucratic system or political culture played a vital role in the high maternal death rate in Nigeria. For instance, evidence showed that there was insufficient political drive or support in terms of funding and the provision of resources to promote maternal healthcare services. It would be useful to understand the reasons for this from the perspective of political and national policy makers. This suggested research will offer insights into the political culture that may further extend knowledge about the cultural complexities that impact on preventable maternal death in Nigeria.

The findings from the scoping review showed that there was a limited understanding about the awareness, knowledge and economic status of women and their households as social determinants that impact on maternal death. The previous studies that explored these issues predominantly utilised a quantitative approach. This implies that studies utilising a qualitative method are required to explore this issue because such

research will enhance an in-depth understanding of how these social determinants impact on maternal death. However, more importantly, it will provide evidence that could be used to plan specific interventions to improve awareness and knowledge, which could promote the use of maternal health services in order to reduce preventable maternal deaths during pregnancy and childbirth.

A feasibility study and subsequent clinical trial is required to explore the incorporation of TBAs services into hospital environments. This is necessary because such a study will provide evidence of the feasibility of introducing an indigenous midwifery framework where TBAs and Midwives partner within a hospital environment in the provision of maternal services. This could enable the delivery of a service that is culturally sensitive to the needs of community members. This may facilitate the uptake of maternal services that will promote the wellbeing of mothers and may reduce maternal deaths.

Finally, a quantitative research would be useful to identify if the wider population of individuals from South-East Nigeria who hold a similar set of identified beliefs about pregnancy, childbirth, and maternal death. A cross-cultural study that compares the belief systems of various cultural geopolitical zones of Nigeria about pregnancy, childbirth and maternal death is needed because this would offer an opportunity to test the correlations between ethno-religious beliefs and social metrices among a larger population in Nigeria. Such research would generate evidence that could be used to persuade the government about the need to improve maternal health, and how this could be achieved.

10.3 Final reflections on the research

In this section, I reflect on the main aspects of my learning over the last four years of this doctoral journey and identify the ways in which my learning would improve in my future research endeavour. Reflecting on the research process and particularly the challenges encountered at different stages of this study, I achieved an in-depth knowledge about the topic and the context of maternal mortality in Nigerian society. Notably, all decisions related to every stage of the research process were shaped by my educational and cultural background. This aligned with the statement by Rogoff (2003) that everything is culture.

Considering this was the first qualitative research project I have conducted; I initially developed a view that it would be challenging to me. Thus, I spent time reading and learning about conducting qualitative research. However, during fieldwork, I encountered several challenges. For instance, it was difficult to recruit some focus groups discussion participants, and the traditional birth attendants, because they considered me as a spy who had come to elicit information that could be used to report their practices to the police or other government agencies. Assembling women for a specific time and day for a focus group discussion was also challenging. I nearly gave up because I felt exhausted and frustrated after making several efforts with no success. I persisted and successfully completed the recruitment, focus group discussions and interviews. The richness of the data elicited from participants compensated for my initial frustration. I have learnt the importance of being resilient and focused on achieving a set goal, which will be drawn upon in my future research.

Furthermore, I noted that interviewing was initially quite challenging because some participants were either unwilling to talk or did not talk freely. Also, I realised that

women who economically relied on their husbands for survival were reserved when recounting their views and experiences. Reflecting at the end of each interview, I noted some of my mistakes and developed new strategies for approaching women differently, such as reassuring them of the confidentiality of the information they provided, not starting with sensitive questions, and using prompts to encourage participants to continue to talk. I developed these skills and applied them during subsequent interviews, which yielded more relaxed and open discussions between the researcher and the researched. I will build on these skills in my future research and would recommend this for other researchers, especially PhD students, because it is critical for research success in terms of completion.

I will not fail to highlight my learning about the research design. I initially designed this research as an ethnography study and was a bit rigid about the use of this qualitative research approach. This could imply that I was a bit naïve of the flexible nature of qualitative research and I have learnt from this. As the study progressed, my understanding of the field meant that it was not possible to conduct participant observations as I had originally hoped. It became obvious that an ethnographic approach was not suitable, which thus meant I needed to reconsider other approaches. If I did this study again, I would spend more time thinking critically and considering possible alternatives prior to fieldwork during the design phase. By completing this thesis, I have improved my critical thinking abilities and enhanced my analytical skills, which stemmed from substantial reading, thoroughly reviewing all research processes, and learning through feedback and interactions with my supervisory team and other colleagues. Although I am still a novice researcher somewhat, I can confidently argue that I have developed as an individual and as a

professional; I now have the ability to complete independent future research and I aim to continue to enhance my research and writing skills.

Finally, I have learnt to maintain critical self-awareness and to see how this may or may not influence the research processes. Overall, I would declare that I commenced the PhD journey without a clear understanding of the processes it required but came to realise that it is a journey of discovery that is filled with periods of failure and self-accomplishment. The negative moments of this journey were overcome by my passion and commitment to contribute to making positive changes that will translate into a society whereby childbirth becomes safer and the chances of women dying while giving life reduce. I have learnt immensely from undertaking this study and am ever grateful to my supervisors, all the participants and other individuals who have rendered encouragement and support all though the PhD journey.

10.4 Concluding thought

Every woman hopes for a safe pregnancy and childbirth to bring joy to their families and society, but until recently pregnancy and childbirth has turned into a period of sorrow and tragedy for several families, especially amongst middle and low-income countries. This is reflected by the long-term trend of maternal mortality in Nigeria and other countries. Roser and Ritchier (2019) said:

> *What could be more tragic than a mother losing her life in the moment that she is giving life to her new-born?*

This calls for more dedicated effort, public engagement, policy intervention and investment to provide resources that can be used to improve maternal health through the provision of maternal healthcare services that are culturally sensitive to the needs of society. Despite continued national and international efforts to reduce maternal death in Nigeria and other countries, I argue that more research needs to be done

because women are still dying from preventable pregnancy-related causes. If maternal deaths are rare in some countries, like the United Kingdom and other wealthy countries, it implies that a decline in maternal death is possible in Nigeria and other less wealthy countries. Evidence generated from this thesis suggests that a cultural shift is required as well as a bureaucratic mindset that prioritises maternal healthcare and utilises its resources to make childbirth safer and so reduces the risk of maternal death.

References

Abani, C., Igbuzor, O. and Moru, J. (2015). Attaining the Millennium Development Goals in Nigeria: Indicative Progress and a call for action. *Journal of Social Forum*, **3**(1), Pp. 61-69.

Abara, C. J. (2012). Inequality and discrimination in Nigeria tradition and religion as negative factors affecting gender. *Federation of International Human Rights Museums*, pp.1-18.

Abdulkarim, G. M., Kawuwa, M. B. and Kullima, A. (2008). Community perception of maternal mortality in North Eastern Nigeria. *African Journal of Reproductive Health,* **12**(3), pp.27-34.

Abimbola, S., Ogunsina, K., Charles-Okoli, A. N., Negin, J., Martiniuk, A. L., and Jan, S. (2016). Information, regulation, and coordination: realist analysis of the efforts of community health committees to limit informal health care providers in Nigeria. *Health economics review*, ***6***(1), p.51.

Abimbola, A. K. and Ajiboye, O. E. (2012). Socio-Cultural Factors Affecting Pregnancy Outcome among the Ogun Speaking People of Badagry area of Lagos State, Nigeria. *International Journal of Humanity Social Science*, ***2*****:** pp.133 -144.

Abimbola, S., Okoli, U., Olubajo, O., Abdullahi, M. J. and Pate, M. A. (2012). The midwives service scheme in Nigeria. *PLoS Medicine,* **9**(5), p.541, e1001211.

Abdulkarim, G. M., Abubakar, A. K., Babagana, B. and Mustapha, A. K. (2010). Socio-cultural factors influencing decision-making related to fertility among the Kanuri tribe of north-eastern Nigeria. *African Journal of Primary Health Care and Family Medicine*, **2**(1), pp.1-16.

Abdullateef, R., Muhammed, A. Y., Abdulbaqi, S. Z., Raji, A. A., Sulaiman, L. A., Joseph, A. O. (2016). Socio-cultural factors and male-child preference among couples in Ilorin-West Local Government Area of Kwara-State, Nigeria. *Ethiopia Journal of Social Language Study. **3***(1), pp.57-73. eISSN: 2408-9532; pISSN: 2412-5180.7.

Achebe, C. (1984). *The trouble with Nigeria*. Heinemann.

Adamu, Y. M. and Salihu, H. M. (2002). Barriers to the use of antenatal and obstetric care services in rural Kano, Nigeria. *Journal of Obstetrics and Gynaecology*, ***22***(6), pp.600 - 603.

Addai, I. (1999). Does religion matter in contraceptive use among Ghanaian women? *Review of Religious Research*, ***40***(3).

Adefolaju, T. (2014). Traditional and orthodox medical systems in Nigeria: The imperative of a synthesis. *American Journal of Health Research*, ***2***(4), pp.118-124.

Adegoke, A. (2008). Community-based investigation of the avoidable factors of maternal mortality in Nigeria: Unpublished Ph.D. thesis, Manchester, University of Manchester, School of Nursing, Midwifery and Social Works.

Adegoke, A. A., Campbell, M., Ogundeji, M. O., Lawoyin, T. and Thomson, A. M. (2010). "Place of birth or place of death: An evaluation of 1139 maternal deaths in Nigeria". *Midwifery,* **29**(11), pp. e115-e121.

Adejoh, S. O., Olorunlana, A., and Olaosebikan, O. (2018). Maternal health: A qualitative study of male partners' participation in Lagos, Nigeria. *International Journal of Behavioral Medicine*, *25*(1), pp.112-122.

Adekanmbi, J. (2018). Whistle blowing: a way of fostering accountability and transparency in public sectors in Nigeria.

Adeleke, I. T., Suleiman-Abdul, Q. B., Aliyu, A., Ishaq, I. A., and Adio, R. A. (2019). Deploying unqualified personnel in health records practice: Role substitution or quackery? Implications for health services delivery in Nigeria. *Health Information Management Journal*, ***48***(3), pp.152-156.

Adeleke, I. T., Lawal, A. H., Adio, R. A. and Adebisi, A. A., (2015). Information technology skills and training needs of health information management professionals in Nigeria: a nationwide study. *Health Information Management Journal*, ***44***(1), pp.30-38.

Adeloye, D., Adigun, T., Misra, S., and Omoregbe, N. (2017). Assessing the Coverage of E-Health Services in Sub-Saharan Africa. *Methods of Information in Medicine*, ***56***(03), pp.189-199.

Adetoro, R. A. Omiyofa (2012). Using Multicultural Education to solve Ethno-Religious violence in Nigeria. *Nigeria Journal of Social Studies*, ***15***(2).

Adewemimo, A. W., Msuya, S. E., Olaniyan, C. T. and Adegoke, A. A., (2014). Utilisation of skilled birth attendance in Northern Nigeria: a cross-sectional survey. *Midwifery*, ***30(***1), pp. e7-e13.

Adewoye, K. R., Musa, I. O., Atoyebi, O. A., Babatunde, O. A. (2013). Knowledge and utilization of antenatal care services by women of childbearing age in Ilorin-East local government area, North Central Nigeria. *International Journal of Science and Technology*, ***3***(3), pp.17-22.

Adewole, I. O., Kayode, F., Giwa, S. O., Shoga, M. O., Adejumo, A. O., and Ademiluyi, S. A. (2012). Ambulance services of Lagos State, Nigeria: a six-year (2001–2006) audit. *West African Journal of Medicine*, ***31***(1), pp.8-13.

Adindu, A., Ndep, A. O, and Alexander, P. (2012). Advancing Participation in Primary Health Care through Community Health Management Information Systems in Rural Africa. *International Journal of Development Studies,* **5**(4), pp.132-144.

Adkins, L., and Skeggs, B. (2004). *Feminism after Bourdieu,* Blackwell Oxford.

African Population and Health Research (2017). Maternal Health in Nigeria: Facts and Figures. (online) Available from: https://aphrc.org/publication/maternal-health-in-nigeria-facts-and-figures/.

Agbo, M. (2013). Training of traditional birth attendants: a strategy for reduction of maternal and infant mortality. *West African Journal of Nursing*, ***24***(1).

Agho, K. E., Ezeh, O. K., Issaka, A. I., Enoma, A. I., Baines, S. and Renzaho, A. M. (2016). Population attributable risk estimates for factors associated with non-use of postnatal care services among women in Nigeria. *British Medical Journal, Open Access Research,* **6**(7), pp.e010493-2015-010493. doi:10.1136/bmjopen-2015-010493 [doi].

Agom, J. C., Agom, D. A., Ekuma, C. V., Ominiyi, J. N., and Onwe, S. N. (2015). Effectiveness of Misoprostol for the preventing postpartum Haemorrhage: A Review. *Journal of Medical Science and Clinical Research*, ***3***(3), pp.4891-4905.

Agus, Y., Horiuchi, S., and Porter, S. E. (2012). Rural Indonesia women's traditional beliefs about antenatal care. *BMC research notes*, ***5***(1), pp.589.

Ahmed, I., Ali, S.M., Amenga-Etego, S., Ariff, S., Bahl, R., Baqui, A.H., Begum, N., Bhandari, N., Bhatia, K., Bhutta, Z.A. and Biemba, G., (2018). Population-based rates, timing, and causes of maternal deaths, stillbirths, and neonatal deaths in south Asia and sub-Saharan Africa: a multi-country prospective cohort study. *The Lancet Global Health*, ***6***(12); Pp. e1297-e1308.

Airhihenbuwa, C. O., Ford, C. L., and Iwelunmor, J. I. (2014). Why culture matters in health interventions: lessons from HIV/AIDS stigma and NCDs. *Health Education and Behavior*, ***41***(1), pp.78-84.

Aja-Okorie, U. (2013). Women education in Nigeria: Problems and implications for family role and stability. *European Scientific Journal,* **9**(28), pp. 272-282.

Ajiboye, O. E. and Adebayo, K. A. (2012). Socio-Cultural Factors Affecting Pregnancy Outcome among the Ogu Speaking People of Badagry Area of Lagos State, Nigeria. *International Journal of Humanities & Social Science*, **2:** p.133.

Ajzen, I. (1985). From intentions to actions: A theory of planned behavior. In *Action control* (pp. 11-39). Springer, Berlin, Heidelberg.

Akande, T. M and Owoyemi, J. O. (2014). Healthcare Seeking Behaviour in Anyigba, North-Central, Nigeria. *Research Journal of Medical Sciences*, **3**(2), pp. 47-51.

Akinwaare, M. O. and Adejumo, P. O. (2015). Determinants of choice of place of birth and skilled birth attendants among women in Ibadan, Nigeria. *African Journal of Midwifery and Women's Health*, ***9***(3), pp. 121-124.

Akintunde, D. O. (2006) Women as Healer: The Nigerian (Yoruba) Example. In Phiri, I. A. and Nadar, S. (Ed) *African Women, Religion, and Health: Essays in Honour of Mercy Amba EwudZiwa Uduyoye*. New York: Orbis Books Pp.157-169.

Alaimo, Stacy. And Susan Hekman, (2007). Material Feminisms, Bloomington, IN: Indiana University Press.

Alenoghena, I., Isah, E. and Isara, A. (2015). Maternal health services uptake and its determinants in public primary health care facilities in edo state, Nigeria. *The Nigerian Postgraduate Medical Journal*, ***22***(1).

Alenoghena I., Aigbiremolen, A. O., Abejegah, C., and Eboreime, E. (2014) Primary Health Care in Nigeria: strategies and constraints in implementation. *International Journal of Community Research,* **3**(3), pp. 74-79.

Alford, R. D. (1988). Naming and identity: A cross-cultural study of personal naming practices. New Haven, CT: HRAF Press.

Aljumah, A. A., Ahamad, M. G. and Siddiqui, M. K., (2013). Application of data mining: Diabetes health care in young and old patients. *Journal of King Saud University-Computer and Information Sciences*, ***25***(2), pp. 127-136.

Alkema, L., Chou, D., Hogan, D., Zhang, S., Moller, A., Gemmill, A., Fat, D.M., Boerma, T., Temmerman, M. and Mathers, C., (2016). Global, regional, and national levels and trends in maternal mortality between 1990 and 2015, with scenario-based projections to 2030: a systematic analysis by the UN Maternal Mortality Estimation Inter-Agency Group. *The Lancet,* **387**(10017), pp.462-474.

Alobo, G., Ochejele, S. and Ngwan, S. (2013). "A Review of Underlying Causes of Maternal Deaths in Benue North Central Nigeria", *Journal of Infertility and Reproductive Biology,* **1**(2), pp. 42-47.

Ahmed, D. A. A., Hundt, G. L., Blackburn, C. (2011). Issues of gender, reflexivity, and positionality in the field of disability: researching visual impairment in an Arab society. *Qualitative Social Work*, ***10***(4), pp. 467-484.

Ana, J. (2011). Are traditional birth attendants good for improving maternal and perinatal health? Yes. *British Medical Journal*, pp. *342*, d3310.

Anastasia, E., Ekanem, E., Hill, O., Oluwakemi, A. A., Abayomi, O. and Bernasconi, A. (2017). Unmasking inequalities: Sub-national maternal and child mortality data from two urban slums in Lagos, Nigeria tells the story. *PloS one*, ***12***(5), p. e0177190.

Aninyei, I. R., Onyesom, I., Ukuhor, H. O., Uzuegbum, U. E., Ofili, M. I., and Anyanwu, E. B. (2008). Knowledge attitude to modern family planning methods in Abraka communities, Delta State, Nigeria.

Anney, V. N. (2014). Ensuring the quality of the findings of qualitative research: looking at trustworthiness criteria. *Journal of Emerging Trend in Educational Research and Policy Studies*. **5**(20), pp. 272-281.

Antaki, C., Billig, M., Edwards, D., and Potter, J. (2003). Discourse analysis means doing analysis: A critique of six analytic shortcomings.

Appleton, J. V. and King, L. (1997). Constructivism: A naturalistic methodology for nursing inquiry. *Advances in Nursing Science,* **20**(2), pp. 13-22.

Archibong, E. I., Agan, T. U., Ekabua, J. E., Ekanem, E. I., Abeshi, S. E. Edentekhe, T. and Bassey, E. E. (2010). Trends in maternal mortality at the University of Calabar Teaching Hospital, Nigeria, 1999-2009. *International Journal of Women's Health,* **2:** pp.249-254.

Aregbeshola, B. S. (2016). Out-of-pocket payments in Nigeria. *The Lancet*, ***387***(10037), p.2506.

Ariyo, O., Ozodiegwu, I. D., and Doctor, H. V. (2017). The influence of the social and cultural environment on maternal mortality in Nigeria: Evidence from the 2013 demographic and health survey. *PloS one*, ***12***(12), e0190285.

Arksey, H. and O'Malley, L. (2005) Scoping studies: towards a methodological framework. *International Journal of Social Research Methodology: Theory and Practice.* **8**(1), pp.19-32.

Arowolo, D. (2010). The effects of western civilisation and culture on Africa. *Afro Asian Journal of Social Sciences*, ***1***(1), pp.1-13.

Asakitikpi, A. E., (2008). Born to die: The Ogbanje phenomenon and its implication on childhood mortality in southern Nigeria. *The Anthropologist*, ***10***(1), pp.59-63.

Assimeng, M. (1989). Religion and Social Change in West Africa (Accra, Ghana Universities Press).

Atkinson, P., Coffey, A., Delamont, S. and Lofland, L. (2001). *Handbook of ethnography*. London: Sage.

Avegalio, P. F. (2009). Reconciling modern knowledge with ancient wisdom.

Awolude, O. A., Olagunju, A. S., and Agbana, R. D. (2019). Practice of hot abdominal compression among parturient women at the University College Hospital, Ibadan, Nigeria. *Journal of Community Medicine and Primary Health Care*, ***31***(1), pp.1-10.

Aziken, M., OMO-AGHOJA, L. A. W. R. E. N. C. E., and Okonofua, F. (2007). Perceptions and attitudes of pregnant women towards caesarean section in urban Nigeria. *Acta Obstetricia et Gynecologica Scandinavica*, ***86***(1), pp.42-47.

Azim, C. and Loffi, M. (2011). Association of Socioeconomic status with Health and Birth Outcomes: Maternal Variables. *International Journal of Medicine and Medical Science,* **3:** pp.346-352.

Aziato, L., Odai, P. H., and Omenyo, C. (2016). Religious beliefs and practices in pregnancy and labour: An inductive qualitative study among post-partum women in Ghana. *Pregnancy and Childbirth*, **16**:138. Pp.doi:10.1186/s12884-016-0920-1.

Azuh, D. E., Azuh, A. E., Fasina, F., Adekola, P. O., Amoo, E. O. and Oladosun, M., (2017a). Knowledge of socio-demographic factors influencing health service usage among pregnant mothers in Nigeria. *International E-Journal of Advances in Social Sciences, **3***(9), pp.1043-1050.

Azuh, D. E., Azuh, A. E., Iweala, E. J., Adeloye, D., Akanbi, M. and Mordi, R. C., (2017b). Factors influencing maternal mortality among rural communities in southwestern Nigeria. *International journal of women's health*, ***9:*** p.179.

Azuh, D. E., Fayomi, O. O. and Yartey Ajayi, L., (2015). Socio-cultural factors of gender roles in women's healthcare utilization in Southwest Nigeria. *Open Journal of Social Sciences, **3*****:*** pp.105-117.

Azuh, D. E., Nwaubani, O. O. and Ugwuanyi, B. E., (2014a). Socio-Demographic Determinants of Health Care Programme Usage by Women During Pregnancy and Childbirth in ADO-ODO/OTA Local Government Area of Ogun State, Nigeria. *International Journal of Scientific Research*, ***3***(6), pp.459-464.

Babalola, S. and Fatusi, A. (2009). Determinants of Use of Maternal Health Services in Nigeria: looking Beyond Individual and Household Factors. *BMC Pregnancy and Childbirth*, **9**(43), doi: 10.1186/1471-2393-*9-43.*

Baergen, R. N., Thaker, H. M., and Heller, D. S. (2013). Placental release or disposal? Experiences of perinatal pathologists. *Pediatric and Developmental Pathology*, ***16*****(**5), pp.327-330.

Bailey, J. (2008). First steps in qualitative data analysis: transcribing. *Family Practice,* **25**(2), pp.127-131.

Ball, P. (2009) Phenomenology in nursing research: methodology, interviewing and transcribing. *Nursing Times.* **10**5: pp.30-33.

Barbour, R. S. (2005). Making sense of focus groups. *Medical Education*, **39**: pp.742–50.

Barbour, R. S. (2003). The newfound credibility of qualitative research? Tales of technical essentialism and co-option. *Qualitative Health Research*, ***13***(7), pp.1019-1027.

Barker, C., and Pistrang, N. (2005). Quality criteria under methodological pluralism: Implications for conducting and evaluating research. *American Journal of Community Psychology*, ***35***(34), pp.201-212.

Barrientos, S., Kabeer, N. and Hossain, N. (2004). The Gender Dimension of the Globalisation of Production. Geneva: International Labour Organisation.

Batchelor, J. A., and Briggs, C. M. (1994). Subject, project, or self. *Thoughts on ethical*.

Baumeister, R. F. (1991). *Meanings of life*. Guilford Press.

Bazeley, P. and Jackson, K. (2013). *Qualitative data analysis with NVivo.* Sage Publications Limited.

Bernard, H. R. (2002). Research methods in anthropology: Qualitative and quantitative approaches (3rd ed.). Walnut Creek, CA: Altamira Press.

Ben-Joseph, E. P. (2007). Medical Care During Pregnancy. *The Nemours Foundation*.

Berg, M. (2001). Implementing information systems in health care organizations: myths and challenges. *International journal of medical informatics*, ***64***(2-3), pp.143-156.

Berlant, L. (2008). Race, Gender and Nation in The Color Purple. *Bloom's Modern Critical Interpretation*, pp.21-48.

Bird, C. M. (2005). How I stopped dreading and learned to love transcription. *Qualitative Inquiry,* **11**(2), pp.226-248.

Birdsong, W. M. (1998). The placenta and cultural values. *Western Journal of Medicine*, ***168***(3), p.190.

Blumer, H. (1969). Symbolic interactionism: Perspective and method. Berkeley.

Blumer, H. (1969). The methodological position of symbolic interactionism. *Symbolic interactionism: Perspective and method*, ***1:*** p.60.

Bohren, M. A., Vogel, J. P., Tunçalp, Ö., Fawole, B., Titiloye, M. A., Olutayo, A. O., ... and Idris, H. A. (2017). Mistreatment of women during childbirth in Abuja, Nigeria: a qualitative study on perceptions and experiences of women and healthcare providers. *Reproductive health*, ***14***(1), p.9.

Borbasi, S., Jackson, D. and Wilkes, L., (2005). Fieldwork in nursing research: positionality, practicalities, and predicaments. *Journal of Advanced Nursing*, **51:** pp.493–501.

Bouma, G. D., and Hughes, P. (1998). Religion and age in Australia. *People and Place*, ***6***(1), pp.8-25.

Bourke, B. (2014). Positionality: Reflecting on the research process. *The qualitative report*, ***19***(33), pp. 1-9.

Bott, E. (2010). Favorites and others: reflexivity and the shaping of subjectivities and data in qualitative research. *Qualitative Research Journal,* **10**(2), pp.159-173.

Bover, A. (2013). Reflexivity and positionality tools to promote theoretical-methodological congruency on commencing a qualitative study. *Enfermería Clínica.* **23**(1), pp.33-37.

Boyacioğlu, A. Ö., and Türkmen, A. (2008). Social and cultural dimensions of pregnancy and childbirth in eastern Turkey. *Culture, health, and sexuality*, ***10***(3), pp.277-285.

Braun, V., and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, **3***(2), pp.77-101.

Braun, V., Clarke, V. and Terry, G. (2014). Thematic analysis. *Qualitative Research Clinical Health Psychology,* pp.95-114.

Braun, V., and Clark, V. (2014). Thematic analysis in Encyclopedia of critical psychology.

Brewer, J. D. (2000) *Ethnography*. Buckingham: Open University Press.

Brien, S. E., Lorenzetti, D. L., Lewis, S., Kennedy, J. and Ghali, W. A. (2010). Overview of a formal scoping review on health system report cards. *Implementation Science.* **5**(1), p. 2.

Brizuela, V., and Tunçalp, Ö. (2017). Global initiatives in maternal and newborn health. *Obstetric Medicine*, ***10***(1), pp.21-25.

Bryman, A. (2012). *Social research methods.* (4th edition). Oxford: Oxford Press.

Bryman, A. (2008). *The End of Paradigm Wars?* In: P. Alasuutari., L. Bickman, and J. Brannen, (Eds), The Sage Handbook of Social Research Methods. London: Sage Publications, pp.13-25.

Bryman, A. (2001). *Social Research Methods*. Oxford, Oxford University Press.

Budhathoki, N., Bhusal, S., Ojha, H., and Basnet, S. (2013). Violence against women by their husband and postpartum depression. *Journal of Nepal Health Research Council*, ***10***(22), pp.176-180.

Bulmer, M. (2008) The Ethics of Social Research, in Gilbert, N. (Ed.) Researching Social Life, (Third Edition), London, Sage, pp.145- 161.

Burnard, P., Gill, P., Stewart, K., Treasure, E. and Chadwick, B. (2008). Analysing and presenting qualitative data. *British Dental Journal,* **204**(8), pp.429-432.

Burns, E., Fenwick, J., Schmied, V., and Sheehan, A. (2012). Reflexivity in midwifery research: The insider/outsider debate. *Midwifery*, **28**(1), pp.52-60.

Burns, E. (2014). More than clinical waste? Placenta rituals among Australian home-birthing women. *The Journal of Perinatal Education*, ***23*(**1), pp.41-49.

Burns, N. and Grove, S. K. (1997). The Practice of Nursing Research. W. B. Saunders, Philadelphia.

Cairns, J. B. (2005). Maori maternity in the land of the long white cloud. *British Journal of Midwifery*, ***13***(2), pp.74-77.

Callaghan, H. (2007). Birth dirt. In Kirkham M., editor. (Ed.), Exploring the dirty side of women's health. New York, NY: Routledge.

Capps, P. (2019). Interpretivism. In *Concepts for International Law*. Edward Elgar Publishing.

Casey, D., and Murphy, K. (2009). Issues in using methodological triangulation in research. *Nurse researcher*, ***16***(4).

Cavalli-Sforza, L. L., and Feldman, M. W. (1981). *Cultural transmission and evolution: A quantitative approach* (No. 16). Princeton University Press.

Ceglowski, D. (2000). Research as relationship. *Qualitative Inquiry*, ***6***(1), pp.88-103.

Cham, M., Sundby, J. and Vangen, S. (2005). Maternal Mortality in the Rural Gambia, a qualitative study on access to emergency obstetric care. *Reproductive Health,* pp.1

Chapman, S., McNeill, P., and Mcneill, P. (2005). *Research methods*. Routledge.

Chambliss, D. F. and Schutt, R. K. (2006). *Making Sense of the Social World: Methods of Investigation*. California: Thousand Oaks.

Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis.* London: Sage Publications.

Charmaz, K. (2000). *Grounded theory: Objectivist and constructivist methods*. In N. K. Denzin and Y. S. Lincoln (Eds.), Handbook of qualitative research (2nd ed., pp.509–535). Thousand Oaks, CA: Sage.

Chant, S. (2000). From 'Woman-Blind' to 'Man-Kind' Should Men Have More Space in Gender and Development? *IDS Bulletin*, **31**(2), pp.7-17.

Charlier, P., Coppens, Y., Malaurie, J., Brun, L., Kepanga, M., Hoang-Opermann, V., Correa Calfin, J. A., Nuku, G., Ushiga, M., Schora, X. E., Deo, S., Hassin, J. and Herve, C. (2016). A new definition of health? An open letter of autochthonous peoples and medical anthropologists to the WHO*. European Journal of Internal Medicine*, http://dx.doi.org/10.1016/j.ejim.2016.06.027.

Christian, C. G. (2011). *Ethics and politics in qualitative research*. In N. K. Denzin and N. K.

Chukuezi, C. (2010). Socio-cultural factors associated with maternal mortality in Nigeria. *Research journal of social sciences*, ***1***(5), pp. 22-26.

Denzin and Y. S. Lincoln (eds.), The sage handbook of qualitative research (4th edn., pp. 61-81). London Sage.

Cohen, D. J., and Crabtree, B. F. (2008). Evaluative criteria for qualitative research in health care: controversies and recommendations. *The Annals of Family Medicine*, *6*(4), 331-339.

Cohen, L., Manion, L. and Morrison, K. (2013). *Research Methods in Education.* Routledge.

Cohen, Manion, L. and Morrison, K. (2011). Research Methods in Education. 7th ed. Routledge.

Collins, P. H. (1998). *Fighting words: Black women and the search for justice* (Vol. 7). U of Minnesota Press.

Conti, J. A., and O'Neil, M. (2007). Studying power: Qualitative methods and the global elite. *Qualitative research*, ***7***(1), pp. 63-82.

Connelly, M. P., Li, T. M., MacDonald, M. and Parpart, J. L. (2000). Feminism and development: Theoretical perspectives. *Theoretical Perspectives on Gender and Development,* pp. 51-159.

Cooker, J. G. and Tahir, F. (2013). Maternal Health in Nigeria; With Leadership, progress is possible (online) Available from: www.csis.org/files/publication/130111_cooke_maternalHealthNigeria_web.pdf [Accessed on 29th July, 2015].

Corbin, J. M. and Strauss, A. L. (2008). *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. Thousand Oaks, California: Sage Publication.

Corbett, Michael, and Lynne, R. (2002). *A MicroCase Workbook for Social Research*. Belmont, CA: Wadsworth/Thompson Learning.

Cotton, S., Zebracki, K., Rosenthal, S. L., Tsevat, J., and Drotar, D. (2006). Religion/spirituality and adolescent health outcomes: A review. *Journal of Adolescent Health*, ***38***(4), pp. 472-480.

Cree, A., Kay, A. and Steward, J. (2012). The economic and social cost of illiteracy: A snapshot of illiteracy in a global context. *World Literacy Foundation.*

Creswell, J. W. (2018). *Qualitative inquiry and research design: Choosing among five approaches*. 4th ed. Thousand Oaks, CA: Sage.

Creswell, J. W. (2014). *A concise introduction to mixed methods research*. SAGE publications.

Creswell, J. W. (2013) *Qualitative inquiry and research design: Choosing among five approaches*. 3rd ed. Thousand Oaks, CA: Sage.

Creswell, J. W. (2009). Research design: qualitative, quantitative, and mixed methods approach. Los Angeles: Sage.

Cresswell, J. W. (2007). *Qualitative Inquiry and Research Design: Choosing Among Five Approaches*. California, London, New Delhi: Sage Publication.

Crooks, D. L. (2001). The importance of symbolic interaction in grounded theory research on women's health. *Health Care for Women International,* **22**: pp.11-27.

Crotty, M. (1998). *The foundations of Social Research: Meaning and perspectives in the Research Process*. London: Sage.

Crotty, M. (1996). *Phenomenology and Nursing Research.* South Melbourne: Churchill Livingstone.

Crow, Barbara, 2000, Radical Feminism. A Documentary Reader, New York: New York University Press.

Dairo, M. D. and Owoyokun, K. E. (2010). Factors Affecting the Utilization of Antenatal Care Services in Ibadan, Nigeria. Benin. *Journal of Postgraduate Medicine*, **12:** pp.3-13.

Danawi, H., and Ogbonna, F. (2014). Impact of Socioeconomic Status and Household Structure on Infant Mortality Rate in Abia State of Nigeria. *International Journal of Childbirth Education*, *29*(4).

Darawsheh, W. (2014). Reflexivity in research: Promoting rigour, reliability, and validity in qualitative research. *International Journal of Therapy and Rehabilitation,* **21**(12), pp.560-568.

Daudt, H. M., van Mossel, C., and Scott, S. J. (2013). Enhancing the scoping study methodology: a large, inter-professional team's experience with Arksey and O'Malley's framework. *BMC Medical Research Methodology*, ***13***(1), p. 48.

Davis, K., Drey, N. and Gould, D. (2009) What is scoping studies? A review of the nursing literature. *International Journal of Nursing Studies.* **46**(1), pp.1386-1400.

D'Cruz, H., Gillingham, P. and Melendez, S. (2007). Reflexivity, its meanings, and relevance for social work: A critical review of the literature. *British Journal of Social Work,* **37**(1), pp.73-90.

De Casterle, B. D., Gastmans, C., Bryon, E., and Denier, Y. (2012). QUAGOL: A guide for qualitative data analysis. *International Journal of Nursing Studies, **49***(3), pp.360-371.

Denzin, N. K. and Lincoln, Y. S. (2011) *The sage handbook of qualitative research*. Thousand Oaks; Sage publication.

Denzin, N. K., Lincoln, Y. S., and Giardina, M. D. (2006). Disciplining qualitative research. *International Journal of Qualitative Studies in Education*, ***19***(6), Pp.769-782.

Denzin, N. K. and Lincoln, Y. S. (2000). The discipline and practice of qualitative research. *In:* Denzin, N. K. and Lincoln, Y. S. (eds.) *Handbook of Qualitative Research.* Thousand Oaks, California: Sage Publication.

Denzin, N. K., and Lincoln, Y. S. (1994). Entering the field of qualitativeresearch. In N. K. Denzin, and Y. S. Lincoln (Eds.), Handbook of qualitative research (pp.1–17). Thousand Oaks: Sage.

Descombe, M. (1999). The good research guide for small-scale social research. *Buckingham: Open University Press. Acedido a Novembro*, *13*, 2016.

Desmond, J. (1997). Marketing and the war machine. *Marketing Intelligence and Planning*, *15*(7), 338-351.elano, E. (2006). *Guide to family planning*; Ibadan, Academy press Limited.

De Villiers, M. R. (2005). Interpretive research models for Informatics: action research, grounded theory, and the family of design-and development research. *Alternation,* **12**(2), pp.10-52.

Dey, I. (2003). *Qualitative data analysis: A user-friendly guide for social scientists* Routledge.

Dhakal, S. (2008). Nepalese women under the shadow of domestic violence. *The Lancet*, ***371***(9612), pp.547-548.

DiCicco-Bloom, B. and Crabtree, B. (2006). The qualitative research interviews. *Medical Education*, **40:** 314–321 doi:10.1111/j.1365-2929.2006.02418.

Dieronitou, I. (2014). The ontological and epistemological foundations of qualitative and quantitative approaches to research. *International Journal of Economics,* **2**(10), pp. 1-17.

Doctor, H. V., Findley, S. E. and Afenyadu, G. Y. (2018). "Estimating maternal mortality level in rural northern Nigeria by the sisterhood method". *International Journal of Population Research,* **2012**(2012), doi:10.1155/2012/464657.

Doctor, H.V., Findley, S. E., Ager, A., Cometto, G., Afenyadu, G.Y., Adamu, F. and Green, C., (2012). Using community-based research to shape the design and delivery of maternal health services in Northern Nigeria. *Reproductive health matters*, ***20***(39), pp.104-112.

Dollard, J., Miller, N. E., Doob, L. W., Mowrer, O. H., and Sears, R. R. (1939). Frustration and aggression.

Doorenbos, A. Z., Schim, S. M., Benkert, R., and Borse, N. N. (2005). Psychometric evaluation of the cultural competence assessment instrument among healthcare providers. *Nursing Research*, ***54***(5), pp.324-331.

Doyle, S., (2013). Reflexivity and the capacity to think. *Qualitative health research,* **23**(2), pp.248-255.

Durkheim, E. (1965). The elementary forms of the religion life. *The Origin and Development of Religion*.

Dwyer, S. C. and Buckle, J. L. (2009). The space between on being an insider–outsider in qualitative research. *International Journal of Qualitative Methods,* **8:** pp.54–63.

Eakin, J. M., and Mykhalovskiy, E. (2003). Reframing the evaluation of qualitative health research: reflections on a review of appraisal guidelines in the health sciences. *Journal of evaluation in clinical practice*, ***9***(2), pp.187-194.

Eckersley, R., (2006). Is modern Western culture a health hazard? *International Journal of Epidemiology,* **35**(2), pp.252-258.

Edewor, Patrick and Aluko, Y. A. and Folarin, S. F. (2014) *Managing Ethnic and Cultural Diversity for National Integration in Nigeria. Developing Country Studies*. **4**(6), pp.70-76.

Edward, R. and Holland, J. (2013) *What is qualitative interview.* London: Bloomsbury.

Egharevba, J., Pharr, J., van Wyk, B. and Ezeanolue, E., (2017). Factors influencing the choice of child delivery location among women attending antenatal care services and immunization clinic in Southeastern Nigeria. *International journal of MCH and AIDS*, *6*(1), p.82.

Eguavoen, A. N.T., Odiagbe, S. O., &Obetoh, G. I. (2007). The status of women, sex preference, decision making and fertility control in Ekpoma community of Nigeria. J. Soc. Sci., 15(1): 43-49.

Ejidokun, O. O., (2000). Community attitudes to pregnancy, anaemia, iron and folate supplementation in urban and rural Lagos, south-western Nigeria. *Midwifery*, *16*(2), pp.89-95.

Ekechi, C., Wolman, Y. and De Bernis, L., (2012). Maternal and Newborn Health road maps: a review of progress in 33 sub-Saharan African countries, 2008–2009. *Reproductive health matters,* **20**(39), pp. 164-168.

Ekwochi, U., Osuorah, C. D., Ndu, I. K., Ifediora, C., Asinobi, I. N., and Eke, C. B. (2016). Food taboos and myths in South Eastern Nigeria: The belief and practice of mothers in the region. *Journal of ethnobiology and ethnomedicine*, *12*(1), 7.

Ella, R. E., Esienumoh, E. E., and Ojong, I. N. (2017). Personal characteristics and compliance to health education among pregnant women attending antenatal clinic in University of Calabar Teaching Hospital, Nigeria. *Global Journal of Pure and Applied Sciences*, *23*(2), 327-335.

Ellison, C. G., and Levin, J. S. (1998). The religion-health connection: Evidence, theory, and future directions. *Health Education and Behavior*, *25*(6), 700-720.

Elson, D. (1992). From survival strategies to transformation strategies: women's needs and structural adjustment. In Beneria, L., Fieldman, S., ed., Unequal burden: economic crises, persistent poverty, and women's work. Westview press, Boulder, CO, USA. Pp. 26-48.

Elujoba, A. A., Odeleye, O. M., and Ogunyemi, C. M. (2005). Traditional Medicine Development for Medical and Dental Primary Health Care Delivery System in Africa. *African journal of traditional, complementary, and alternative medicines*, ***2*(**1), pp. 46-61.

Emelumadu, O. F., Ukegbu, A.U., Ezeama, N. N., Kanu, O. O., Ifeadike, C. O. and Onyeonoro, U.U., (2014). Socio-demographic determinants of maternal health-care service utilization among rural women in Anambra State, South East Nigeria. *Annals of medical and health sciences research*, **4**(3), pp.374-382.

Envuladu, E. A., Agbo, H. A., Ashikeni, M. A., and Zoakah, A. I. (2013). Determinants of substance abuse among pregnant women attending ANC in a tertiary hospital in Jos Plateau State Nigeria.

EON Group International (2015). About Ebonyi State (online) Available from: www.ebonyionline.com/about-ebonyi-state. [Accessed on 21st May 2015].

Erim, D. O., Resch, S. C., and Goldie, S. J. (2012). Assessing health and economic outcomes of interventions to reduce pregnancy-related mortality in Nigeria. *BMC Public Health*, **12**(1), 786.

Erinosho, O. A. (2005). *Sociology for Medical, Nursing, and Allied Professions in Nigeria*.

Essien, A. (2005). Religion and Reproductive Health in Nigeria: Series in Sociology of Religion, Nigeria. African Heritage Publication. Nigeria: Bulwark Consult.

Essien, D. (2006). Reduction of Maternal Mortality in Akwa Ibom State Nigeria. Akwa Ibom State Council for Health.

Evans, E. C. (2013). A review of cultural influence on maternal mortality in the developing world. *Midwifery*, **29**(5), 490-496.

Evely, A. C., Fazey, I. R. A., Pinard, M. and Lambin, X. (2008) The influence of philosophical perspectives in integrative research: a conservation case study in the Cairngorms National Park. Eco*logy and Society,* **13**(2), p.52.

Ewa, E. E., Lasisi, C. J., Maduka, S. O., Ita, A. E., Ibor, U. W. and Anjorin, O. A. (2012). Perceived Factors Influencing the Choice of Antenatal Care and Delivery Centres among Childbearing Women in Ibadan North South-Western, Nigeria. *Ethiopian Journal of Environmental Studies and Management*, **5**: pp.373-383.

Ezegwui, H. U., Onoh, R. C., Ikeako, L. C., Onyebuchi, A., Umeora, O. U. J., Ezeonu, P. and Ibekwe, P. (2013). Investigating Maternal Mortality in a Public Teaching Hospital, Abakaliki, Ebonyi State Nigeria. *Journal of Annals Medical and Health Sciences Research*, ***3(***1), Pp.75-80.

Ezekwonna, F. C. (2005). *African communitarian ethic: The basis for the moral conscience and autonomy of the individual: Igbo culture as a case study*. Lang.

Ezeonwu, M. C, (2015). Determinants of Access to Specialty Care for Community Health Clinic Patients, *43rd Biennial Convention (07 November-11 November 2015)* 2015, STTI.

Ezeonwu, M. C. (2013). Nursing education and workforce development: Implications for maternal health in Anambra State, Nigeria. *International Journal of Nursing and Midwifery*, ***5***(3), pp.35-45.

Ezeonwu, M. C. (2011). Maternal birth outcomes: processes and challenges in Anambra State, Nigeria. *Health Care for Women International*, ***32***(6), pp.492-514.

Ezugwu, E. C., Agu, P. U., Nwoke, M. O., and Ezugwu, F. O. (2014). Reducing maternal deaths in a low resource setting in Nigeria. *Nigerian Journal of Clinical Practice*, ***17***(1), pp.62-66.

Fakeye, T. O., Adisa, R., and Musa, I. E. (2009). Attitude and use of herbal medicines among pregnant women in Nigeria. *BMC Complementary and Alternative medicine*, ***9***(1), p.53.

Fawole, A., Shah, A., Fabanwo, A., Adegbola, O., Adewunmi, A., Eniayewun, A., Dara, K., El-Ladan, A., Umezulike, A. and Alu, F. (2012), "Predictors of maternal mortality in institutional deliveries in Nigeria". *African Health Sciences,* **12**(1), pp.32-40.

Federal Ministry of Health Nigeria (2010) National Family Planning/ Reproductive Health Service Protocols (online). Available from: http://www.health.gov.ng/doc/FPRHProtocols.pdf (Accessed on September 2016).

Federal Ministry of Health (FMOH), (2009). Midwives Service Scheme: Abuja, Nigeria, Federal Ministry of Health and National Primary Health Care Development Agency. Nigeria. Planted News, Lagos, Nigeria, The Nigerian Tribune, p. 6. Available [online] at: www.achpr.org/files/sessions/56th/.../staterep5_**nigeria**_2013_eng.pdf. Accessed, Augst 10, 2015.

Federal Ministry of Health (FMoH), (2004a). Health Sector Reform: 2004-2007, Abuja, Nigeria, Federal Ministry of Health. Available [online] at: www.who.int/pmnch/countries/**nigeria**-plan-chapter-3.pdf. Accessed, August 10, 2015.

Federal Ministry of Health (FMoH) (2004b). Revised National Health Policy, Federal Ministry of Health. Reduce Maternal and Newborn Death in Nigeria: Make Pregnancy Safer, Abuja, Nigeria, Federal Ministry of Health. Available [online] at: www.savethechildren.org/.../**NIGERIA**-**NEWBORN**-**HEALTH**-REPORT-20. Accessed, August 10, 2015.

Federal Ministry of Health (1999) *Organisation of Health Sector*. Abuja, Nigeria: Federal Ministry of Health.

Ferguson, A. (1984). Sex war: The debate between radical and libertarian feminists. *Signs: journal of women in culture and society*, **10**(1), pp 106-112.

Fetterman, D. (2010*) Ethnography: step by step*. 3rd edition. London: Sage.

Fielding, N. and Thomas, H. (2001) 'Qualitative interviewing', in Gilbert, N (ed.), Researching in social life (2nd edition). London: Sage.

Finlay, L. (2003). *The reflexive journey: Mapping multiple routes*. In: L. Finlay and B. Gough (eds.) Reflexivity: A Practical Guide for Researchers in Health and Social Sciences (pp. 3-21). Oxford: Blackwell Science.

Firestone, S. (1970). The dialect of sex. *The Case for Feminist Revolution, New York: Morrow*.

Flax, J. (1990). *Thinking fragments: Psychoanalysis, feminism, and postmodernism in the contemporary West*. University of California Press.

Foster, G. M., and Anderson, B. G. (1978). *Medical anthropology*. John Wiley & Sons, Inc. 605 3rd Avenue, New York, NY 10016, USA.

Freire, P. (2000). Pedagogy of the oppressed. New York, NY: Continuum International.

Galadanci., Ejembi, C., Iliyasu, Z. and Umar, U. (2007). Maternal health in Northern Nigeria- a far cry from ideal, *BJOG: An International Journal of Obstetrics and Gynaecology*, **14**(4), pp. 448-452.

Gallie, D. (2013). Direct participation and the quality of work. *Human Relations,* **66**(4), pp.453-473.

Gandonu, A. (1978). *Nigeria's 250 ethnic groups: realities and assumptions*. In: Holloman, R. E. and Arutiunov, S. A. (eds) Perspectives on Ethnicity. Paris: Mouton Publisher.

Garry, Ann, Serene J. Khader, and Alison Stone (eds), 2017, The Routledge Companion to Feminist philosophy, New York Routledge.

George, J. and Jones, G. (2008). *Understanding and Managing Organizational Behaviour*, (5th edition) Upper Saddle River, New Jersey, McGraw- Hill Professional.

Geertz, C. (2000). *Local knowledge: Further essays in interpretive anthropology.* Basic books.

Geertz, C. (1973). *Quantitative Research Method: A Health Focus.* Oxford, Oxford University Press.

Geller, S. E., Cox, S. M., Callaghan, W. M., and Berg, C. J. (2006). Morbidity and mortality in pregnancy: laying the groundwork for safe motherhood. *Women's health issues*, ***16***(4), pp.176-188.

Gerring, J. (2004). What is a case study and what is it good for? *The American Political Science Review.* **98** (2), pp.341–354.

Gerrish, Kate and Lacey, Ann (eds) (2006) The Research Process in Nursing, 5th edn. Oxford: Blackwell.

Gerstl-Pepin, C., and Patrizio, K. (2009). Learning from Dumbledore's pensieve: Metaphor as an aid in teaching reflexivity in qualitative research. *Qualitative Research*, ***9***(3), pp.299-308.

Giddens, A. (2012). *Sociology* (4th Edition) UK: Polity Press.

Gill, P., Stewart, K., Treasure, E., and Chadwick, B. (2008). Methods of data collection in qualitative research: interviews and focus groups. *British Dental Journal*, ***204***(6), p.291.

Given, L. M. (2008). *The sage encyclopedia of qualitative research methods* Sage Publications.

Gläser, J., and Laudel, G. (2013). Life with and without coding: Two methods for early-stage data analysis in qualitative research aiming at causal explanations. In *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research****,14***(2).

Glaser, B. G. and Strauss, A. L. (1967). The discovery of grounded theory: strategies for qualitative research. New York: Aldine De Gruyter.

Goldkuhl, G. (2012). Pragmatism vs interpretivism in qualitative information systems research. *European Journal of Information Systems,* **21**(2), pp.135-146.

Graczyk, K. (2007). “Adolescents Maternal Mortality: An Overlooked Crisis”. From Advocates for youth. Available [online] at: http://www.advocatesfor youth.org/publication/. Accessed on August 10, 2015.

Graneheim, U. H., and Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse education today*, ***24***(2), pp.105-112.

Gray, D.E. (2014), *Doing research in the real world.* 3rd edition. London*:* SAGE publication.

Green, J., Thorogood, N., (2009). Qualitative Methods for Health Research. Sage Publications, London, pp.198–203.

Grenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. The University of Chicago Legal Forum, **140**, pp 139-168.

Grbich, C. (2012). *Qualitative data analysis: An introduction* Sage.

Griffith, A. I. (1998). Insider/Outsider: Epistemological Privilege and Mothering Work. Human Studies, **21**(4), pp.361-376.

Grotegut, C. A., Chisholm, C. A., Johnson, L. N., Brown, H. L., Heine, R. P., and James, A. H. (2014). Medical and obstetric complications among pregnant women aged 45 and older. *PLoS One*, ***9***(4), pp.e96237.

Guba, E. G., and Lincoln, Y. S. (2005). Paradigmatic controversies, contradictions, and emerging confluences.

Guba, E.G. and Lincoln, Y.S. (1994) *competing paradigm in qualitative research'*. In: Denzin, N.K. and Lincoln, Y.S. (eds.) Handbook of qualitative Research. thousand Oaks, CA: Sage.

Guba, E. G. (ed) (1990) The paradigm dialog. Newbury Park, CA: Sage.

Guerrier, G., Oluyide, B., Keramarou, M. and Grais, R. (2013). High maternal and neonatal mortality rates in Northern Nigeria: an 8-month observational study. *International Journal of Women's Health,* ***5*****:** pp.495-499.

Gyekye, K. (1996). *African cultural values: An introduction*. Sankofa Publishing Company.

Ha, W., Salama, P., Gwavuya, S., and Kanjala, C. (2014). Is religion the forgotten variable in maternal and child health? Evidence from Zimbabwe. *Social Science and medicine*, ***118***: pp.80-88.

Hall, W. A. and Gallery, P. (2001). Enhancing the rigor of grounded theory: Incorporating reflexivity and relationality. *Qualitative Health Research*, **11**(2), pp.257-272.

Hammersley, M. and Atkinson, P. (2007). *Ethnography: Principles in Practice*. Routledge, New York.

Hammersley, M. (2006). Philosophy's contribution to social science research on education. *Journal of Philosophy of Education,* **40**(2), pp.273-286.

Harding, S. G. (2004). *The feminist standpoint theory reader: Intellectual and political controversies* Psychology Press.

Hare-Mustin, R. T. and Marecek, J. (1995). *Making a difference: Psychology and the construction of gender* Yale University Press.

Harris, J. L., Fleming, V. B. and Harris, C. L., (2012). 'A focus on health beliefs: What culturally competent clinicians need to know', Perspectives on Communication Disorders and Sciences in Culturally and Linguistically Diverse Populations **19**(2), pp, 40–48.

Harrison, K. A. (2011). Are traditional birth attendants good for improving maternal and perinatal health? No. *Bmj*, *342*, d3308.

Hanson, D. (2010). *Data on Maternal Mortality: Historical information compiled for 14 countries (up to 200 years).*

Hatamleh, R., Shaban, I. A., and Homer, C. (2013). Evaluating the experience of Jordanian women with maternity care services. *Health Care for Women International*, **34**(6), pp. 499-512.

Hesse-Biber, S. N. (2007). The practice of feminist in-depth interviewing. *Feminist research practice: A primer*, *111148*, pp. 111-138.

Heywood, A. (2002). Political Ideology. Chapter 3 In. *Politics*, *2*.

Hill, T. D., Ellison, C. G., Burdette, A. M., Taylor, J., and Friedman, K. L. (2016). Dimensions of religious involvement and leukocyte telomere length. *Social Science and Medicine*, ***163*****:** pp.168-175.

Hillier, D. (2013). *Childbirth in the global village: Implications for midwifery education and practice*. Routledge.

Hoang, H.T., Le, Q. and Kilpatrick, S.I., (2009). 'Having a baby in the new land: A qualitative exploration of the experiences of Asian migrants in rural Tasmania, Australia', Rural and Remote Health **9**(1), p. 1084.

Holmes, M. (2010). The emotionalization of reflexivity. *Sociology,* **44**(1), pp. 139-154.

Homer, C. S., Friberg, I. K., Dias, M. A. B., ten Hoope-Bender, P., Sandall, J., Speciale, A. M., and Bartlett, L. A. (2014). The projected effect of scaling up midwifery. *The Lancet*, ***384*****(**9948), pp. 1146-1157.

Holloway, I. and Biley, F. C. (2011). Being a qualitative researcher. *Qualitative Health Research,* **21**(7), pp. 968-975.

Holton, J. A. (2007). The coding process and its challenges. *The Sage handbook of grounded theory,* (Part III), pp. 265-289.

Hunt, P. and Bueno, D. M. (2007). Reducing Maternal Mortality: The Contribution of the Right to the Highest Attainable Standard of Health. United Nation Population Fund.

Hunt, S. C., and Symonds, A. (1995). *The social meaning of midwifery*. Macmillan International Higher Education.

Ibeh, C. C. (2008). Is poor maternal mortality index in Nigeria a problem of care utilization? A case study of Anambra State. *African Journal of Reproductive Health,* **12**(2), pp. 132-140.

Ibor, U. W., Anjorin, O. A., Ita, A. E., Otu, M. A. and Bassey, T. I. (2011). Utilization of antenatal care in Ibadan north local government area, Oyo state, Nigeria. *Trends in Medical Research*, ***6***(4), pp. 273-280.

Ibrahim, D. O., (2016). Social-Economic Determinants of Maternal Mortality in Rural Communities of Oyo State, Nigeria. *International Journal of Scientific and Research Publications*, ***6***(9), pp. 280-5.

Idowu, A., Deji, S. A., Ogunlaja, O., and Olajide, S. O. (2015). Determinants of intention to use post partum family planning among women attending immunization clinic of a tertiary hospital in Nigeria. *American Journal of Public Health Research*, ***3***(4), pp. 122-127.

Idowu, A. E, Osinaike, M. O, and Ajayi, M. P. (2011). Maternal Health Challenges and Prospects for National Development: A Study of Badagry Local Government, Lagos State. *Gender and Behaviour, **9***(20), pp. 4224-4246.

Idris, S. H., Sambo, M. N., and Ibrahim, M. S. (2013). Barriers to utilisation of maternal health services in a semi-urban community in northern Nigeria: The clients' perspective. *Nigerian medical journal: journal of the Nigeria Medical Association*, pp. *54*(1), 27.

Igboanugo, G. M., and Martin, C. H. (2011). What are pregnant women in a rural Niger Delta community's perceptions of conventional maternity service provision? An exploratory qualitative study. *African journal of reproductive health*, ***15***(3), pp. 63-77.

Igwegbe, A. O., Eleje, G. U., Ugboaja, J. O. and Ofiaeli, R. O. (2012). "Improving maternal mortality at a university teaching hospital in Nnewi, Nigeria". *International Journal of Gynecology & Obstetrics,* **116**(3), pp. 197-200.

Ikpeazu, A. E. (2018). Can the Midwives Service Scheme (MSS) present an effective and health systems strengthening response to the shortages in human resources for maternal health services in Nigeria? DrPH thesis, London School of Hygiene & Tropical Medicine. DOI: https://doi.org/10.17037/PUBS.04647053.

Ingebrenebor, U. (2013). Bridging the Gap between Concept and Reality in the Nigerian Midwives Service Scheme. *International Journal of Community Research*, *2*(4), 58-63.

Innes, R. A. (2009). "Wait a second. Who are you anyways?": The insider/outsider debate and American Indian studies. *American Indian Quarterly*, **33**(4), pp. 440-461,601.

International Labour Organisation (ILO), (2010). Maternity Protection at Work: A key Human Right to Prevent Maternal Mortality and Morbidity. Available [online] at: www.ohchr.org/english/issues/women/docs/responses/ilo. Accessed, August 10, 2015.

International Code of Ethics for Midwives (2018). Roles of midwives (online) available from: https://www.internationalmidwives.org/our-work/policy-and-practice/international-code-of-ethics-for-midwives.html.

Isenalumbe, A. E. (1990). Integration of traditional birth attendants into primary health care.

Iyaniwura, C. A. and Yussuf, Q. (2009). Utilization of antenatal care and delivery services in Sagamu, south western Nigeria. *African journal of reproductive health*, ***13***(3).

Izugbara, C. O. and Wekesah, F. (2018). What does quality maternity care mean in a context of medical pluralism? Perspectives of women in Nigeria. Health Policy Plan. ***33***(1), pp. 1–8

Izugbara C., Wekesah F. M. and Adedini S. A. (2016). Maternal Health in Nigeria: A Situation Update Nairobi, African Population and Health Research Center (APHRC).

Izugbara, C. and Ukwanyi, J. (2007). *The hospital as a birthing site: narratives of local women in Nigeria in: Reproduction, Childbearing and Motherhood*. Nova Sciences Publishers, pp. 143-158.

Jackson, C. (2001). *Men at Work: Labour, Masculinities, Development*. New York: Routledge.

Janevic, T., Sripad, P., Bradley, E. and Dimitrievska, V. (2011). " There's no kind of respect here" A qualitative study of racism and access to maternal health care among Romani women in the Balkans. *International journal for equity in health*, ***10***(1), p. 53.

Jaggar, A. (1992). Feminist Ethics. In Becker L, Becker C (eds), Encyclopedia of ethics. Garland, New York.

Jegede, A. S. (2010). *African Culture and health*. Ibadan: BookWright Publishers.

Joffe, H. and Yardley, L. (2004). 4. content and thematic analysis. *Research Methods for Clinical and Health Psychology.California: Sage,* pp. 56-68.

Johnson, E. O., Roth, T. and Breslau, N. (2006). The association of insomnia with anxiety disorders and depression: exploration of the direction of risk. *Journal of psychiatric research*, ***40***(8), pp. 700-708.

Joseph K. S, Liston R. M., Dodds, L., Dahlgren, L. and Allen, A. C. (2007). Socioeconomic Status and Prenatal Outcomes in a Setting with Universal Access to Essential Health Care Services. *Canadian Medical Association Journal*, **177**(6), pp. 583-590.

Kabeer, N. (1994). *Reversed Realities: Gender Hierarchies in Development*. New York: York House Typographic Ltd.

Kabir, M., Iluyasu, Z., Abubakar, I. S. and Sani, A. A. (2005). Determinants of Utilization of Antenatal Care Services in Kumbotso Village, Northern Nigeria. *Tropical Doctor*, **35:** pp. 110-111.

Kagawa-Singer, M., Dressler, W. W., George, S. M. and Elwood, W. N. (2015). The cultural framework for health. *Washington, DC: National Institutes of Health*.

Kana, M. A., Doctor, H. V., Peleteiro, B., Lunet, N., and Barros, H. (2015). Maternal and child health interventions in Nigeria: a systematic review of published studies from 1990 to 2014. *BMC Public Health*, ***15*****(**1), pp. 334.

Kanyoro, R. A. (2002). Introducing Feminist Cultural Hermeneutics an African Perspective.

Kao, C. and Lincoln, B. (2004). Simple stability criteria for systems with time-varying delays. *Automatica,* **40**(8), pp. 1429-1434.

Kawulich, B. (2012). *Selecting a research approach: Paradigm, methodology and methods*. In: Wagner, C., Kawulich, B., Garner, M. (eds) Doing Social Research; A global context. London: McGraw Hill.

Kawuwa, M. B., Mairiga, A. G. and Usman, H. A. (2007). Community perspective of maternal mortality: Experience from Konduga local government area, Borno State, Nigeria. *Annals of African Medicine,* **6**(3), pp. 109-114.

Kayne, S. B. and Whitehouse, P.J., (2009). Complementary and alternative medicine. *The Journal of Alternative and Complementary Medicine*, *15*(12), pp.1383-1384.

Kenneth, D. M., Marvellous, M., Stanzia, M., and Memory, D. M. (2016). Praying until death: apostolicism, delays and maternal mortality in Zimbabwe. *PloS one*, ***11***(8), e0160170.

Keenan, K. F., van Teijlingen, E. and Pitchforth, E. (2015). The analysis of qualitative research data in family planning and reproductive health care. *Journal of Family Planning and Reproductive Health Care,* **31**(1), pp. 40-43.

Kessing, L.V., Jensen, H. M., Grøn, R., Lidegaard, Ø., Pedersen, L. H., and Andersen, P. K. (2013). The effects of maternal depression and use of antidepressants during pregnancy on the risk of a child small for gestational age. *Psychopharmacology,* **228**(2), pp. 199-205.

Kezar, A. (2002). Reconstructing static images of leadership: An application of positionality theory. Journal of Leadership Studies, **8**(3), pp. 94-109.

Khan, F. (2008). Understanding the spread of systemic corruption in the Third World. *American review of political economy*, ***6***(2), 16.

Khanlou, N., Haque, N., Skinner, A., Mantini, A., and Kurtz Landy, C. (2017). Scoping review on maternal health among immigrant and refugee women in Canada: prenatal, Intrapartum, and postnatal care. *Journal of pregnancy*, *2017*.

Kingdon, C. (2005). Reflexivity: Not just a qualitative methodological research tool. *British Journal of Midwifery,* **13**(10), pp. 622-627.

Kitayama, S., Markus, H. R., Matsumoto, H., and Norasakkunkit, V. (1997). Individual and collective processes in the construction of the self: self-enhancement in the United States and self-criticism in Japan. *Journal of personality and social psychology*, ***72***(6), pp. 1245.

Kistiana, S. (2009). *Socio-Economic and Demographic Determinants of Maternal Health Care Utilization in Indonesia*. Unpublished Master's Thesis, The Flinders University of South Australia, Adelaide.

Kitzinger, J. (1995). Qualitative research: introducing focus groups. *British Medical Journal*, **311**(7000), p. 299.

Kitzinger, J. (1994). The Methodology of Focus Groups: The Importance of Interaction between Research Participants. *Sociology of Health and illness*, **16**: pp. 103-121.

Kleinman, S. (1991). Field-workers' feelings: What we feel, who we are, how we analyse. In W. B. Shaf®r and R. A. Stebbins (Eds.), Experiencing ®eldwork: An inside view of qualitative research (pp. 184±195). Newbury Park, CA: Sage.

Knight, M., Acosta, C., Brocklehurst, P., Cheshire, A., Fitzpatrick, K., Hinton, L., ... and Lindquist, A. (2016). Beyond maternal death: improving the quality of maternal care through national studies of 'near-miss' maternal morbidity.

Kroeber, A. L. and Kluckhohn, C. (1952). Culture: A critical review of concepts and definitions. *Papers.Peabody Museum of Archaeology and Ethnology,* Harvard University.

Kroeze, J. H. (2011). Interpretivism in information systems: a postmodern epistemology*. Sprouts: Working Papers on Information Systems,* **11**:171.

Krueger, R. A., and Casey, M. A. (2014). *Focus groups: A practical guide for applied research* Sage publications.

Lahiri-Dutt, K. (2007). *Diluted Citizenship: Women, water and rights in the midst of inequities in India* (No. 07/02). Participatory development working papers.

Lambert, V. A., and Lambert, C. E. (2012). Qualitative descriptive research: An acceptable design. *Pacific Rim International Journal of Nursing Research, **16***(4), pp.255-256.

Lambert, C., Jomeen, J., and McSherry, W. (2010). Reflexivity: A review of the literature in the context of midwifery research. *British Journal of Midwifery*, ***18***(5), pp.321-326.

Lanre-Abass, B. A. (2008). Poverty and maternal mortality in Nigeria: Towards a more viable Ethics of Modern Medical Practice. *International Journal for Equity in Health. Vol. 7* http://www.equityhealthj.com/content/7/1/11. Accessed, August 10, 2015.

Larson, J. S. (1999). The conceptualization of health. *Medical care research and review*, **56(**2), pp.123-136.

Lawoyin, T. O., Lawoyin, O. O. C. and Adewole, D. A. (2007). Men's Perception of Maternal Mortality in Nigeria. *Journal of Public Health Policy*, **28:** pp.299-318.

Lawson, G.W. and Keirse, M.J., (2013). Reflections on the maternal mortality Millennium Goal. *Birth,* **40**(2), pp.96-102.

LeGrand, S., Scheid, T. L., and Whetten, K. (2016). The Differential Impact of Social Relationships on Health Outcomes for HIV Positive Men and Women. In *Special Social Groups, Social Factors and Disparities in Health and Health Care*, pp.153-174. Emerald Group Publishing Limited.

Leslie, H., and McAllister, M. (2002). The benefits of being a nurse in critical social research practice. *Qualitative Health Research*, ***12***(5), pp.700-712.

Levac, D., Colquhoun, H., and O'Brien, K. K. (2010). Scoping studies: advancing the methodology. *Implementation Science*. **5**: p.69.

Levine, S. (2017). *Social stress*. Routledge.

Lewis, J. L., and Sheppard, S. R. (2006). Culture and communication: can landscape visualization improve forest management consultation with indigenous communities? *Landscape and Urban Planning*, ***77***(3), pp.291-313.

Lieberson, S. (2000). *A matter of taste: How names, fashions, and culture change*. Yale University Press.

Lincoln, Y. S., and Guba, E. G. (2000). The only generalization is: There is no generalization. *Case study method*, pp. 27-44.

Lincoln, Y. S. and Guba, E. G. (1985). *Naturalistic Inquiry*. Beverly Hills, CA.: Sage.

LoBiondo-Wood, G. and Harber, J. (2006). *Methods and Critical Appraisal of Evidence-Based Practice*. St. Louis: Mosby.

Lofland, J., and Lofland, L. H. (1971). Analyzing social settings.

Löhr, G. (2019). Social constructionism, concept acquisition and the mismatch problem. *Synthese*, pp.1-15.

Longhurst, B., Smith, G., Bagnall, G., Crawford, G., Ogbom, M., Baldwin, E. and MacCracken, S. (2008). Cultural theories. In E. Baldwin and S, MacCracken (eds), Introducing cultural studies, 2nd edition (pp. 107-303). Harlow: Pearson Longman.

Louik, C., Gardiner, P., Kelley, K., and Mitchell, A. A. (2010). Use of herbal treatments in pregnancy. *American journal of obstetrics and gynecology*, ***202***(5), pp.439-e1.

Lowe, M., Chen, D. R. and Huang, S. L. (2016). Social and Cultural Factors Affecting Maternal Health in Rural Gambia: An Exploratory Qualitative Study. *PLoS ONE* **11**(9): e0163653. doi:10.1371/journal.pone.0163653.

Machiyama, K., Hirose, A., Cresswell, J.A., Barreix, M., Chou, D., Kostanjsek, N., Say, L. and Filippi, V. (2017). Consequences of maternal morbidity on health-related functioning: a systematic scoping review. *BMJ open*, *7*(6), p.e013903.

Macnee, C. L., and McCabe, S. (2008). *Understanding nursing research: Using research in evidence-based practice*. Lippincott Williams and Wilkins.

Mackay, F. (2015). Radical Feminism. *Theory, Culture and Society*, ***32***(78), pp.332-336.

Madiforo, A, N., (2010). Superstition and nutrition among pregnant women in Nwangele Local Government Area of Imo State, Nigeria. Journal of Research in National Development, **8**(2): pp.16-20

Madsen, D. L. (2000). *Feminist theory and literary practice*. Pluto press.

Makama, G. A. (2013). Patriarchy and gender inequality in Nigeria: the way forward. *European Scientific Journal*, ***9***(17).

Male, T. (2016). Analysing qualitative data. *Doing research in education: Theory and practice*, pp.177-191.

Malinowski, B. (1922). *Argonaunts of the Western Pacific, London*. London: Routledge and Kegan.

Marchie, C. L. (2012). Socio-cultural factors as correlates of maternal mortality in Edo South Senatorial District, Nigeria. *Asian Pacific Journal of Reproduction,* **1**(4), pp.315-317.

Marchie, C. L. and Anyanwu, F. C. (2008). A Comparative study of socio-cultural factors contributing to maternal mortality in urban and rural Areas of the Southern part of Edo State, Nigeria. *Asian Women Journal,* **24**(3), pp.43-54.

Markula, P. and Silk, M. L. (2011). *Qualitative research for physical culture* Springer.

Mateos, P., Longley, P. A., and O'Sullivan, D. (2011). Ethnicity and population structure in personal naming networks. *PloS one*, ***6***(9), e22943.

Matsumura, M., and Gubhaju, B. (2001). Women's Status, Household Structure and the Utilization of Maternal Health Services in Nepal: Even primary-leve1 education can

significantly increase the chances of a woman using maternal health care from a modem health facility. *Asia-Pacific Population Journal*, ***16***(1), pp.23-44.

Mattebo, M., Lindkvist, M., Pedersen, C., Sayami, J., and Erlandsson, K. (2016). The influence of a patriarchal culture on women's reproductive decision-making: exploring the perceptions of 15 Nepali healthcare providers. *Evidence Based Midwifery.*, ***14***(3), pp.94-100.

Mavalankar, D. V., and Rosenfield, A. (2005). Maternal mortality in resource-poor settings: policy barriers to care. *American Journal of Public Health*, ***95***(2), pp.200-203.

May, T. (2002). *Qualitative Research in Action*. London, Sage Publications.

Mboho, M., Furber, C. and Waterman, H. (2013). Social-cultural practices and beliefs influencing maternal mortality". *African Journal of Midwifery and Women's Health,* **7**(1), pp.26-31.

MBRRACE-UK (2016). Saving Lives, Improving Mothers' Care 2016 (online) Available from: https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202016%20-%20website.pdf (Accessed on January, 2017).

McGarry, O. (2015). Repositioning the research encounter: exploring power dynamics and positionality in youth research. *International Journal of Social Research Methodology*. **19**(3), pp.339-354.

McGhee, G., Marland, G. R. and Atkinson, J. (2007). Grounded theory research: literature reviewing and reflexivity. *Journal of Advanced Nursing,* **60**(3), pp.334-342.

McLeroy, K. R., Bibeau, D., Steckler, A., and Glanz, K. (1988). An ecological perspective on health promotion programs. Health Education Qarterly, **15**(4), pp.351-377.

McMahon, S. A., George, A. S., Chebet, J. J., Mosha, I. H., Mpembeni, R. N., and Winch, P. J. (2014). Experiences of and responses to disrespectful maternity care and abuse during childbirth; a qualitative study with women and men in Morogoro Region, Tanzania. *BMC pregnancy and childbirth*, ***14***(1), p.268.

Mekonnen, Y., and Mekonnen, A. (2003). Factors influencing the use of maternal healthcare services in Ethiopia. *Journal of Health, Population and Nutrition*, pp.374-382.

Mensah, F. A. (2008). The Spiritual Basis of Health and Illness in Africa. In Falola, T and Heaton, M. M (Ed). *Health Knowledge and Belief Systems in Africa.* USA: Carolina Academic Press. Pp.171-180.

Miller, N. E. (1941). I. The frustration-aggression hypothesis. *Psychological review*, *48*(4), p.337.

Miles, M. B. and Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* Sage.

Milligan, L. (2016) Insider-outsider-inbetweener? Researcher positioning, participative methods and cross-cultural educational research. Compare: *A Journal of Comparative and International Education*. **46**(2), pp.235-250.

Millett, K. 1977. Sexual Politics. London: Virago.

Moffat, L., Geadah, Y and Stuart, R. (1991). *Two halves make a whole: balancing gender relations in development.* Canadian council for international co-operation, MATCH International centre, Ottawa, ON Canada.

Moher, D., Stewart, L., and Shekelle, P. (2015). All in the family: Systematic reviews, rapid reviews, scoping reviews, realist reviews, and more. Systematic Reviews, **4**(1), pp.183–194. doi: 10.1186/s13643-015-0163-7.

Mojekwu, J. and Ibekwe, U. (2012). Maternal Mortality in Nigeria: Examination of Intervention Methods'. *International Journal of Humanities and Social Science,* **2**(20), pp.23-34.

Monjok, E., Smesny, A., and Essien, E. J. (2009). HIV/AIDS-related stigma and discrimination in Nigeria: review of research studies and future directions for prevention strategies. *African Journal of Reproductive Health*, ***13***(3),

Monti, E. J. and Tingen, M. S. (1999). Multiple paradigms of nursing science. *Advances in Nursing Science,* **21**(4), pp.64-80.

Moon, K. and Blackman, D. (2014) A Guide to Understanding Social Science Research for Natural Scientists. *Conservation Biology*. **28** (55), pp.1167-117.

Moore, B., Alex-Hart, B. and George, I., (2011). Utilization of health care services by pregnant mothers during delivery: a community-based study in Nigeria. *Age*, *15*, p.4.

Moran, A. C., Jolivet, R. R., Chou, D., Dalglish, S. L., Hill, K., Ramsey, K., ... and Say, L. (2016). A common monitoring framework for ending preventable maternal mortality,

2015–2030: phase I of a multi-step process. *BMC pregnancy and childbirth*, ***16***(1), p.250.

Mordi, C. and Ojo, S. (2011). Work-Life Balance Practices in The Banking Sector: Insights from Nigeria. *Ife Psychological*, **19**(2), pp.285-295.

Morehouse, R. E. (2012). *Beginning interpretive inquiry: A step-by-step approach to research and evaluation.* Routledge.

Morgan, D. L. (1998). *The Focus Group Guidebook*. Thousand Oaks CA, Sage.

Morris, J. L., Short, S., Robson, L., and Andriatsihosena, M. S. (2014). Maternal health practices, beliefs and traditions in southeast Madagascar. *African Journal of Reproductive Health*, ***18***(3), pp.101-117.

Moser, C. O. N. (2012). *Gender planning and development: Theory, practice and training*. London: Routledge.

Morse, J. M. (2003). *Principles of mixed methods and multimethod research design*. In A. Tashakkori and C. Teddlie (Eds.), Handbook of mixed methods in social and behavioural research (pp.189–208). Thousand Oaks, CA: Sage.

Morse, J. (2001). *Situating grounded theory within qualitative enquiry*. In: R. Schreiber, and P. Stern (eds.) Using Grounded Theory in Nursing. New York: Springer Publishing Company.

Mothupi, M. C. (2014). Use of herbal medicine during pregnancy among women with access to public healthcare in Nairobi, Kenya: a cross-sectional survey. *BMC complementary and alternative medicine*, ***14***(1), p.432.

Moustakas, C. (1994). *Phenomenological research methods*. Sage.

Moyer, C. A., Adongo, P. B., Aborigo, R. A., Hodgson, A., and Engmann, C. M. (2014). 'They treat you like you are not a human being': maltreatment during labour and delivery in rural northern Ghana. *Midwifery*, ***30***(2), pp.262-268.

Mpembeni, R. N., Killewo, J. Z., Leshabari, M. T., Massawe, S. N., Jahn, A., Mushi, D., and Mwakipa, H. (2007). Use pattern of maternal health services and determinants of skilled care during delivery in Southern Tanzania: implications for achievement of MDG-5 targets. *BMC Pregnancy and Childbirth*, ***7***(1), p. 29.

Mullick, S., Kunene, B., and Wanjiru, M. (2005). Involving men in maternity care: health service delivery issues. *Agenda Special Focus*, *6*: pp.124-35.

Munn, Z., Peters, M. D., Stern, C., Tufanaru, C., McArthur, A., and Aromataris, E. (2018). Systematic review or scoping review? Guidance for authors when choosing between a systematic or scoping review approach. *BMC Medical Research Methodology*, ***18***(1), pp.143.

Namageyo-Funa, A., Rimando, M., Brace, A. M., Christiana, R. W., Fowles, T. L., Davis, T. L., ... and Sealy, D. A. (2014). Recruitment in qualitative public health research: Lessons learned during dissertation sample recruitment. *The Qualitative Report*, ***19***(4), pp.1-17.

Namasivayam, A., Osuorah, D. C., Syed, R., and Antai, D. (2012). The role of gender inequities in women's access to reproductive health care: a population-level study of Namibia, Kenya, Nepal, and India. *International Journal of Women's Health*, ***4:*** pp.351.

National Bureau of Statistics (2018). Labor Force Statistics - Volume I: Unemployment and Underemployment Report (online) Available from: file:///C:/Users/99903901/Downloads/q4_2017_-_q3_2018_unemployment_report.pdf.

National Bureau of Statistics. (2017). Labour force statistics Vol. 1: Unemployment and underemployment report.

National Institutes of Health (NIH), (2008). "Protecting Human Research Participants." Retrieved October 2016, from http://phrp.nihtraining.com.

National Population Commission (NPC) and ICF Macro (2014). Nigeria Demographic and Health Survey 2013. Abuja, Nigeria.

National Population Commission (NPC) (2010). Nigeria Demographic and Health Survey 2008. Abuja, Nigeria: National Population Commission and ICF Macro. Available [online] at: dhsprogram.com/pubs/pdf/fr222/fr222.pdf. Accessed on July 21, 2015.

Nawaz, F. (2012). Overview of Corruption and Anti-Corruption in Malawi.

Ndep, A. (2014). Informed community participation is essential to reducing maternal mortality in Nigeria. *International Journal of Health and Psychology Research,* **2**(1), pp.26-33.

Ndiaye, K., Portillo, E., Ouedraogo, D., Mobley, A., and Babalola, S. (2018). High-Risk Advanced Maternal Age and High Parity Pregnancy: Tackling a Neglected Need Through Formative Research and Action. *Global Health: Science and Practice*, ***6***(2), pp.372-383.

Ndikom, C. M., Ojoye, T. O. and Nkwonta, C. A., (2017). Factors Influencing the Choice of Health Care Provider during Childbirth by Women in Ibadan, Oyo State, Nigeria. *International Journal of Caring Sciences*, ***10***(1), p.511.

Ndububa, V. I. (2007). Medical quackery in Nigeria; why the silence? *Nigerian journal of medicine: journal of the National Association of Resident Doctors of Nigeria*, ***16***(4), pp.312-317.

Nencel, L. (2014, March). Situating reflexivity: Voices, positionalities, and representations in feminist ethnographic texts. In *Women's Studies International Forum* (Vol. 43, pp. 75-83). Pergamon.

Newell, R. and Burnard, P. (2011) Research for Evidence-Based Practice in healthcare. 2nd edition. Oxford: Blackwell.

Ngozo, C. (2011). Malawi: uncertainty over role for traditional birth attendants. *global issues*.

Nielson, N. R., Kristensen, T. S., Schnohr, P., and Gronbaek, M. (2008). Perceived stress and cause-specific mortality among men and women: Results from a prospective study. *American Journal of Epidemiology*, ***168***(5), pp.481-491.

Nigeria Demographic and Health Survey (2018). Nigeria Demographic and Health Survey 2018: maternal mortality data (online) Available from: https://www.dhsprogram.com/pubs/pdf/FR359/FR359.pdf.

Nigeria Demographic and Health Survey (2013). Nigeria Demographic and Health Survey 2013 (online) Available from: https://dhsprogram.com/pubs/pdf/FR293/FR293.pdf.

Nigeria Bixby center (2012). Bixby centre for population, Health, and Sustainability. University of California, Berkeley bixby.berkeley.edu/research/maternal-health/miso/Nigeria.

Nigeria Demographic and Health Survey (NDHS) (2010). Nigeria: DHS, 2010—Final Report. Measure DHS, Calverton. Available [online] at: www.unicef.org/**nigeria**/ng_publications_**Nigeria_DHS**_2008_**Final_Rep**. Accessed, August 10, 2015.

Nsirim, R. O., Iyongo, J. A., and Olayinka Adekugbe, M. U. (2015). Integration of traditional birth attendants into prevention of mother-to-child transmission at primary health facilities in Kaduna, North-West Nigeria. *Journal of Public Health in Africa*, ***6***(1).

Nursing and Midwifery Council of Nigeria (2019). Codes of professional conducts (online) Available from: https://www.nmcn.gov.ng/codec2.html.

Obaid, T. A. (2009). Fifteen years after the International Conference on Population and Development: What have we achieved and how do we move forward. *International Journal of Gynecology and Obstetrics*, ***106***(2), pp.102-105.

Obansa, S. A. J., and Orimisan, A. (2013). Health care financing in Nigeria: prospects and challenges. *Mediterranean Journal of Social sciences*, ***4***(1), pp.221-236.

Obiechina, N., Okolie, V., Okechukwu, Z., Oguejiofor, C., Udegbunam, O., Nwajiaku, L., Ogbuokiri, C. and Egeonu, R. (2013). "Maternal mortality at Nnamdi Azikiwe University Teaching Hospital, Southeast Nigeria: a 10-year review (2003–2012)". *International Journal of Women's Health,* **5:** p.431.

Odebiyi, A. (2008). 'Policies and Measures for Achieving Millennium Development Goals in Africa: The Nigerian Case' in Akinnowo, E. (eds) *Socio-Economic Policies and Millennium Development Goals in Africa*. Akure; Logos- Universal Publisher, Inc.

Odetola, T. D., (2015). Health care utilization among rural women of child-bearing age: a Nigerian experience. *The Pan African Medical Journal*, *20*.

Odhiambo, A. (2011). Stop making excuses. Accountability for maternal health care in South Africa.

Oduyoye, M. (2001). *Introducing African women's theology* (Vol. 6). A and C Black.

OECD. Publishing, and Organisation for Economic Co-operation and Development Staff. (2007). *Employment Outlook 2007*. Organisation for Economic Co-operation and Development, (OECD).

Ogba, K. (1995). *Igbo: Heritage Library of African Peoples*. New York: Rosen Publishing Group.

Ogujuyigbe, P. and Liasu, A. (2007). Perception and health-seeking behaviour of Nigerian women about pregnancy-related risks: strategies for improvement. *Journal of Chinese Clinical Medicine,* **2**(11), pp.643-654.

Ogun, R., Okonofua, F., Hammed, A., Okpokunu, E., Mairiga, A., Bako, A., Abass, T., Garba, D., Alani, A. and AgholoR, K. (2012). Outcome of an intervention to improve the quality of private sector provision of postabortion care in northern Nigeria. *International Journal of Gynecology and Obstetrics,* **118**: pp.121-126.

Okafor, I. I., Ugwu, E. O., and Obi, S. N. (2015). Disrespect and abuse during facility-based childbirth in a low-income country. *International Journal of Gynecology and Obstetrics*, ***128***(2), pp.110-113.

Okafor, I. P., Sekoni, A. O., Ezeiru, S.S., Ugboaja, J. O. and Inem, V. (2014). Orthodox versus unorthodox care: a qualitative study on where rural women seek healthcare during pregnancy and childbirth in Southwest, Nigeria. *Malawi Medical Journal*, ***26***(2), pp.45-49.

Okafor, C. B. (2000). Folklore linked to pregnancy and birth in Nigeria. *Western Journal of Nursing Research*, ***22***(2), pp.189-202.

Okeshola, F. B. and Ismail, T. (2013). Determinants of Home Delivery among Hausa in Kaduna South Local Government Area of Kaduna State, Nigeria. *American International Journal of Contemporary Research,* **3**: p.78.

Okolocha, C., Chiwuzie, J., Braimoh, S., Unuigbe, J. and Olumeko, P., (1998). Socio-cultural factors in maternal morbidity and mortality: a study of a semi-urban community in southern Nigeria. *Journal of Epidemiology amd Community Health*, ***52(***5), pp.293-297.

Okonofua, F. E., Ntoimo, L. F. C. and Ogu, R. N., (2018). Women's perceptions of reasons for maternal deaths: Implications for policies and programs for preventing maternal deaths in low-income countries. *Health care for women international*, ***39***(1), pp.95-109.

Okonofua, F., Ogu, R., Agholor, K., Okike, O., Abdus-Salam, R., Gana, M., ... and Galadanci, H. (2017). Qualitative assessment of women's satisfaction with maternal health care in referral hospitals in Nigeria. *Reproductive Health*, ***14***(1), p.44.

Okonofua, F., and Ogu, R. (2017). Editorial Reproductive Health after the US Elections: Implications for subSaharan Africa. *African Journal of Reproductive Health*, ***20***(4).

Okonofua, F. E., Hammed, A., Abass, T., Mairiga, A. G., Mohammed, A. B., Adewale, A. and Garba, D. (2011). Private medical providers' knowledge and practices concerning medical abortion in Nigeria. *Studies in Family Planning,* **42**(1), pp.41-50.

Okorontah, F. C. and Odionye, J. C. (2015). Corruption, corrupt practices and economic development: The Nigeria experience. International Journal of Advanced Research, **3**(2): pp.494-505.

Okpani, A. I., and Abimbola, S. (2015). Operationalizing universal health coverage in Nigeria through social health insurance. *Nigerian Medical Journal: Journal of the Nigeria Medical Association*, ***56***(5), p.305.

Okusanya, B., Aigere, E., Abe, A., Ibrahim, H. and Salawu, R. (2013). "Maternal deaths: initial report of an on-going monitoring of maternal deaths at the Federal Medical Centre Katsina, Northwest Nigeria". *The Journal of Maternal-Fetal and Neonatal Medicine,* **26**(9), pp.885-888.

Oladeji, D. (2008). Socio-cultural and Norms Factors Influencing Family Planning Choice Among Couples in Ibadan Metropolis, Nigeria. *European Journal of Scientific Research,* **23:** pp.212-218.

Oladigbolu, R. A., Oche, M. O., Kaoje, A. U. and Gana, G. J., (2017). Socio–economic Factors Influencing Utilization of Healthcare Services in Sokoto, North-Western Nigeria. *International Journal of Tropical Disease and Health*, pp.1-13.

Olaitan, O. L. (2011). Factors influencing the choice of family planning among couples in South West Nigeria. *International Journal of Medicine and Medical Sciences, **3***(7), pp.227 232.

Olaitan, O. L. (2009). HIV/AIDS' Knowledge and condom usage as preventive measures among University Students in South West Nigeria. *Egypt Academic Journal of Biological Science.* **1**(1), pp.1-5.

Olakunde, B. O. (2012). Public health care financing in Nigeria: which way forward? *Annals of Nigerian Medicine*, ***6***(1), p.4.

Olatunde, O., Gbenga, O. and Temitope, G. (2012). The Trend in Maternal Mortality in an upgraded Tertiary Facility in North Central Nigeria". *Nigerian Journal of Medicine,* **21**(3), pp.282-289.

O'Leary, K. D., Smith Slep, A. M., and O'leary, S. G. (2007). Multivariate models of men's and women's partner aggression. *Journal of Consulting and Clinical Psychology*, ***75***(5), 752.

Olubayo, O. (2013). Son preference in Nigeria: The human rights implications. Lagos, Nigeria: Concept Publication.

Olusegun, A. (2012). 'Curbing Maternal and Child Mortality: The Nigerian Experience'. *International Journal of Nursing and Midwifery*. **4**(3), pp.33-39.

Olusegun, O. L., Ibe, R. T., and Micheal, I. M. (2012). Curbing maternal and child mortality: The Nigerian experience. *International Journal of Nursing and Midwifery*, ***4***(3), pp.33-39.

Omideyi, A. K., Akinyemi, A. I., Aina, O. I., Adeyemi, A.B., Fadeyibi, O. A., Bamiwuye, S. O., Akinbami, C. A. and Anazodo, A. (2011). Contraceptive practice, unwanted pregnancies and induced abortion in Southwest Nigeria. *Global Public Health,* **6**(1), pp.52-72.

Omo-Aghoja, L., Aisien, O., Akuse, J., Bergstrom, S. and Okonofua, F. (2010). Maternal mortality and emergency obstetric care in Benin city, South-South Nigeria. *Journal of Clinical Medicine and Research,* **2**(4), pp.055-060.

Omoruyi, F. E and Egenti, M. N. (2008). Challenges of Women Participation in Continuing Higher Education Programme: Implications for Adult Women Counselling and Education." *Edo Journal of Counselling* **4**(2), pp.131-143.

Onah, H. E., Ikeako, L. C. and Iloabachie, G. C., (2006). Factors associated with the use of maternity services in Enugu, southeastern Nigeria. *Social Science and Medicine*, ***63***(7), pp.1870-1878.

O'Neil, D. (2006). Characteristics of Culture. Available [online] at: anthro.palomar.edu/**culture**/**culture**_1.htm. Accessed August 10, 2015.

Oni, O. A., and Tukur, J. (2012). Identifying pregnant women who would adhere to food taboos in a rural community: a community-based study. *African Journal of Reproductive Health*, ***16***(3).

Onoka, C. A., Onwujekwe, O. E., Hanson, K., and Uzochukwu, B. S. (2011). Examining catastrophic health expenditures at variable thresholds using household consumption expenditure diaries. *Tropical Medicine and International Health*, ***16***(10), pp.1334-1341.

Onwuegbuzie, A. J., Dickson, W. B., Leech, N. L. and Zoran, A. G. (2009). Qualitative framework for collecting and analyzing data in focus group research. *International Journal of Qualitative Methods,* **8**(3), pp.1-21.

Onwuegbuzie, A. J., and Collins, K. M. (2007). A typology of mixed methods sampling designs in social science research. *The Qualitative Report*, ***12***(2), pp.281-316.

Onwuegbuzie, A. and Leech, N. (2007). Validity and Qualitative Research: An Oxymoron? Quality and Quantity, **41**(2), pp.233-249.

Onwurah, C. C., Ilo, C. I., Nwimo, I. O., and Onwunaka, C. (2015). Research and Reviews: Journal of Medical and Health Sciences, ***4***(4), pp.26-32.

Onwutuebe, C. J. (2013). Religious interpretations, gender discrimination and politics in Africa: A case study of Nigeria. Retrieved from http://c.ymcdn.com/sites/www.istr.org/resource/resmgr/africaregional2014wp/james_religious_interpretat.pdf.

Oppong, C. (2006). Familial roles and social transformations older men and women in sub-Saharan Africa. *Research on Aging,* **28**(6), pp.654-668.

O' Reilly (2012) *Ethnographic methods.* 2nd edition. USA: Routledge.

Osain, M. (2011). 'The Nigerian Health Care System: Need for Integrating Adequate Medical Intelligence and Surveillance Systems'. *Journal of Pharmacy and Bio-allied Science*. ***3***(4), pp.470–478.

Osubor, K., Fatusi, A. and Chiwuzie, J. (2006). Maternal Health Seeking Behaviour and Associated Factor in a Rural Nigeria Community: *Maternal and Child Health Journal*, **10**(2): pp.159-169.

Oxaal, Z. and Baden, S. (2006). Challenges to Women's Reproductive Health: Maternal Mortality. Report Challenges to Women's Reproductive Health: Maternal Mortality. Report prepared at the Request of the Social Development Department: Department of Oversea Development (DFID), UK.

Oye-Adeniran, B. A., Umoh, A. V. and Nnatu, S. N. (2014). Complications of unsafe abortion: a case study and the need for abortion law reform in Nigeria. *Reproductive health matters,***10**(19), pp. 18-21.

Oyedeji, R., and Abimbola, S. (2014). How tertiary hospitals can strengthen primary health care in Nigeria. *Nigerian medical journal: journal of the Nigeria Medical Association*, *55*(6), 519.

Oyetunde, M. O. and Eleri, G. O. (2014). Factors influencing the use of antenatal care and delivery services in Gwagwalada area council, Nigeria. *African Journal of Midwifery and Women's Health,* **8**(4), pp. 195-202.

Oyibo, N., Weller, G. and Watt, J., (2016). Evaluating lay perceptions of maternal mortality to improve risk communication: a case study in Rivers State, Nigeria. *Global Public Health,* pp. 1-14.

Panelli, R., and Tipa, G. (2007). Placing well-being: a Maori case study of cultural and environmental specificity. *EcoHealth*, *4*(4), 445-460.

Parpart, J. L., Connelly, P., Connelly, M. P., and Barriteau, E. (Eds.). (2000). *Theoretical perspectives on gender and development*. IDRC.

Parpart, J. L. (1993). Who is the 'Other '?: A postmodern feminist critique of women and development theory and practice. *Development and change*, *24*(3), 439-464.

Patton, M. Q. (2015*). Qualitative research and evaluation methods: Integrating theory and practice*. 4th edition. Thousand Oaks, CA: Sage.

Patton, M. Q. (2005). *Qualitative research* Wiley Online Library.

Patwardhan, M., Eckert, L. O., Spiegel, H., Pourmalek, F., Cutland, C., Kochhar, S., ... and Brighton Collaboration Maternal Death Working Group. (2016). Maternal death: Case definition and guidelines for data collection, analysis, and presentation of immunization safety data. *Vaccine*, ***34***(49), 6077.

Pham, M. T., Rajic, A., Greig, J. D., Sargeant, J.M., Papadopoulos, A. and McEwen, S.C. (2014). A scoping review of scoping reviews: advancing the approach and enhancing the consistency. *Research Synthesis Methods.* **5**, pp.371-385.

Piane, G. M. (2019). Maternal Mortality in Nigeria: A Literature Review. *World Medical and Health Policy*, ***11***(1), pp. 83-94.

Pillow, W. (2003). Confession, catharsis, or cure? Rethinking the uses of reflexivity as methodological power in qualitative research. *International Journal of Qualitative Studies in Education,* **16**(2), pp. 175-196.

Platt, M. W. (2016). The MBRRACE-UK perinatal surveillance report.

Poduval, J., & Poduval, M. (2009). Working mothers: how much working, how much mothers, and where is the woman hood? *Mens Sana Monographs*, *7*(1), 63.

Polit, D. F. and Beck, C. T. (2006). *Essentials of Nursing Research Method, Appraisal and Utilisation, (*6th edn). Philadelphia: Lippincott William & Wilkins.

Potrac, P., Jones, R. L. and Nelson, L. (2014). *Interpretivism*. London: Routledge.

Preissle, J. (2006). Envisioning qualitative inquiry: a view across four decades. *International Journal of Qualitative Studies in Education,* **19**(6), pp. 685-695.

Probst, B. and Berenson, L. (2013). The double arrow: How qualitative social work researchers use reflexivity. *Qualitative Social Work,* pp. 1473325013506248.

Putnam Tong, R. (1998). Feminist thought: A more comprehensive introduction. *NSW Australia Allen and Unwin*.

Pyone, T., Adaji, S., Madaj, B., Woldetsadik, T., and Van Den Broek, N. (2014). Changing the role of the traditional birth attendant in Somaliland. *International Journal of Gynecology & Obstetrics*, *127*(1), 41-46.

Rabiee, F. (2004). Focus-group interview and data analysis. *Proceedings of the Nutrition Society, 63*(04), 655-660.

Ransom, E., and Yinger, N. (2002). Making Motherhood Safer: Overcoming Obstacles on the Pathway to Care. 2002: Population Reference Bureau.

Rao, D., Angell, B., Lam, C., and Corrigan, P. (2008). Stigma in the workplace: Employer attitudes about people with HIV in Beijing, Hong Kong, and Chicago. *Social science and medicine*, ***67***(10), pp. 1541-1549.

Reeves, S., Peller, J., Goldman, J. and Kitto, S. (2013). Ethnography in qualitative educational research: AMEE Guide No. 80. Medical Teacher. **35** (8), pp. 1365-1379.

Reeve, C. L. (2009). Expanding the g-nexus: Further evidence regarding the relations among national IQ, religiosity and national health outcomes. *Intelligence*, ***37***(5), pp. 495-505.

Reeves, S., Kuper, A. and Hodges, B. D. (2008) Qualitative research methodologies: ethnography. *British Medical Journal.* **337**:1020.

Renert, H., Russell-Mayhew, S., and Arthur, N. (2013). Recruiting ethnically diverse participants into qualitative health research: Lessons learned. *The Qualitative Report*, ***18***(12), pp. 1-13.

Renfrew, M. J., Mcfadden, A., Bastos, M. H., Campbell, J., Channon, A. A., Cheung, N. F., Silva, Deborah Rachel Audebert Delage, Downe, S., Kennedy, H.P. and Malata, A. (2014). Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care. *The Lancet,* **384**(9948), pp. 1129-1145.

Rich, A. (1976). Of woman born. New York: Norton.

Rich, A. (1994). Compulsory heterosexuality and lesbian existence. In Jaggar A (ed) Living with contradictions: controversies in feminist social ethics. Westview Press, Boulder, CO.

Ritchie, J., Lewis, J., Nicholls, C. M. and Ormston, R. (2013). *Qualitative research practice: A guide for social science students and researchers* Sage.

Ritchie, J. and Lewis, J. (2004). *Qualitative Research Practice: A Guide for Social Science Studies and Researchers.* London, Sage Publications.

Riman, H. B., and Akpan, E. S. (2012). Healthcare financing and health outcomes in Nigeria: A state level study using multivariate analysis.

Robson, C. (2002). *Real world research.* (2nd edn.). Oxford: Blackwell.

Rogoff, B. (2003). *The cultural nature of human development*. Oxford university press.

Rosenfield, A., and Maine, D. (1985). Maternal mortality-a neglected tragedy: Where is the M in MCH. *The Lancet*, ***326***(8446), pp. 83-85.

Rosenfield, R. L., Lipton, R. B. and Drum, M. L., (2009). Thelarche, pubarche, and menarche attainment in children with normal and elevated body mass index. *Pediatrics,* **123**(1), pp. 84-88.

Roser, M. and Ritchie, H. (2019). "Maternal Mortality". Published online at OurWorldInData.org. Retrieved from: 'https://ourworldindata.org/maternal-mortality' [Online Resource].

Roudsari, R. L., Zakerihamidi, M., and Khoei, E. M. (2015). Socio-cultural beliefs, values and traditions regarding women's preferred mode of birth in the North of Iran. *International journal of community-based nursing and midwifery*, ***3(***3), p. 165.

Rowthorn, B. (1980). *Capitalism, conflict and inflation* (pp. 48-78). London: Lawrence and Wishart.

Rumrill, P. D., Fitzgerald, S. M. and Merchant, W. R. (2010) Using scoping literature reviews as a means of understanding and interpreting existing literature. *Work.* **35** (3), pp. 399-404.

Ryan, L., Kofman, E., and Aaron, P. (2011). Insiders and outsiders: working with peer researchers in researching Muslim communities. *International Journal of Social Research Methodology*, ***14(***1), pp. 49-60.

Sadiq, A. A., Poggensee, G., Nguku, P., Sabitu, K., Abubakar, A. and Puone, T. (2016). Factors associated with adverse pregnancy outcomes and perceptions of risk factors among reproductive age women in Soba LGA, Kaduna State 2013. *The Pan African Medical Journal*, *25*.

Salako, A. A., Oloyede, O. A. and Odusoga, O. L., (2006). Factors influencing non-utilisation of maternity care services in Sagamu, South Western Nigeria. *Tropical Journal of Obstetrics and Gynaecology*, ***23***(1), pp.48-53.

Sandelowski, M. (2015). A matter of taste: evaluating the quality of qualitative research. *Nursing inquiry*, ***22***(2), pp. 86-94.

Sarantakos, S. (2012). *Social Research* Palgrave Macmillan.

Sarantakos, S. (2005). Social Research. 3rd Edition, Palgrave Mac-Millan, New York.

Sarantakos, S. (1998). Varieties of social research. In *Social research* (pp. 31-71). Palgrave, London.

Savage, J. (2000). Ethnography and healthcare. *British Medical Journal*. **321**: pp.1400-2.

Sawyer, A. (2010). Pre-and postnatal psychological wellbeing in Africa: a systematic review. *Journal of Affective Disorders,* **123**(1), pp.17-29.

Say, L., Chou, D., Gemmill, A., Tunçalp, Ö., Moller, A., Daniels, J., Gülmezoglu, A.M., Temmerman, M. and Alkema, L. (2014). Global causes of maternal death: a WHO systematic analysis. *The Lancet Global Health,* ***2***(6), pp. e323-e333.

Schwandt, T. A. (2001). Dictionary of qualitative inquiry. 2nd edition. Thousand, Oaks: Sage.

Schwarz, M. T. (2009). Emplacement and contamination: Mediation of Navajo identity through excorporated blood. *Body and Society*, ***15***(2), pp.145-168.

Seale, C. (1999). Quality in qualitative research. *Qualitative Inquiry*, ***5***(4), pp.465-478.

Sepielli, A. (2013). Moral uncertainty and the principle of equity among moral theories. *Philosophy and Phenomenological Research*, ***86***(3), pp.580-589.

Shetty, S. (2005). Millennium Declaration and Development Goals: Opportunities for Human Rights. *International Journal of Human Rights*. **2**(2), pp.34-42.

Shiffman, J. (2007). Generating political priority for maternal mortality reduction in 5 developing countries. *American Journal of Public Health*, ***97(***5), pp.796-803.

Shole, R. N. (2015). An impact of socio-cultural practices on maternal mortality in Masasi District, Tanzania. *Malaysian Journal of Medical and Biological Research*, ***2***(3), pp.45-78.

Sholeye, O. O., Badejo, C. A., and Jeminusi, O. A. (2014). Dietary habits of pregnant women in Ogun-East Senatorial Zone, Ogun State, Nigeria: A comparative study. *International Journal of Nutrition and Metabolism*, ***6***(4), pp.42-49.

Sieverding, M., Liu, J., and Beyeler, N. (2015). Social support in the practices of informal providers: the case of patent and proprietary medicine vendors in Nigeria. *Social Science and Medicine*, ***143:*** pp.17-25.

Silverman, D. (2013). *Doing qualitative research: A practical handbook*. SAGE publications limited.

Silverman, D. (2011) *Qualitative research: issues of theory, method and practice*. 3rd edition. London: Sage.

Simons, H. (2009) *Case study research in practice*. London: SAGE.

Sin, C. (2005). Seeking Informed Consent: Reflections on Research Practice. *Sociology of Health Illness*, **39:** pp.277-294.

Smith, J. and Firth, J. (2011). Qualitative data analysis: the framework approach. *Nurse.*

Smith J A, ed (2008). Qualitative Psychology: A Practical Guide to Research Methods. 2nd edition. Sage, London *Researcher,* **18**(2), pp.52-62.

Smith, J. K. (1983). Quantitative versus qualitative research: An attempt to clarify the issue. *Educational Researcher, **12***(3), pp.6-13.

Snilstveit, B., Oliver, S., and Vojtkova, M. (2012). Narrative approaches to systematic review and synthesis of evidence for international development policy and practice. *Journal of Development Effectiveness*, ***4(***3), pp.409-429.

Soble, A. (1978). Deception in social science: Is inform consent possible? *Hasting Center Report*, pp.40-46.

Sobreperez, P. (2008). Using plenary focus groups in information system research: more than a collection of interviews. *Electronic Journal of Business Research Methods*, **6**(2), pp.181-188.

Spirkin, A. (1983). *Dialectical materialism*. Progress Publishers: Moscow.

Spradley, J. P. (2016). *Participant observation*. United State of America: Waveland press, Inc.

Starman, B. S. (2013). The case study as a type of qualitative research. *Journal of contemporary educational studies.* **1**: pp.28- 43.

Stake, R. E. (2005). *Qualitative case studies*. In: Denzin, N.K and Lincoln, Y.S (eds.) The SAGE handbook of qualitative research. 3rd edition. Thousand Oaks, CA: Sage.

Starrs, A. (2006). Safe Motherhood Initiative: 20 years counting, Lancet, **368:** pp.1130-1132.

Steen, M., and Roberts, T. (2011). *The handbook of midwifery research*. John Wiley and Sons.

Stephenson, R., Koenig, M. A, Acharya, R. and Roy, T. K. (2008). Domestic Violence, Contraceptive Use, and Unwanted pregnancy in Rural India. *Studies in Family Planning*, **39**(3), pp.177-186.

Stewart, D. W., P. N. Shamdasani, and D. W. Rook (2007). Focus Groups: Theory and Practice, 2nd edition, vol. 20, Newbury Park, CA: Sage Publications.

Strauss, A., and Corbin, J. (1998). Basics of Qualitative Research: Grounded Theory Procedures and Technique, 2nd Edition.Sage, Newbur yPark, London.ARTICLEINPRESSH. Heath, S. Cowley / International Journal of Nursing Studies ***41***(2004), pp.141–150150.

Stroebe, W. (2010). *Social Psychology and Health* (Second Edition). Buckingham: Open University.

Sturman, A. (1997). Case study methods. In: J. P. Keeves (ed.) Educational research, methodology and measurement: an international handbook. 2nd edition. Oxford: Pergamon.

Tanyi, P. L., André, P., and Mbah, P. (2018). Care of the elderly in Nigeria: Implications for policy. *Cogent Social Sciences*, ***4***(1), pp.1555201.

Tayo, A., Akinola, O., Babatunde, A., Adewunmi, A., Osinusi, D., and Shittu, L. (2011). Contraceptive knowledge and usage amongst female secondary school students in Lagos, Southwest Nigeria. *Journal of Public Health and Epidemiology*, ***3***(1), pp.34-37.

ten Hoope-Bender, P., de Bernis, L., Campbell, J., Downe, S., Fauveau, V., Fogstad, H., ... and Renfrew, M. J. (2014). Improvement of maternal and newborn health through midwifery. *The Lancet*, *384*(9949), pp.1226-1235.

Thaddeus, S., and Maine, D. (1994). Too far to walk: maternal mortality in context. *Social Science and Medicine*, ***38***(8), pp.1091-1110.

Thomas, G. (2011). A Typology for the case study in social science following a review of definition, discourse and structure. *Qualitative Inquiry.* **17**(6), pp.511–521.

Thanh, N. C., and Thanh, T. T. (2015). The interconnection between interpretivist paradigm and qualitative methods in education. *American Journal of Educational Science*, ***1***(2), pp.24-27.

Thomas, D. R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation,* ***27***(2), pp.237-246.

Thompson, M., Ellis, R., and Wildavsky, A. (1990). *Political cultures. Cultural theory.* Boulder, CO: Westview Press.

Tinker, I. (Ed.). (1990). *Persistent inequalities: Women and world development* (pp. 27-54). New York: Oxford University Press.

Transparency International (TI). (2017). How Do You Define Corruption? *Transparency International*.

Tricco, A. C., Lillie, E., Zarin, W., O'Brien, K., Colquhoun, H., Kastner, M., ... and Kenny, M. (2016). A scoping review on the conduct and reporting of scoping reviews. *BMC medical research methodology*, ***16***(1), p.15.

Tuckett, A. G. (2005). Applying thematic analysis theory to practice: A researcher's experience. *Contemporary Nurse,* ***19***(1-2), pp.75-87.

Ugwu, N. U., and de Kok, B. (2015). Socio-cultural factors, gender roles and religious ideologies contributing to Caesarian-section refusal in Nigeria. *Reproductive Health*, ***12*****(**1), p.70.

Ujah, O. I., Ocheke, A. N., Mutihir, J. T., Okopi, J. A., and Ujah, I. A. (2017). Postpartum contraception: determinants of intention and methods of use among an obstetric cohort in a tertiary hospital in Jos, North Central Nigeria. *International Journal of Reproduction, Contraception, Obstetrics and Gynecology,* ***6***(12), pp.5213-5218.

Ujah, I. A. O., Aisien, O. A., Mutihir, J. T., Vanderagt, D. J., Glew, R. H. and Uguru, V. E. (2005). Factors Contributing to Maternal Mortality in North-Central Nigeria: A Seventeen-Year Review. *African Journal of Reproductive Health,* **9:** pp.27-40.

Uneke, C. J., Ndukwe, C. D., Ezeoha, A. A., Uro-Chukwu, H. C. and Ezeonu, C. T. (2015). Implementation of a health policy advisory committee as a knowledge translation platform: The Nigeria experience. *International Journal of Health Policy and Management,* **4**(3), p.161.

Uneke, C. J., Ndukwe, C. D., Ezeoha, A. A., Urochukwu, H. C., and Ezeonu, C. T. (2014). Improving maternal and child healthcare programme using community-participatory interventions in Ebonyi State Nigeria. *International Journal of Health Policy and Management*, ***3***(5), p.283.

UK, N. G. U. T. (2019). Health economic model report. In *Prostate cancer: diagnosis and management*. National Institute for Health and Care Excellence (UK).

UNICEF, WHO, UNFPA, World Bank (2013). Trends in maternal mortality: 1990 to 2010. *Geneva: World Health Organization.* Available [Online) at www. WHO**,** UNICEF - Geneva: World Health Organization, 2013. Accessed August 10, 2015.

United Nations (2009). Millennium Development Goals Report, UN Statistics Division, New York, Millennium Development Goals. Available [online] at: www.**un**.org/**millenniumgoals**/**reports**.shtml. Accessed August 10, 2015.

United Nations (2007). Millennium Development Goals Report 35, UN Statistics Division, New York, Millennium Development Goals. Available [online] at: www.**un**.org/**millenniumgoals**/pdf/**mdg2007**.pdf. Accessed August 10, 2015.

United Nations International Children's Emergency Fund, Nigeria (UNICEF) (2016) Maternal and child health (online) Available from: https://www.unicef.org/nigeria/children_1926.html. (Accessed on January 2017).

United Nations International Children's Emergency Fund (UNICEF), (2014). The state of World's Children: Re-imagine the future. Available [online] at: www.**unicef**.org/publications/. Accessed September 2, 2015.

United States Agency International Development (USAID) (2010). MNPI- Maternal and Neonatal Program Effort Index. A Tool for Maternal Health Advocates. Available [online] at http://www.usaid.gov/our-work/global-health/. Accessed August 10, 2015.

United Nations Development Programme (UNDP), (2015). The Millennium Development Goals Report. Available [online] at www.un.org/.../**2015_MDG_Report**/.../**MDG**%20**2015**%20rev%20. Accessed September 2, 2015.

United Nations Development Programme (UNDP), (2008). Human Development Report. Available [online] at: www.eoearth.org/view/article/156755/. Accessed September 2, 2015.

Utoo, B. T. and Utoo, P.M., (2013). Preferred place of childbirth in rural southern Nigeria: a necessary step towards maternal death reduction. *Tropical Journal of Obstetrics and Gynaecology*, ***30***(2), pp.27-33.

Utz, B., and Halim, A. (2014). Wim Van Lerberghe, Petra ten Hoope-Bender. *BMC Pregnancy Childbirth*, *14*: p.130.

Uwakwe, K. A., Duru, C. B., Oluoha, R. U., Diwe, K. C., Merenu, I. A., Emereole, C. O., and Okeudo, C. (2015). Assessment of the Use of Malaria Prophylaxis, (Intermittent Preventive Therapy) and Its Related Outcome among Pregnant Women in Imo State, Nigeria. *British Journal of Medicine and Medical Research*, ***10***(11).

Van Lerberghe, W., Matthews, Z., Achadi, E., Ancona, C., Campbell, J., Channon, A., DE Bernis, L., D. E Brouwere, V., Fauveau, V. and Fogstad, H. (2014). Country experience with strengthening of health systems and deployment of midwives in countries with high maternal mortality. *The Lancet,* **384**(9949), pp.1215-1225.

Van Manen, M. (1990). Beyond assumptions: Shifting the limits of action research. *Theory into Practice*, ***29***(3), pp.152-157.

Beek, K. A. V. (2002). Spirituality: A development taboo. In *Development and Culture* (pp. 60-77). Oxfam Publishing.

Verschuren, P. J. M. (2003). Case study as a research strategy: some ambiguities and opportunities. *International Journal of Social Research Methodology*. **6**(2), pp.121–139.

Visvanathan, N., Duggan, L., Wiegersma, N. and Nisonoff, L. (1997). The Women, Gender and Development Reader. Chicago: University of Chicago press.

Walby, S. (1990). *Theorizing patriarchy*. Basil Blackwell.

Warren, C. (2002). *Qualitative Interviewing*. In: J. Gubrium and J. Holstein (eds). Handbook of Qualitative Interviewing. Thousand Oaks, California: Sage. Pp.83–101.

Weaver, K. and Olson, J. K. (2006). Understanding paradigms used for nursing research. *Journal of Advanced Nursing,* **53**(4), pp.459-469.

Weindling, P. J. (2004). *Nazi Medicine and the Nuremberg Trials: From Medical War Crimes to Informed Consent.* New York: Palgrave Macmillan.

White, S.C. (2000) Did the Earth Move? The Hazards of Bringing Men and Masculinities into Gender and Development. *IDS Bulletin,* **31**(2), pp.33-40.

Wiegman, R. (2014). The times we are in: Queer feminist criticism and the reparative 'turn'. *Feminist Theory*, ***15***(1), pp.4-25.

Wilkinson, S. (2004). Focus groups. *Doing social psychology research*, pp.344-376.

Williams, B. (2008). *Shame and necessity* (Vol. 57). Unit of California Press.

Willis, J. W. (2007). World views, paradigms, and the practice of social science research. *Foundations of qualitative research: Interpretive and critical approaches*, pp.1-26.

Willis, J. W. and Jost, M. (2007). *Foundations of qualitative research: Interpretive and critical approaches.* Sage.

Wilson, A. (2015). A guide to phenomenological research. *Nursing Standard (2014+)*, ***29***(34), pp.38.

Woodman, J. L., Simon, A., Hauari, H., and Gilbert, R. (2019). A scoping review of 'think-family'approaches in healthcare. *Journal of Public Health*, pp.1-17.

Wong, J. Y. (2008). *Theory of ground vehicles*. John Wiley and Sons.

World Bank Group. (2016). *World development report 2016: digital dividends*. World Bank Publications.

World Health Organization, (2019). Trends in maternal mortality 2000 to 2017: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.

World Health Organisation, (2019b). Facility-based maternal death review in Nigeria https://www.who.int/maternal_child_adolescent/epidemiology/maternal-death-surveillance/case-studies/nigeria-study/en/.

World Health Organisation, (2019C). Health statistics and information systems https://www.who.int/healthinfo/statistics/indmaternalmortality/en/.

World Health Organisation, (2017). Nigeria Midwives Service Scheme (online) Available from: http://www.who.int/workforcealliance/forum/2011/hrhawardscs26/en/ (Accessed on January, 2017).

World Health Organisation, Health in (2015). In: From MDGs, millennium development goals to SDGs, sustainable development goals [internet]. Geneva: World Health Organisation; 2015. Available from: http://www.who.int/gho/publications/mdgs-sdgs/en/.

World Health Organisation, (2016). maternal mortality: key facts (online) Available from: **http://www.who.int/mediacentre/factsheets/fs348/en/** (Accessed on January, 2017).

World Health Organisation, (2017). The reproductive health. Available (online) from: http://www.who.int/topics/reproductive_health/en/ (Accessed on January 2017).

World Health Organisation, (2013). The World Health Statistics. World Health Organization, Geneva, Switzerland. Available [online] at www.who.int/iris/bitstream/10665/44844/1/9789241564441_eng.pdf. Accessed September 2, 2015.

World Health Organization and UNICEF, (2014). Trends in maternal mortality: 1990 to 2013: estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division: executive summary.

World Health Organisation, (2014). Key facts on Maternal Mortality. [Online], Available from www.who.int/entity/mediacentre/factsheets/fs348/en/ - 41k.

World Health Organisation, (2012). Trends in maternal mortality 1990-2010. www.unfpa.org/webdav/site/global/shared/documents/publications/2012/trends_in_maternal_mortality_A4-1pdf.

World Health Organisation, (2008). Closing the Gap in a Generation: Health Equity through Action and the Social Determinants of Health. Geneva. Available [online] at: http://whqlibdoc.who.int/publications /9789241563703. Accessed, August 10, 2015.

World Health Organisation, (2008). Gender, equity and human rights (online). Available from: https://www.who.int/gender-equity-rights/knowledge/poverty-gender-in-health-programmes-sexual-reproductive-health/en/

World Health Organisation, UNICEF, UNFPA, World Bank Group and the United Nations Population Division (2015). Trends in Maternal Mortality: 1990 to 2015 (online) Available from: http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf?ua=1 (Accessed on January, 2017).

World Health Organization, (2010). *World Health Statistics,* Available [online] at *www.who.int/gho/publications/world_health.../EN_WHS10_Full.pdf.* Accessed on July 20, 2015.

World Health Organisation, (2007). Maternal Mortality in 2005; Estimates Developed by WHO, UNICEF, UNFPA and The World Bank. Available [online] at: http://whqlibdoc.who.int/publications /9789241563703. Accessed, August 10, 2015.

World Health Organisation, (WHO) (2000). Making pregnancy safer (online) Available from: http://apps.who.int/gb/archive/pdf_files/EB107/ee26.pdf.

Wydra K. And JohsonGrob (2013). Maternal Child Health; Inter disciplinary aspects within the perspective of global health. Germany: University of Gottinge.

Yang, W., Jin, S., He, S., Fan, Q., and Zhu, Y. (2015). The impact of power on humanity: Self-dehumanization in powerlessness. *PloS One*, ***10***(5), p.e0125721.

Yanow, D., and Schwartz-Shea, P. (2011). *Interpretive approaches to research design: Concepts and processes*. Taylor and amp.

Yar'Zever, I. S. and Said, I. Y. (2013). Knowledge and barriers in utilization of maternal health care services in Kano state, Northern Nigeria. *European Journal of Biological Medical Science Research*, ***1***(1), pp.1-14.

Yaya, J. A., Asunmo, A. A., Abolarinwa, S.T. and Onyenekwe, N. L. (2015). challenges of record management in two health institutions in Lagos state, Nigeria. *International Journal of Research*, *1.*

Ybema, S., Keenoy, T., Oswick, C., Beverungen, A., Ellis, N., and Sabelis, I. (2009). Articulating identities. *Human Relations*, ***62***(3), pp.299-322.

Yeheskel, A. and Rawal, S. (2018). Exploring the 'Patient Experience'of Individuals with Limited English Proficiency: A Scoping Review. *Journal of Immigrant and Minority Health*, pp.1-26.

Yin, R. K. (2009). *Case study research: design and methods*. 4th ed. Thousand Oaks, CA: Sage.

Appendices

Appendix 1: Data extraction table for articles that meet inclusion criteria

S/N	Authors(s); Year of publication	Part of Nigeria	Title	Study methodology	Study aims/objectives	Relevant Key Findings	themes
1	Oke and Ugwu, 2010	Ebonyi state	Maternal and healthcare services in Nigeria factors affecting choice	Cross-sectional study using questionnaires	To examine the pattern of use of maternal healthcare services in a remote part of Nigeria and to highlight factors that determine the choice of service.	Distance, mothers' education, and age were the choice of MCH service	Distance Mothers' education
2	Okonofua et al 2018	Edo State	Predictors of women's utilization of primary health care for skilled pregnancy care in rural Nigeria	Cross-sectional study	To identify the factors that lead pregnant women to use or not use existing primary health care facilities for antenatal and delivery care	Reasons for use and non-use of PHCs for antenatal and delivery care given by women were related to perceptions about long distances to PHCs, high costs of services and poor quality of PHC service delivery	Distance Cost of service
3	Adewemimo et al., 2014	Kastina State	Utilisation of skilled birth attendance in Northern Nigeria: A cross-sectional survey with Four hundred women aged 15–49 years	a population-based survey using a structured questionnaire	To determine the level and determinants for utilisation of Skilled Birth Attendance (SBA)	Barriers to SBA utilisation identified included lack of health care provider, lack of equipment and supplies and poverty Enablers mentioned included availability of staff, husband's approval and affordable service	Poverty

						Maternal education, husband's occupation, presence of complication and previous place of childbirth were found to be statistically significant predictors for SBA utilisation	
4	Okolocha et al., 1998	Ekpoma	Socio-cultural factors in maternal morbidity and mortality: a study of a semi-urban community in Southern Nigeria	Exploratory multidisciplinary operations research.	To understand community based or socio-cultural factors that determine maternal morbidity and mortality in a semi-urban setting.	Knowledge of haemorrhage is circumscribed by attitudes, practices, and situations that distance women from or delay the decision to seek modern obstetric care.	Knowledge
5	Osubor et al., 2006	Edo State	Maternal Health-Seeking Behavior and Associated Factors in a Rural Nigerian Community	Cross-sectional study using questionnaires	To assess maternal health services and health-seeking behaviour in a rural community (Ologbo), located in the South–south zone of Nigeria	Government facility was preferred by only 15.7%: reasons for the low preference included irregularity of staff at work (31.4%), poor quality of services (24.3%), and high costs (19.2%). Education was found to be significantly associated with choice of place for delivery ($p < 0.05$), but no association was found with respect to age and marital status.	Cost of care Education
6	Azuh et al., 2017a	Ado-Odo/Ota LGA, Ogun State	Factors influencing maternal mortality among rural communities in Southwestern Nigeria	Multistage design and an informant-based survey		Pregnancy complications, Knowledge of place ANC treatment, place of delivery, payment of treatment cost and attendance of noninstitutional delivery centres, were factors influencing maternal mortality	Knowledge Treatment cost

7	Oladigbolu et al, 2017	Sokoto State	Socio – economic Factors Influencing Utilization of Healthcare Services in Sokoto, North-Western Nigeria	Descriptive cross – sectional study	To assess the socio – economic factors influencing utilization of healthcare services in Sokoto, Northern Nigeria	Social class, user – fees and educational status were the three predictors of utilization of healthcare services at the health facilities as households in the lower social class were 2 times the odds to find it difficult in paying for the services utilized at the health facilities	Education Economic status
8	Azuh et al., 2015	Ado-Odo/Ota LGA, Ogun State	Socio-Cultural Factors of Gender Roles in Women's Healthcare Utilization in Southwest Nigeria	Cross-sectional study using questionnaires	To understand the influence of socio-cultural factors influencing health care utilization among women during pregnancy and childbirth	The findings show that husband perception of pregnancy complications, age at marriage, who pays ante-natal bills, family type, treatment place decision is significant towards use of health care services by mothers.	Age at marriage Cost of care
9	Anastasi et al., 2017	Lagos state	Unmasking inequalities: Sub-national maternal and child mortality data from two urban slums in Lagos, Nigeria tells the story	Cross-sectional, community-based household survey	To estimate perinatal mortality and to assess women's health seeking behaviour around pregnancy and childbirth	One third of females reportedly delivered outside the of the health facility without access to skill birth attendant Proximity to home, trust or familiarities of the facility, and husband/family decisions were the topmost reasons for choice of place for delivery	Distance, Husband/family decisions
10	Ewa et al 2012	Oyo State	Perceived factors influencing the choice of antenatal care and delivery centres among childbearing women in Ibadan north south-western, Nigeria	Cross-sectional study structured questionnaire	To investigate the supposed factors apart from socioeconomic influencing the choice of antenatal care and delivery centres among childbearing women in Ibadan North Local	The study revealed that husband's decision or preference of ANC and privacy constituted the prominent factors that influenced the choice of ANC as well as place of delivery. It further revealed that the highest patronage of ANC and delivery	Husband's decision Distance

					Government Area of Oyo State.	centres was achieved with distance of 10km	
11	Ndikom et al 2017	Oyo State	Factors Influencing the Choice of Health Care Provider during Childbirth by Women in Ibadan, Oyo State, Nigeria	Descriptive design, using self-administered questionnaires for data collection	To ascertains the factors influencing the choice of health care provider by women during childbirth in Ibadan, Oyo state Nigeria.	Some of the factors identified to influence delivery from a TBA are ignorance, lack of alternative, accessibility, lesser time consumption and availability. **Income of women and satisfaction with services provided does not** have significant association with the choice of health care provider (p= 0.180) but age was significantly associated with choice of Provider (p=0.017).	Education Distance Cost of care income
12	Marchie, C.L 2012	Edo State	Socio-cultural factors as correlates of maternal mortality in Edo South Senatorial District, Nigeria	Descriptive survey method	To investigate socio-cultural factors that contribute to maternal mortality in Edo South Senatorial District.	The findings show that socio-cultural variables when taken together contributed positively to maternal mortality	Cultural
13	Ibrahim, D.O 2016	Oyo State	Socio-economic determinant of maternal mortality in rural community of Oyo State, Nigeria	Descriptive survey design Using two thousand two hundred (2200) women of childbearing age from rural communities in	To investigate Socio-economic determinant of maternal mortality in rural community of Oyo State, Nigeria	Low access to health facilities, level of income, purchasing power and educational status determined maternal mortality in rural communities of Oyo State There was relative contribution of	Income Education Distance

				Oyo state, Nigeria		educational status, proximity to health facilities, level of income and purchasing power on maternal mortality	
14	Ibor et al 2011	Oyo State	Utilization of Antenatal Care in Ibadan North Local Government Area, Oyo State, Nigeria	Descriptive survey	To evaluate the utilization of antenatal care centers among child-bearing women in Ibadan North Local Government Area, Oyo State, Nigeria.	Result indicated that 6.3% of the utilization of ANC by childbearing women was explained by age, cultural preference, income, education, religion, marital status and occupation	Income Age Education Religion Occupation Cultural preferences
15	Egharevba et al., 2017	Ebonyi State	Factors Influencing the Choice of Child Delivery Location among Women Attending Antenatal Care Services and Immunization Clinic in Southeastern Nigeria	cross-sectional survey, used structured questionnaire for data collection from 220 pregnant women	To examine the factors that influenced or determined utilization of healthcare facility delivery services among women who attended antenatal care (ANC) services.	In the final model, number of children, having planned to deliver at a hospital, labour occurring at night, and labour allowing time for transportation were significant predictors of child delivery location among the women.	Distance Attitude of healthcare professionals
16	Abimbola and Ajiboye 2012	Lagos State	Socio-cultural factors affecting pregnancy outcome among the Ogu speaking people of Badagry area of Lagos state, Nigeria.	Mix methods using questionnaires and interview to collect data	To explore socio-cultural factors affecting pregnancy outcome among the Ogu speaking people of Badagry area of Lagos State, Nigeria	In spite of modernisation, the culture of the people of Ogu Community still play dominant role in shaping their reproductive behaviour. Hence, the study found positive relationship between socio-cultural factors and pregnancy outcome among Ogu	Culture

						speaking people of Badagry of Lagos State, Nigeria.	
17	Fagbamigbe and Idemudia 2016	Rural and urban localities and Enumeration Areas (EAs) in all the 36 states and the Federal Capital Territory	Wealth and antenatal care utilization in Nigeria: Policy implications	Retrospective review and cross-sectional study	To determine the effect of wealth and other socioeconomic and behavioral factors on ANC utilization in Nigeria	Respondents in the wealthiest quintile were over five times (aOR D 5.5 (95% CI: 4.2–7.2) more likely to adequately use ANC. The odds of ANC use were generally lower among the poor and the least educated women living in rural areas who need ANC the most	Economic status Education
18	Adegoke et al., 2010	Oyo State	Community perceptions of the causes and prevention of maternal mortality	Qualitative and quantitative using questionnaires and interviews for data collection	To identify community members' perceptions of the causes and prevention of maternal mortality in Ibadan, North East Local Government Area of Oyo State, Nigeria.	Over half of the 256 responses to the question on perceived causes (n=155, 60.5%) blamed the high incidence of maternal deaths in the area on individual or pregnant women themselves, with individual factors ranging from failure to attend antenatal care, noncompliance, financial constraints to ignorance Religious or supernatural factors were also identified as causes of maternal deaths (9%), with some participants commenting that women who died of pregnancy and	Knowledge Poverty Religion

						childbirth-related causes had been destined to die or willed by God.	
19	Ejidokun, 2000	Lagos State	Community attitudes to pregnancy, anaemia, iron and folate supplementation in urban and rural Lagos, south-western Nigeria	Qualitative using focus group discussions, observational data and in-depth interviews.	To identify community perspectives and attitudes to pregnancy, anaemia, iron and folate supplements during pregnancy in Lagos, south-western Nigeria	Pregnancy was seen as a `special', natural condition which links the woman and the coming baby to the gods as well as to the husband's family Since pregnancy was not considered to be an illness, pregnant women are expected to continue their normal activities. Some even carry heavy loads on their heads, cook, wash, clean, pound grain, gather firewood, draw water from wells, smoke fish and trade. woman are then given some advice by traditionalist on `taboos' in pregnancy such as: not allowed to go out at midday or after dark, must always carry a sharp object, such as a safety pin, in her handbag, attached to her underwear or worn as a pendant, and to avoid some food items	Culture

20	Mboho et al 2013	Akwa-Ibom State	Social-cultural practices and beliefs influencing maternal mortality	Ethnography comprising observation, interviews and focus group interviews	To explore how sociocultural practices and beliefs may influence maternal mortality in Nigeria by examining the cultural practices and popular traditional beliefs of the Ibibio and Annang ethnic groups of Akwa Ibom state	All believed that having children generated security and economic support for parents in old age Participants described childbearing as a natural, normal function of women, crucial to a woman's role and identity In this study, childbearing was described as a risky time for women. The pregnant woman would therefore seek solace either from a TBA operating in her own home, or in the church as TBAs were considered to possess supernatural powers capable to check witchcraft, having insight into pending dangers and possessing the powers to avert such dangers	Culture
21	Okafor et al., 2014	Lagos State	Orthodox versus unorthodox care: A qualitative study on where rural women seek healthcare during pregnancy and childbirth in Southwest, Nigeria	A qualitative study was done and involved three focus group discussions and semi-structured interview with women within the reproductive age group (15-45 years)	To determine the use of orthodox versus unorthodox maternity healthcare and determinants among rural women in southwest Nigeria	Traditional belief exerts a strong influence on decision of where to access maternal healthcare services Actual place of delivery is determined by individual and household factors including financial resources	Traditions Income Decision of individuals/households

22	Okonofua et al., 2017	Kano State, Kaduna State, Oyo State, Ogun State, Niger State, Federal Capital Territor, Delta State and Edo State	Women's perceptions of reasons for maternal deaths: Implications for policies and programs for preventing maternal deaths in low-income countries	Qualitative study using Focus groups discussions	To investigate what women attending antenatal and delivery care in eight secondary and tertiary health facilities in Nigeria know or do not know about maternal mortality and its determinants and explored their perceptions on medical and other reasons for maternal mortality.	Delays in reaching hospitals or after women arrive in hospitals featured prominently as lead causes mentioned by women. Listening to women as end-users is an important approach to identify points of remediation in the provision of maternal health care	Distance Poverty Ignorance
23	Akinwaare and Adejumo 2015		Determinants of choice of place of birth and skilled birth attendants among women in Ibadan, Nigeria	A descriptive cross-sectional study using self-reported questionnaires	To examine factors influencing women's choice of place to give birth	Several factors influenced women's choice of place of birth, particularly level of education, parity and religion	Education Religion Distance Economic status Spouse preferences
24	Doctor et al., 2012	Katsina, Yobe and Zamfara State	Using community-based research to shape the design and delivery of maternal health services in Northern Nigeria	Mix methodology using a quantitative survey, interviews and focus group discussions	To identify the specific programme elements needed to encourage women to attend the appropriate antenatal and delivery services to reduce maternal deaths	Most pregnant women had little or no contact with the health care system for reasons of custom, lack of perceived need, distance, lack of transport, lack of permission, cost and/or unwillingness to see a male doctor.	Distance Custom Lack of permission Cost of maternal care

							Unwillingness to see a male doctor
25	Emelumadu et al., 2014	Anambra State	Socio-Demographic Determinants of Maternal Health-Care Service Utilization Among Rural Women in Anambra State, South East Nigeria	Descriptive survey	It aimed at exploring pattern of maternal health (MH) services utilization and the socio-demographic factors influencing it in Anambra State, South East Nigeria	Socio-demographic factors were found to be significantly associated with places where MH care services are accessed Odds of utilizing formal health facility for MH services were found to be significantly associated with increasing age ($P < 0.001$) and educational status of mothers ($P < 0.001$)	Education
26	Alenoghena et al., 2015	Edo State	Maternal Health Services Uptake and its Determinants in Public Primary Health Care Facilities in Edo State, Nigeria.	Descriptive cross-sectional study	To assess the uptake of maternal health services; its determinants and the perception of users about these services	The predictors of the antenatal services utilization included: educational status, cost per illness, self-assessment of health, clean environment and sources of information on maternal care. Marital status, average income and type of community were the predictors of family planning services utilization.	Education Cost of care
27	Oyetunde and Eleri 2014	FCT	Factors influencing use of antenatal care and delivery services in Gwagwalada Area Council, Nigeria	Descriptive cross-sectional study	To identify factors influencing the use of these services in Gwagwalada Area Council, Abuja, Nigeria.	The husbands' educational level and occupation positively affected the pattern of use of these services. Perceived importance of antenatal care, attitude of health workers and cost of care were the most	Education Occupation Cost of care

						important factors that influenced service use.	
28	Utoo and Utoo 2013	Cross- River State	Preferred place of childbirth in rural southern Nigeria: a necessary step towards maternal death reduction.	Cross sectional study	To determine the preferred place of delivery in the index pregnancy amongst antenatal attendees	Cost 0.6%, distance 1.1%, Trust in God for safety 2.2%, self-confidence 1.7% and harshness of hospital staff 0.6% were reasons for preference to deliver outside the hospital. Preference for hospital delivery was not associated with education (0.97) and parity (0.85).	Distance Cost of care Education
29	Envuladu et al., 2013	Plateau state	Factors determining the choice of a place of delivery among pregnant women in Russia village of Jos North, Nigeria: achieving the MDGs 4 and 5	Community-based cross-sectional study that was conducted among 140 pregnant women selected by simple random sampling	To assess the determinants of a choice of a place of delivery among pregnant women in Russia village of Jos North Local Government Area of Plateau state, Nigeria.	Determinants of choice of delivery place include cost of hospital bill (93.6%), unfriendly attitude of health care workers (61.4%), unexpected labour (75%), distance to health care centres (36.4%), and failure to book for ANC (10.7%). Religion and parity however had no significant association with the choice of a place of delivery	Cost of care Distance
30	Nneka et al., 2018	Sokoto State	Determinants of Ante-natal Care, Place of Delivery and Post-natal Care Services of Rural Women in Northern Nigeria	Descriptive cross-sectional design	To identify the determinants of Ante-natal care, place of delivery and postnatal care services of rural women in Northern Nigeria.	Determinants of Ante-natal care services, place of delivery and post-natal care was found to be maternal education and socioeconomic status. Mothers with formal education were twice more to attend Ante-natal care services ($p \leq 0.05$, OR = 2.11, 95% C.I = 0.99 – 4.450. Mothers with non-formal education were more likely to	Education Economic status

						deliver at home (p = 0.01, OR = 0.29, 95% C.I = 0.14 – 0.59) while those in the upper class were more to attend post-natal care (	
31	Fagbamigbe and Idemudia, 2015	rural and urban areas in all 36 states and the Federal Capital Territory (FCT) in Nigeria,	Barriers to antenatal care use in Nigeria: evidences from non-users and implications for maternal health programming	cross-sectional study	To evaluate barriers to the use of ANC services in Nigeria from the perspective of non-users.	Over half (56.4%) of the non-users reported having a problem with getting money to use ANC services while 44.1% claimed they did not attend ANC due to unavailability of transport facility. he reasons for non-use of ANC varied significantly with respondents' wealth status, educational attainment, residence, geographical locations, age and marital status.	Economic status Distance Education
32	Azuh et al., 2017b	Ogun State	knowledge of socio-demographic factors influencing health service usage among pregnant mothers in Nigeria	face-to-face structured interview and focus group discussion	To examine the factors which influence health care usage and to suggest policy guidelines to boost the use of healthcare particularly among antenatal women	Educational attainments, payment of treatment bills, respondent's age and husband's perception about pregnancy are positively associated to antennal care (ANC) use	Education Decision of husbands Economic status Age
33	Azuh et al., 2014a	Ogun State	Socio-Demographic Determinants of Health Care Programme Usage by Women During Pregnancy and ChildBirth in ADO-ODO/OTA Local Government Area of Ogun State, Nigeria	Descriptive survey research design. Used face-to-face structured interview and focus group discussion	To determine the socio-demographic factors responsible for health-care programme usage by women during pregnancy and childbirth in a developing country like	The factors are level of educational attainment, distance to health-care facility, male domination women's perpetual dependence on men, poverty and so on	Education Distance Decision of husbands Economic status

					Nigeria, especially in Ado-Odo/ Ota Local Government Area of Ogun State		
34	*Dairo and* Owoyokun, 2010	Oyo State	Factors affecting the utilization of antenatal care services in Ibadan, Nigeria	cross-sectional study using pre-tested questionnaires to collect data from 400 women	To assess the factors that determine the utilization of antenatal care service in Ibadan	Women in urban areas were more than 2 times likely to attend antenatal clinic than women in urban areas [(OR=2.177, 95% CI, 1.081-4.382)]. Women who were Muslims or other religions were more than 2 times likely to attend ANC clinic than women who were Christians [(OR=2.398, 95% CI	Distance Location Religion
35	Onah et al., 2006	Enugu State	Factors associated with the use of maternity services in Enugu, southeastern Nigeria	cross-sectional study	To identify the factors which influenced choice of place of delivery by pregnant women in Enugu, southeastern Nigeria, and to recommend ways to improve women's access to skilled attendants at delivery	The major factors influencing choice of place of delivery included promptness of care, competence of midwife/doctor, affordability, health education, 24 h presence of doctors, teamwork among doctors and presence of specialist obstetricians. There were statistically significant associations between choice of institutional or non-institutional deliveries and socio-demographic/ economic factors such as place of residence (urban/rural), religion, educational status, tribe, marital status, occupational level, husband's occupational and educational levels, age and parity (po0:05).	Economic status Place of residence Education Husbands' education and occupation

36	Iyaniwura and Yussuf, 2009	Ogun State	Utilization of Antenatal care and Delivery services in Sagamu, South Western Nigeria	Descriptive cross-sectional study	To determine the pattern of use of maternity services and assess factors that may influence the observed pattern	Higher educational status and higher level of income positively affected the pattern of use of these services. A considerable proportion of those who used traditional birth attendants (36.1%) used it to please their husbands	Decision of husband Education Economic status
37	Moore et al., 2011	Rivers State	Utilization of Health Care Services by Pregnant Mothers during Delivery: A community-based study in Nigeria	Cross-sectional, questionnaire; based study involving 112 mothers aged 15 years to 49 years from Gokana Local Government Area of Rivers State, Nigeria.	To determine the level of utilization of health care services by pregnant women during delivery in Gokana Local Government Area of River State, Nigeria.	Factors responsible for non-utilization of health facility for delivery include: Long distance to health facility 33(68.7%), onset of labour at night 40(83.3%), unavailability of means of transportation 37(77.1%), Lack of money for transportation 26(54.2%), unsatisfactory services at health facility 26(54.2%), unfriendly attitude of staff of the health facility 34(70.8%), unavailability of staff at health facility 32(64.0%), lack of urgency at health facility 36(75.0%), previous uneventful delivery at the health facility 32(66.7%).	Distance Means of transportation Economic status
38	Yar'zever et al., 2013	Kano State	Knowledge and barriers in utilization of maternal health care services in kano state, northern Nigeria	Descriptive cross-sectional study using questionnaire, focus group discussion and in-depth interview	To explore knowledge and Utilization of maternal health services among Urban and Rural reproductive women	There was a statistically significant association between the respondents‟ level of education, income, age and their knowledge score ($p = 0.005$) for both urban and rural	Education Economic status Age

39	Salako et al., 2006	Ogun State	Factors influencing non-utilisation of care services in Sagamu, South Western Nigeria	cross-sectional study	To determine the factors influencing the utilization of maternity care in the public health facilities in the Sagamu Community.	Rather, socio-cultural beliefs in the TBA services, low educational status, and husband and family decision (gender influence) were found to be strong determinants of the non-utilization of the maternity centres by expectant mothers in this community	Sociocultural beliefs Education Husband and family decisions
40	Odetola, 2015	Oyo State	Health care utilization among rural women of child-bearing age: a Nigerian experience	descriptive study	To explore clients' perceptions about what factors, influence where they access health care services	major findings revealed that level of education, proximity to place of residence, affordability and quality of services rendered, spousal and significant other's influences were active determinants of choice for health institutions among pregnant women in Nigeria.	Education Distance Economic status Family decision
41	Adamu and Salihu, 2000	Kano State	Barriers to the use of antenatal and obstetric care services in rural Kano, Nigeria	Structured interview conducted by a Midwife on 107 pregnant women	To identify the sociocultural and economic factors that act as barriers to women's use of antenatal care services and hospital delivery in a rural community in Kano State, Northern Nigeria	Key reasons for non-attendance of antenatal care are financial constraint, God's will, Husband denial	Economic status Family decision Religion

Appendix 2: participant invitation letter

University of Salford,
Greater Manchester,
England.
United Kingdom
December 2015.

TO WHOM IT MAY CONCERN

REQUEST TO PARTICIPATE IN FOCUS GROUP DISCUSSION

I hereby humbly invite you to be one of my participants in the study titled '**community perceptions of the socio-cultural factors that influence maternal mortality including its prevention in southeast Nigeria'.** The study is focused on the investigation of socio-cultural factors that influence pregnancy and maternal wellbeing in Onuenyim Agbaja community. In so doing, the researcher will elicit information on the socio-cultural influences on maternal health and wellbeing, including impacts on mortality and morbidity. You will be expected to participate and discuss with other women on issues related to pregnancy, maternal health, maternal wellbeing, and maternal mortality and morbidity. The discussion will include approaches to improve maternal health and reduce maternal mortality

This study has been approved by ethical committee at the University of Salford and Ebonyi State University Abakaliki, under the supervision of two members of the academic staff of the University of Salford. Further details about this research can be found in the form called participant information sheet.

Thanks for your anticipated participation.

……

PhD researcher

(Name, Contact details to be inserted here)

University of Salford,
Greater Manchester,
England.
United Kingdom
December 2015.

TO WHOM IT MAY CONCERN

REQUEST TO PARTICIPATE IN ONE-ON-ONE INTERVIEW

I hereby humbly invite you to be one of my participants in the study titled '**community perceptions of the socio-cultural factors that influence maternal mortality including its prevention in southeast Nigeria'.** The study is focused on the investigation of socio-cultural factors that influence pregnancy and maternal wellbeing in Onuenyim Agbaja community. In so doing, the researcher will elicit information on the socio-cultural influences on maternal health and wellbeing, including impacts on mortality and morbidity. You will be expected to participate in one-on-one interview with the researcher to discuss issues related to pregnancy, maternal health, maternal wellbeing, and maternal mortality and morbidity. The interview will include approaches to improve maternal health and reduce maternal mortality

This study has been approved by ethical committee at the University of Salford and Ebonyi State University Abakaliki, under the supervision of two members of the academic staff of the University of Salford. Further details about this research can be found in the form called participant information sheet.

Thanks for your anticipated participation

……

PhD researcher

(Name, Contact details to be inserted here)

Appendix 3: Focus group participant information sheet

Title of study: Community perceptions of socio-cultural factors that influence maternal mortality and their solutions for its prevention in Southeast Nigeria.

Name of Researcher: Joy C. Oko Uka

Invitation paragraph

I would like to invite you to take part in the research as titled above. Before you decide whether to participate, you need to understand the purpose of the research and how you will be involved in this study. Please take time to read the following information carefully. Ask questions if anything you read is not clear or you need more explanation. Take time to decide whether or not to take part.

What is the purpose of the study?

The purpose of this research project is to investigate the community perceptions of socio-cultural factors that influence maternal health, well-being and mortality, including its potential perceived preventive measures in a Nigerian community. This is to generate evidence that could be used to plan or strengthen the existing strategies to improve maternal wellbeing and reduce maternal mortality in

Why have I been invited to take part?

You have been chosen to participate in focus group discussion for this project because you are a woman of child bearing age with or without children. Also, you have been invited because your opinion during the discussion is expected to give rich information on the topic under investigation.

Do I have to take part?

It is your decision to make. The information about the study will be explained to you, and we will read through the information sheet together. A consent form will be given to you to sign if you accept to take part in the study. You are free to withdraw at any time without giving any reason

What will happen to me if I take part?

This is a qualitative study using focus group as methods for data collection. You will be invited to join the focus group discussion to discuss the issues under investigation with other women in a group. The focus group discussion session will be held only once which may take about 1hours 30 minutes. The discussion will be audio recorded.

Expenses and payments?

You are not required to pay or settle any expenses. This study is within the community; therefore, no transportation will be needed for you. Light refreshments will be provided by the researcher to the participants at the end of the session.

What are the possible disadvantages and risks of taking part?

No obvious risks have been identified as a consequence of your involvement in the study. However, there may be re-awakening of past feeling and experience that may lead to emotional distress during focus group discussion. Appropriate plans have been made to handle any potential emotional distress that you may suffer.

Is there any support available for you?

Yes, arrangement has been made for the doctors and midwives from Sudan United Mission hospital in the community to be available at the venue of the focus group discussion to handle any potential emotional distress that may occur either during or after the discussion.

What are the possible benefits of taking part?

The researcher cannot promise the study will help you but the information you provided for this study will help to plan or strengthen the existing strategies for reduction of maternal death and improving maternal health and well-being in the community

What if there is a problem?

If you have any concerns about the study, you should ask to speak to the researcher who will do her best to answer your question. If you remain unhappy and wish to complain formerly, you report anything to the village head or you could contact the supervisory team of this project.

Dr Gaynor Bagnall, *Senior Lecturer in Sociology and Culture****,*** *Department of Sociology*
University of Salford, Allerton building, Salford, Greater Manchester, M6 6PU
g.bagnall@salford.ac.uk +44(0)161 295 6554
If you remain dissatisfied you can contact:

Mr ***Anish Kurien****, Research Centres Manager, G.08 Joule House Acton Square, University of Salford, M5 4WT*
a.kurien@salford.ac.uk
0161 295 5276

Will my taking part in the study be kept confidential?

All information which is collected about you during the course of the study will be kept strictly confidential. The information will be stored in a computer which is password protected. The identity of each participant (you) will remain anonymous throughout the research process and in the report. The researcher will assign a number to you, and you will only be called and known by that number. Once the study is completed, the information will be kept for about ten years before it is destroyed. Keeping the information for some years is very important as it will be used to substantiate the findings if they are challenged in the future. When the researcher writes the report of the study, it will not be possible to identify you or anyone else who participated in the research by name. The information you give will be for research purpose only. It will not be given to any other party, but the supervisory team will need to see it to provide necessary guidance for the successful completion of the study.

What will happen if I don't carry on with the study?

You are free to stop participating in this study at any time. No explanation of why you wish to stop will be required from you. Let me know whenever you want to stop. All your personal information will be destroyed and your name will be removed from the entire study file, and this will not affect your normal life.

What will happen to the results of the research study?

The result of the study will be published and also made available to relevant authorities for implementation, so as to plan new strategy or to strengthen the existing ones for reduction of maternal mortality in Nigeria. You will not be identified in any report/publication.

Who is organising or sponsoring the research?

This research is financially supported by Ebonyi State University in conjunction with Federal Government of Nigeria

Further information and contact details:

Name of Researcher to be inserted - PhD Research Student, University of Salford, School of Nursing, Midwifery and Social Work, the Crescent Salford, Greater Manchester, M5 4WT

Email address: joycharis12@yahoo.com

Appendix 4: Focus group consent form

Title of study: Community perceptions of socio-cultural factors that influence maternal mortality and their solutions for its prevention in Southeast Nigeria.

Name of Researcher: Joy C. Oko Uka

Please complete and sign this form **after** you have read and understood the study information sheet. Read the statements below and underline yes if you accept or no if you do not accept, as applicable in the box on the right-hand side.

1. I confirm that I have read and understood the study information sheet version PIS 1, dated 14th December 2015 for the above study. I have had the opportunity to consider the information and ask questions which have been answered satisfactorily.	Yes/No
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.	Yes/No
3. If I do decide to withdraw I understand that the information I have given, up to the point of withdrawal, may be used in the research.	Yes/No
4. I agree to take part in a focus group discussion and for the discussion to be recorded	Yes/No
5. I understand that my personal details will be kept confidential and not revealed to people outside the research team.	Yes/No
6. I understand that my anonymised data will be used in the researcher's thesis/ research report and other academic publications and conferences presentations.	Yes/No
7. I agree that I will keep anything discussed in the group confidential	Yes/No

Name of participant	**Date**	**Signature**
Name of person taking consent	**Date**	**Signature**

Appendix 5: One-on-one interview participant information sheet

Title of study: Community perceptions of socio-cultural factors that influence maternal mortality and their solutions for its prevention in Southeast Nigeria.

Name of Researcher: Joy C. Oko Uka

Invitation paragraph

I would like to invite you to take part in the research as titled above. Before you decide whether to participate, you need to understand the purpose of the research and how you will be involved in this study. Please take time to read the following information carefully. Ask questions if anything you read is not clear or you need more explanation. Take time to decide whether or not to take part.

What is the purpose of the study?

The purpose of this research project is to investigate the community perceptions of socio-cultural factors that influence maternal health, wellbeing and mortality, including its potential perceived preventive measures in a Nigerian community. This is to generate evidence that could be used to plan or strengthen the existing strategies to improve maternal wellbeing and reduce maternal mortality in Nigeria.

Why have I been invited to take part?

You have been chosen to participate in one-to-one interview for this project because you are either a woman or opinion leader in the community, traditional birth attendant, doctor or midwife. Also, you have been invited because your opinion is expected to give rich information on the topic under investigation

Do I have to take part?

It is your decision to make. The information about the study will be explained to you, and we will read through the information sheet together. A consent form will be given to you to sign if you accept to take part in the study. You are free to withdraw at any time without giving any reason

What will happen to me if I take part?

This is a qualitative study using an in-depth interview as methods for data collection. You will be invited to be interviewed on the topic under investigation at your convenient day and time during the day. You will be asked to suggest a venue for the interview which will be assessed to ensure its safety for you and the researcher. The interview will be audio recorded.

Is the any support available for you?

Yes, arrangement has been made for the doctors and midwives from Sudan United Mission hospital in the community to be available at the venue of the interview to handle any potential emotional distress that may occur either during or after the interview.

Expenses and payments?

You are not required to pay or settle any expenses. This study is within the community; therefore, no transportation will be needed for you. Light refreshments will be provided by the researcher to the participants at the end of interview.

What are the possible disadvantages and risks of taking part?

No obvious risks have been identified as a consequence of your involvement in the study. However, there may be re-awakening of past feeling and experience that may lead to emotional distress during the interview. Appropriate plans have been made to handle any potential emotional distress that you may suffer.

What are the possible benefits of taking part?

The researcher cannot promise the study will help you but the information you provided for this study will help to plan or strengthen the existing strategies for reduction of maternal death and improving maternal health and wellbeing in the community

What if there is a problem

If you have any concerns about the study, you should ask to speak to the researcher who will do her best to answer your question. If you remain unhappy and wish to complain formerly, you report anything to the village head or you could contact the supervisory team of this project.

Dr Gaynor Bagnall, *Senior Lecturer in Sociology and Culture****,*** *Department of Sociology*

University of Salford, Allerton building, Salford, Greater Manchester, M6 6PU

g.bagnall@salford.ac.uk +44(0)161 295 6554

If you remain dissatisfied you can contact:

Mr, ***Anish Kurien****, Research Centres Manager, G.08 Joule House Acton Square, University of Salford, M5 4WT*

a.kurien@salford.ac.uk

0161 295 5276

Will my taking part in the study be kept confidential?

All information which is collected about you during the course of the study will be kept strictly confidential. The information will be stored in a computer which is password protected. The identity of each participant (you) will remain anonymous throughout the research process and in the report. The researcher will assign a number to you, and you will only be called and known by that number. Once the study is completed, the information will be kept for about ten years before it is destroyed. Keeping the information for some years is very important as it will be used to substantiate the findings if they are challenged in the future. When the researcher writes the report of the study, it will not be possible to identify you or anyone else who participated in the research by name. The information you give will be for research purpose only. It will not be given to any other party, but the supervisory team will need to see it to provide necessary guidance for the successful completion of the study.

What will happen if I don't carry on with the study?

You are free to stop participating in this study at any time. No explanation of why you wish to stop will be required from you. Let me know whenever you want to stop. All your personal information will be destroyed and your name will be removed from the entire study file, and this will not affect your normal life

What will happen to the results of the research study?

The result of the study will be published and also made available to relevant authorities for implementation, so as to plan new strategy or to strengthen the existing ones for reduction of maternal mortality in Nigeria. You will not be identified in any report/publication.

Who is organising or sponsoring the research?

This research is financially supported by Ebonyi State University in conjunction with Federal Government of Nigeria

Further information and contact details:

Name of Researcher to be inserted - PhD Research Student, University of Salford, School of Nursing, Midwifery and Social Work, the Crescent Salford, Greater Manchester, M5 4WT

Email address: joycharis12@yahoo.com

Appendix 6: Interview consent form

Title of study: Community perceptions of socio-cultural factors that influence maternal mortality and their solutions for its prevention in Southeast Nigeria.

Name of Researcher: Joy C. Oko Uka

Please complete and sign this form **after** you have read and understood the study information sheet. Read the statements below and underline yes if you accept or no if you do not accept, as applicable in the box on the right-hand side.

1. I confirm that I have read and understood the study information sheet version PIS 1, dated 14th December 2015 for the above study. I have had the opportunity to consider the information and ask questions which have been answered satisfactorily.	Yes/No
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.	Yes/No
3. If I do decide to withdraw I understand that the information I have given, up to the point of withdrawal, may be used in the research.	Yes/No
4. I agree to be interviewed and for the interview to be audio recorded	Yes/No
5. I understand that my personal details will be kept confidential and not revealed to people outside the research team.	Yes/No
6. I understand that my anonymised data will be used in the researcher's thesis/ research report and other academic publications and conferences presentation	Yes/No

_____	_____	_____
Name of participant	**Date**	**Signature**
_____	_____	_____
Name of person taking consent	**Date**	**Signature**

Appendix 7: Focus group guide

Title of project: Community perceptions of socio-cultural factors that influence maternal mortality and their solutions in South-East Nigeria

Introduction

1. Welcome
   Introduce myself and send the Sign-In Sheet around to the group while I am introducing the focus group.

   Review the following:

   - Who I am and what I'm trying to do
   - What will be done with this information
   - Why asked to participate

2. Explanation of the process
   Ask the group if anyone has participated in a focus group before. Explain that focus groups are being used more and more often in health and human services research.

   Logistics

   - Focus group will last about two hours
   - Feel free to excuse yourself
   - Where is the bathroom? Exit?
   - Help yourself to refreshments

3. Ground Rules
   Ask the group to suggest some ground rules. After they suggest some, I will ensure the following are on the list.

   - Everyone should participate.
   - No use of abusive words about each other.
   - No shouting or quarrelling
   - Information provided in the focus group must be kept confidential
   - Stay with the group and please don't have side conversations
   - Turn off cell phones if possible
   - Have fun

4. Allow some time (about 20minutes) for the participants to familiarize with each other and have a chat with each other before the focus group discussion

5. Turn on Tape Recorder

6. I will ask the group if there are any questions before we get started, and address those questions.

7. Topics/Questions:
   - What do you think are issues that influence pregnancy?

   For example, where you live, beliefs, lifestyle, family, etc, etc

   - What are the issues that affect maternal wellbeing during pregnancy, delivery and after childbirth?

   Probe for, role of medical staff, midwives, TBA's etc….

   - What do you think could be done to improve the health of the women, especially during pregnancy, childbirth and puerperium?

NB: this is just a guide, questions can and will be generated as the discussion progresses

Appendix 8: Interview guide

The unstructured interview style using an open-ended question will be adopted for this research because it will render opportunity for the participants to express their views and opinion regarding topic under investigation. Also, major issues identified from the analysis of data from the two focus groups discussion will also be explore during one-on-one interview.

The participant information sheet (PIS) will again be discussed with each participant before the start of the interview. This is to confirm the consent to participate in the one-one-one interview.

daq

The initial open questions for this research are

- What do you think are the issues that affect women during pregnancy and childbirth that could lead to maternal death?
- Can you tell me your thought about pregnant women antenatal care seeking practice/behaviour? I mean do you think that many pregnant women seek for antenatal care enough?
- Can you tell me any situation that can influence pregnant women from seeking antenatal care?
- Can you tell me with reasons where you prefer to seek antenatal care during pregnancy?
- Can you tell me your opinion about the quality of care you render to pregnant women? What are the issues that influence the services you render to these women?
- Do you think pregnant women are happy with the service you render to them during pregnancy and childbirth?
- What do you think makes pregnant women to die during pregnancy and childbirth?
- Are there benefits or harms associated with pregnant women giving birth with traditional birth attendants?

- How does role and position of women in our society contributes to maternal death during pregnancy and childbirth
- What do you think could be done to enhance maternal wellbeing and reduce or prevent maternal death during pregnancy and childbirth?

- Further questions will be based on the issues raised by the interviewee.

It is suggested that interviewer can help guide the interviewee through prompts, a form of encouragement (Fielding and Thomas, 2001). The following prompts will be used during the interview to encourage the interviewee to keep talking.

- Do you think…?
- Do you mean…
- Really?
- How does that make you feel?
- Why is that…?
- Uh huh!
- And then?
- How?
- Tell me a little more about that
- Repeat of some key words from the interviewee (will encourage elaboration)
- Why did that happen?
- What happened next

Appendix: 9 Sample of interview transcript

WOMEN LEADER (WL)

Good morning, thanks for giving consent to participate in my research. Please can you tell me what you think that causes maternal death?

Thanks for the opportunity to discuss about these issues. There are so many things that could cause death of a woman during pregnancy or child birth. They include

Lack of family planning. If a woman doesn't space her baby, she may die during childbirth because she has not recover from the effects of previous pregnancies.

If their husband doesn't care for them. Some men don't allow their wives to attend antenatal visit in the hospital. Some women drink herbal concoction during pregnancy and this concoction lack information of frequency and dosage. This can harm a pregnant woman and may lead to death of a woman during pregnancy or childbirth. If a complication arises during childbirth with traditional birth attendants, they may rush the woman to the hospital and of course you know healthcare workers in the hospital, they will start to blame the woman. The hospital will demand that money should be paid as deposit before the woman will receive care. Sometimes, before the relatives would go to look for the money, the woman may die.

You said that some women seek for care with traditional birth attendant. Please can you tell me what could cause pregnant women not to seek for antenatal care in the hospital but prefer to visit traditional birth attendant? Yes, there is high cost of antenatal care in the hospital. Many pregnant women and their husbands don't afford to pay the money always demanded by the hospital for childbirth. Because they can't afford the cost of care in the hospital, they resort to visit to traditional birth attendants. Some people console themselves by saying, my ground mother did not give birth in the hospital, so it's okay to give birth with traditional birth attendants.

Some family are poor, they have no money to care for their children because the woman gave birth to many children (12 or 14 children). In this kind of family, if a pregnant woman asks the husband to give her money to visit hospital for antenatal care, the husband will say that he has no money and of a truth, you will know that the husband has no money. Such pregnant woman will not attend antenatal care and will not visit hospital for childbirth.

Some pregnant women believed that giving birth in the hospital is not necessary because their mothers or ground mother gave birth at home with traditional birth attendants. There was a period the wife of governor declared free maternal care in the hospital but still some pregnant women did not visit the hospital because they considered it not necessary. Also, there are some pregnant women, when requested to be admitted in the hospital because of the problems related to their pregnancy, they will not accept because they have no body to care for the children they left at home. You know our women always give birth to twelve children or more.

You spoke about beliefs; can you tell me more about other beliefs that could affect pregnancy and can lead to maternal death. Some pregnant women don't eat adequate food during pregnancy. For instance, some people believed that if a pregnant woman eat snails during pregnancy, her baby will be sluggish after birth, so they avoid snails, which is a good source of protein. Some believed that pregnant women should not eat egg because if she does, her baby will be greedy and may steal egg after birth. Many of the food stuffs that healthcare workers advised that pregnant women should be taking are believed by some families and pregnant women in this community not to be good. This belief affects pregnancy and may lead to malnutrition in pregnancy and may cause death of woman during childbirth.

Are there any other beliefs or traditions? Yes, some pregnant women don't visit hospital because the midwives must ask them the number of the previous children. The midwives always advise against giving birth to too many children but many pregnant women don't want anybody to tell her to limit the number of children they want to have. Many women want to give birth to as many children as possible. So, some pregnant women prefer not to visit hospital so that they will not be told the consequences of multiparty. It is believed that every woman should give birth to as many children god gave to her. Some pregnant women avoid going to the hospital because of the fear that the midwives or the doctors will scold them for being pregnant after such woman was advised not to get pregnant.

You spoke about believe of giving birth to as many children as possible. Can you tell me more about that? Yes, the belief is due to ignorance because they are not aware of the consequences of giving birth to too many children. Some women want to give birth to more children because another woman that got married at the same year with her had more children than her. She would want to compete with other women on the number of children they will give birth to. Another reason is, if a woman continually give birth to same sex of either male or female, the woman will continue to give birth to too many children in search for opposite sex.

Can you tell me other issues that could lead to death of a woman during pregnancy or childbirth? The issues you have witnessed or heard of. Another issue is belief in church. There was a pregnant woman that went for her antenatal visit in the hospital. After examination, she was told to return to the hospital for admission two weeks before her expected date of delivery because of some medical condition she had. She went home, explained to the husband but they agreed that they will go and inform their pastor. When they told the pastor, the pastor said, God forbid! That she will give birth to her baby safely because bible said that she will give birth safely like Hebrew women. That he will pray for her and there are high chances that she will give birth at home even without going to hospital. The woman and the husband believed in what the pastor said and disobeyed what the midwives said. The woman did not visit the hospital, gave birth to the first baby at home as she was having a twin, but the second baby refused to be delivered. Pastor was invited for prayer, he came prayed but still the second baby could not be delivered. The woman was later rushed to the hospital but on the way, she died. This woman died because of faith in pastor. Chai!

Also, some women die in pregnancy or childbirth because they refuse to adhere to doctor's instructions or advice. Some women as told that they cannot be able to give birth through vagina but it will be by caesarean section. Many of them usually say, God forbid! They instead will visit their pastors for prayer but during childbirth at their homes, they usually die.

You spoke about belief in church and pastors. Can you tell me more about that? Yes, some women die during childbirth because they don't want to go against their church doctrine and beliefs. For instance, Jehovah witness church don't believe in blood transfusion. If a member of this church is pregnant and require blood transfusion, such person will reject and eventually many of them die during childbirth as a result of haemorrhage. Also, some women visit some prayer houses where they are told that God said they will give birth safely to their babies, that there is no need to continue taking drugs from hospital but instead they rather pray daily from 6am to 12. noon. Many pregnant women usually believed and abandoned antenatal visit and their medications from the hospital. During their childbirth, most of them die.

Another one is that our people believed that herbal mixture is more effective than medication from the hospital. That their ground mothers did not visit hospitals but yet they gave birth safely. They believed that herbal mixture prevents pedal oedema during pregnancy and that it helps foetus to grow and develop normally. They believed that medication from hospital usually make foetus to grow big and this will result to difficulty during childbirth.

Sometimes, some pregnant women take the herbal mixture from traditional birth attendants because they have no money to visit hospital or because of long distance between the hospital and their homes. I have seen some women that die after child birth because they drank herbal mixture, although some are fine after drinking the herbal mixture.

Can you tell me more about the woman that died? Yea, Sudan United Mission hospital is close to them but the woman drank herbal mixture and gave birth with the help of traditional birth attendants. A week after the childbirth, she complained of abdominal discomfort, it became serious that she was taken to the hospital but on arrival to the hospital the healthcare workers sent her back to the place she delivered because she did not register for antenatal care. The woman was carried back to her home and she died after few days.

You have children, where did you give birth to them? For me, I gave birth to some of my children in the hospital while some are at home. The ones I gave birth at home was because I had no money to visit the hospital, although I completed the antenatal visits. The traditional birth attendants did not use any equipment during the childbirth but only gave me concoction which later affected me and my baby. I then spent more money to buy medication for myself and my baby.

What would you recommend for pregnant women, either to give birth with traditional birth attendant or in the hospital because you have experienced the two? I will recommend that all the pregnant women should seek antenatal care in the hospital and give birth to their babies in the hospital. This is because herbal mixture given by traditional birth attendants has no dosage or precautions on the usage. The preparation process of this mixture by some traditional birth attendants is not hygienic

When you gave birth in the hospital, were you satisfied with the services rendered by the midwives and doctors? Some nurses and midwives are quarrelsome. They shouted at me because I forgot to take my drugs as prescribed. The way some of the nurse shout could discourage some pregnant women from attending the antenatal visit in their hospital. The cost of antenatal care is high.

Can you tell me if the role and position of woman in the society contribute to maternal mortality? Yes, some women are not allowed to work by their husband and therefore are not able to provide money they will use to seek for antenatal care during pregnancy. Some women fully depend on their husband to provide all their needs. Women should be encouraged to work

in order to support their husband. Lack of money makes women not to attend their antenatal visits and could lead them to give birth with traditional birth attendants.

What could be done for the reduction of maternal death especially in rural communities? There should be community mobilization and sensitization about the need for antenatal care and women giving birth in the hospitals. Hospitals and health centres should be built close to the women in rural communities. It is only one hospital that serve several villages in this community. They should make antenatal care or surgical interventions during childbirth to be affordable to poor rural dwellers. The government should make antenatal care free for pregnant women even if it is for some number of children.

Do you think that a man has a role to play in pregnancy and childbirth? Yes, man and woman should agree on the number of children they want. Men should assist their wives in domestic works during pregnancy. Men should accompany their wives to antenatal visits and be nice and caring to their wives. Men should endeavour to provide things needed by their pregnant wives.

Many thanks for the information, they are very helpful for my research.

Appendix 10: University of Salford ethical approval letter

University of Salford MANCHESTER

Research, Innovation and Academic Engagement Ethical Approval Panel

Research Centres Support Team
G0.3 Joule House
University of Salford
M5 4WT

T +44(0)161 295 2280

www.salford.ac.uk/

19 January 2016

Dear Joy,

RE: ETHICS APPLICATION HSCR 15-129 – Community perceptions of the socio-cultural factors that influence maternal mortality and their solution for its prevention in South East Nigeria

Based on the information you provided, I am pleased to inform you that application HSCR15-129 has been approved.

If there are any changes to the project and/ or its methodology, please inform the Panel as soon as possible by contacting Health-ResearchEthics@salford.ac.uk

Yours sincerely,

Sue McAndrew
Chair of the Research Ethics Panel

Appendix 11: Ebonyi State University Research and Ethical approval

EBONYI STATE UNIVERSITY

Tel: 043-221093
Fax: 043-221093
Email: vc@ebsu-edu.net
frankidike@ebsu-edu.net
profidike@yahoo.com
Website: www.ebsu-edu.net

OFFICE OF THE VICE - CHANCELLOR

P.M.B. 53
Abakaliki, Ebonyi State,
Nigeria

Our Ref.

ETHICAL CLEARANCE/RESEARCH SUPPORT

The project titled "community perceptions of the socio-cultural factors that influence maternal mortality and their solution for its prevention in South East Nigeria" has been reviewed and is been supported by Ebonyi State University, Abakaliki in conjunction with Federal Government of Nigeria.

The Ebonyi State University will provide full support for the participants and the researcher during the field work. Arrangement has been made for the doctors and midwives to be available during field work to handle any potential emotional distress and any other issues that may arise during conduct of this research.

Researcher:

School:	University of Salford Manchester, Greater Manchester United Kingdom.
Study site:	Onuenyim Agbaja Community in Ebonyi State, Nigeria.

14/10/15

Dr NDIE E.C
Chairman, Faculty of Health Sciences Research Ethics Committee
Ebonyi State University
+2347088171419