SOCIO-CULTURAL BELIEFS AND HEALTH SEEKING BEHAVIOR; A STUDY OF CHILD AND MATERNAL HEALTH IN IJERO-EKITI, EKITI STATE.

BY

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CERTIFICATION

This is to certify that this project work was carried out by **ADENIRAN ABIMBOLA ADEBAMIGBE**. It has been read and approved, having met the standard requirements for the award of (B.Sc) Degree in the Department of SOCIOLOGY, Faculty of Social Science, Federal University Oye - Ekiti, State, Nigeria.

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DEDICATION

This project is dedicated to the ALMIGHTY GOD, whose infinite mercies saw me through the course of this study and to my late parent MRAND MRS GABRIEL ADEDAYO ADENIRAN and also to my guardian MR AND MRS OLUSEYI AWE.

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ABSTRACT

The overall aim of this study was to examine the socio-cultural context surrounding the health seeking behavior of women regarding child and maternal health and how this enhance maternal mortality and morbidity in Ijero-Ekiti. This study was necessary due to the high rate of child and maternal mortality that pervaded the sub-Saharan Africa especially Nigeria. It also studied the challenges faced by women in the process of seeking health and the possible solutions to advance child and maternal health in Ijero-EkitI. Questionnaire was used in collecting data, this is a quantitative instrument used for collecting specific information from the respondents The questionnaire used was a semi structured questionnaire that encompasses both open and close ended questions which has four sections and forty-one questions. A purposive sampling techniques was adopted in collecting data from 150 sampled respondent which comprises of pregnant women and nursing mothers within the age of 18-49years. The data gathered was analyzed using the statistical package for social sciences (SPSS) which runs the data and calculate chi square and simple percentages. Findings from this study reveals that women age 30 and above seek health more than those lower than 30 years and that women who are most liable to have complications are 42 years and above. This study also reveals the patriarchal nature of our society as more than 40% of the respondent affirm that their husbands take the decision of where and when to seek healthcare. Also, it was revealed that sociocultural beliefs significantly influence the health seeking behavior of women and the rate of Child and Maternal Mortality in Ijero Ekiti. This study therefore, concludes that socio-cultural beliefs and demographic factors such as; age, education, marital status, and occupation are determinant factors that influences health seeking behavior and that religion, residence and income do not have any influence. Based on the findings in this study, it is therefore recommended that the government should specifically improve the standard of primary healthcare so that women can easily access health care since it is the primary health care that is closer to the women and that government should also improve the standard of the educational sector and give women better chances of been educated so that their decision towards health will be based on logic rather than cultural or superstitious beliefs.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Child and Maternal health has been one of the most focus area when it comes to health issue. This is as a result of the high rate of child and maternal mortality which pervaded the world and most evident in developing countries like Nigeria. Nigeria has one of the highest child and maternal mortality rate which is about 96 per thousand live births in rural area against 75 per thousand life births in urban area Uzochukwu & Akpala (2014). It was estimated globally that 585,000 women die every year from pregnancy related causes, a rate of 430 deaths per 100,000 life birth. (WHO,2014).Despite the goal of reducing infant, child and maternal mortality rate as stated in the MDGs goals, child mortality rates still remain unacceptably high especially in sub-Saharan African countries, where close to 50 percent of childhood deaths takes place, even when the region accounts for only one fifth of the world's child population For instance, in sub-Saharan Africa, 1 in every 8 children dies before age five- nearly 20 times the average of 1 in 167 children in developed parts of the world (Mojekwu and Ajilola, 2012).

Child mortality is the death of children under five years and such deaths are mostly from preventable causes like malaria, pneumonia, diarrhea , measles and also HIV/AIDS which account for more than 71% of the estimated one million under five death in Nigeria in 2004 (FMOTT, 2007). Although being a mother is an exciting and an unforgettable experience to most women, it is often accompanied with ill health and even death which causes pain and a large vacuum which cannot be easily filled hence, it has been described as a major public health problem in developing countries. World health organization defines maternal health as the health

of women during pregnancy, childbirth and the postpartum period. It encompasses the health care dimensions of family planning, preconception, prenatal, and postnatal care in order to reduce maternal morbidity and mortality (WHO, 2012).

Maternal Mortality is the death of a woman while pregnant or within 42 days of termination of a pregnancy, irrespective of the duration or site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental causes and these has been and still continues to be a public health problem particularly in developing countries. It is very sad because women die in the process of performing this essential physiological function of childbearing and in efforts to fulfill their natural role of perpetrating the human race (Diawuo & Issifu, 2015).

Health is a crucial aspect of human life that needs prior attention if we hope to see it functioning at its normal state, whatever we want to achieve in life can greatly be influenced by how healthy we are. Thus, health seeking behavior becomes an important concept in the school of health. Health according to the World Health Organization (WHO, 2010) is the state of complete physical, mental and social well- being and not merely the absence of disease or infirmity. This definition is an holistic perspective that takes into account all aspect of human life, in particular. Health seeking behavior can be described as how individual seek help or treatment from either a qualified means or otherwise. Procter (2013). Women health seeking behavior pertaining to maternal issue is beyond their personal self. Many studies have shown that an individual's health is mostly influenced by a lot of factors ranging from social, economy, cultural and even intellectual factors which thus influence their attitude toward health and health seeking behavior and what they turn to as aid before, during and after pregnancy, (Abdulkarim, 2008).

Socio-cultural beliefs are learned behavior shared by the member of a particular society. Which can include variables like, sex, age, the social status of women, the type of illness, access to services and quality of services and most important of all is religion. Many people are so engrained in their religious that it has dominated their belief system hence, some women believe in their pastor's prescription when it comes to maternal issue, they will choose their pastor, traditional healers, midwifery or untrained doctors above formally trained practitioners or government health facilities (Ahmed et al, 2013). Studies also reveals that women were more likely than men to seek help from traditional healers first or their pastor rather than going to hospital for proper treatment Yamasaki et al (2011).

The utilization of qualified health care system of women for their maternal health may depend on educational levels, economic factors, cultural beliefs and practices and other factors like environmental conditions, socio-demographic factors, and knowledge about the facilities, gender issues, political environment, and the health care system itself. Chuku, (2010). In many health systems particularly in developing countries like Nigerian, illiteracy, poverty, under funding of the health sector, inadequate water and poor sanitation facilities have a big impact on health indicators as well as cost of services, limited knowledge on illness and wellbeing, and cultural prescriptions are all barriers to the provision of health services. These challenges, which are significant in Nigerian's health system, affect the health seeking practices of people, influences health functions and the quality of life of people especially women, (Chuku, 2010).

Amongst all the factors that influences the health seeking behaviour of women culture has been identified has one of the most salient factor of all, women attitudes towards medical care and their ability to understand, manage, and cope with the course of an illness depend largely on their cultural beliefs. Especially those living in extremely rural areas who are more at risk to have

health problems in their maternal health mainly because of their cultural and religious beliefs held in high esteem, environmental hazards such as pollution, increased stress. Socio environmental conditions such as gender biases combined with poverty, stressful work environment, and poor quality of life which results into sickness, poor nutrition, early marriages and repeated pregnancies thereby exacerbating maternal mortality. In view of the above point, this work will examine the sociocultural beliefs and health seeking behavior of women during and after pregnancy Azuh (2012).

1.2 Statement of the Problem

Maternal mortality is the most important indicator of maternal health and well-being in any country Azimi and Loffi (2011). Even though maternal mortality is a worldwide phenomenon, the critical issues associated with it are most profound in developing countries. The situation is even more alarming in Nigeria. For instance, in the year 2000, the maternal mortality ratio per 100,000 live births was 800 compared to 540 for Ghana and 240 for South Africa and by 2003, the maternal mortality ratio in Nigeria had risen to 948 per 100,000, in 2005 it was 1100 per 100,000 and 1400 per 100,000 live births in 2008, ironically,, the number of deaths each year from maternal causes worldwide decreased from 536,000 in 2005 to an estimated 358,000 in 2008 and 273,500 in 2011. (UNICEF, 2010, Zozulya, 2012, NDHS 2008, Ogujuyigbe and Liasu, 2007).

Nigeria, like many other developing countries particularly in Africa, is still far from reducing child mortality to a level of 6 per 100,000 live births as compared to the developed world despite their immunization strategy administered on children. (UNICEF, 2011). Data from the 2008 Nigeria Demographic and Health Survey (NDHS) indicate that the infant mortality rate is 75 deaths per 100,000 live births; while the child mortality rate is 157 deaths per 100,000 live births

for the five- year period immediately preceding the survey. This translates to about one in every six children born in Nigeria dying before their firth birthday and consistently lower in urban areas than in rural areas. (NPC and Macro, 2009). This has brought about serious stress in the health sector and therefore, posed a major challenge to socio-economic development and prompted an unprecedented government response.

Consequently, the chance of a Nigerian woman dying from reproductive health disorders and complications was put at 1 in 10 in 2002, 1 in 18 in 2005, and 1 in 23 in 2008, placing the Nigerian woman at far greater risk than her counterpart in the developed world, (Population Reference Bureau, 2012), Studies have shown that hemorrhage, hypertensive disorders, infection, unsafe abortion, poverty, ignorance or illiteracy are the most common medical causes of child and maternal mortality. Thus, many studies have concentrated on the germ theory or medical causes that surrounds it nevertheless, child and maternal mortality still continues to rise despite numerous strategy to reducing it. (Ogujuyigbe and Liasu (2007).

In an attempt to address the issue of child and maternal mortality this research will focus on the socio-cultural aspect of child and maternal health since it is the socio-cultural context under which pregnancies occur that determines whether a woman will seek health services for herself and for the born or unborn child. Most women act base on what they believe which automatically hinders their health seeking behaviour and why they prefer the traditional means of child delivery incidentally, very few studies have focused exclusively on this aspect. This study, therefore, attempts to fill this gap.

1.3 Research Questions

Based on the statement of problem, the following research questions are addressed;

1. How knowledgeable are women about health seeking behavior in relation to child and maternal health in Ijero-Ekiti?

2. What is the impact of socio-cultural beliefs on the health seeking behavior of women in relation to child and maternal health in Ijero-Ekiti?

3. What are the challenges faced by women in the process of seeking healthcare as regards child and maternal health in Ijero-Ekiti?

4. What are the possible solution to advance child and maternal health in Ijero-Ekiti ?

1.4 Aim and Objectives of Study

The overall aim of this study is to examine the socio-cultural context surrounding the health seeking behavior of women regarding child and maternal health and how this enhance maternal mortality and morbidity in Ijero-Ekiti, In order to achieve this, there are specific objectives which include:

1. To examine the knowledge base of Women about health seeking behavior in relation to child and maternal health in Ijero-Ekiti.

2. To explore the impact of socio-cultural beliefs on the health seeking behavior of women in relation to child and maternal health in Ijero-Ekiti.

3. To examine the challenges faced by women in the process of seeking health as regards child and maternal health in Ijero-Ekiti.

4. To identify the possible solution to advance child and maternal health in Ijero-Ekiti

1.5 Research Hypothesis

Hypothesis One

H0: There is no relationship between socio-cultural beliefs and health seeking behaviour of women.

H0; There is a relationship between socio-cultural beliefs and health seeking behaviour of women.

Hypothesis Two

H0: There is no relationship between sociocultural beliefs and maternal mortality.

H1: There is a relationship between sociocultural beliefs and maternal mortality.

1.6 Significance of the Study

One of the anticipated goal of the Millennium Development Goals (MDGs) is the improvement of maternal health and the reduction in maternal mortality by 75% by the year 2015. With Nigeria's poor record of maternal mortality, it is clear that the global MDG goals cannot be achieved without a significant outcome from Nigeria in terms of reductions in rates of maternal morbidity and mortality. Even though MDG has metamorphosed to become Sustainable Development Goals, her aim of reducing maternal health in the world still stood especially in developing countries where MDG had not been effective. Thus, this study will provide a sociological insight into those salient socio-cultural barriers to the wellbeing of mother and child and what can be done to improve the situation. The maternal mortality rate (MMR) in Nigeria without doubt calls for urgent action as recent United Nations figures,place Nigeria second to

India on the MMR table (Ogbonnaya and Olawale 2008), research into this sensitive aspect of life will therefore, shed more light on certain cultural beliefs that precipitate maternal health challenges, and help to initiate more sensitive intervention strategies.

The significant of this study cannot be overemphasized as the findings could be used as references or documentary sources that would help the government, non-government organization take measure towards reducing and eliminating child and maternal mortality in Ekiti and Nigeria at large, Globally, the importance of understanding these maternal health practices, beliefs and traditions has been recognized as playing a vital role in designing culturally appropriate interventions that are effective in reducing maternal mortality and improving public health. Also, this study will contribute to the existing literature and theoretical framework on how socio-cultural factors influence the health seeking behavior of women and their children.

1.7 Operational Definition

Several key words used in this study includes; child mortality, health, maternal mortality, social cultural, health seeking behavior etc.

Health This can be defined as the state of total wholeness and sound health in every aspect of human life. It encompasses the physical health, mental health, spiritual health and social well-being of women before, during and after pregnancy.

Maternal Health This is defined as the physical wellbeing of a mother in relation to her pregnancy. Maternal health includes prenatal care and postnatal care of the mother and of the child up to the age of five years

Maternal Mortality This is the death of a woman as a result of pregnancy related issues, the death might occur before, during or after labour

Child Mortality This is the death of a child before the age of five

Maternal Morbidity This can be describes as any pregnancy and childbirth-related illness and injury.

Maternal Mortality Ratio (MMR): This is the number of maternal deaths per 100,000 live births during the same time-period, usually a year.

Maternal Mortality Rate: This is the number of maternal deaths in a given period per 100,000 women of reproductive age during the same time-period.

Health Seeking Behavior This is the process of consulting practitioners in maintaining, preventing and restoring of health before it degenerate into something serious, individuals might consult different means either the medical way or the orthodox practices.

Socio-cultural Beliefs. These are the surrounding societal and cultural factors or circumstances, which influence or hinder maternal health. They are also the social and cultural framework in which an individual functions.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

Literature review is a systematic review of the most important published scholarly literature on a particular topic. In the course of this research, previous works that are related to this study will be examined to further understand this study. Several works have been done on health seeking behaviour, maternal health, child mortality, maternal mortality and so on.

2.1 Health Seeking Behaviour

The term health seeking behavior can be defined as a sequence of remedial action that individual undertakes to rectify perceived ill-health. It also refers to activities undertaken by individuals in response to symptoms experienced (Tones, 2014). Health care has become a tool for understanding how people engage with the health care system in their respective socio-cultural, economic and demographic circumstance. The attitude of individual towards health seeking behavior is beyond their control. Many studies have shown that an individual's health is mostly influenced by their sociocultural beliefs which thus influence their attitude toward health seeking behavior and what they turn to as aid. (Abdulkarim2008). This acknowledges that understanding human behaviour is a prerequisite to changing health seeking behaviour and improving health practices.(Ribera and Nyamango 2011).

Health-seeking behaviour is a part and parcel of an individual's, family's or community's identity being the result of an evolving mix of personal, experiential and socio-cultural factors. It is therefore, an important indicator of cultural, social, economic and political realities of a group of people (Iyalomhe and Iyalomhe, 2013) Health Seeking Behaviour can also be defined as any activity undertaken by individuals who perceive themselves to have a health problem or to be ill

for the purpose of finding an appropriate remedy (Kersnik 2013).. It is situated within the broader concept of health behaviour which encompasses activities undertaken to maintain good health, to prevent ill health as well as dealing with any departure from a state of good health (WHO 2008).

2.2 Health Seeking Behaviour and Maternal Health

The health of a women during pregnancy, childbirth, and the postpartum period is refers to as maternal health. Broadly speaking, it is a health care dimensions which encompasses family planning, preconception, prenatal, and postnatal care in order to reduce maternal deaths. (Pathfinder International, 2013). According to the National Nutrition and Health Survey (NNHS, 2014), 47 percent of Nigeria women received some form of prenatal care or health care services during pregnancy; although, access is much lower in rural areas relative to the more urbanized cities in the country. Seeking health care during pregnancy provides women with the knowledge to learn what to do if complications arise during pregnancy, childbirth, or the risky period immediately after childbirth where many maternal deaths occur. (Harding et al. 2002). It also provides education on proper maternal nutrition, treatment for infections (e.g., malaria, syphilis, and tetanus), and testing for HIV/AIDS. (Lindroos 2010).

The Nigerian health system as a whole has been plagued with problems of service quality, including unfriendly personnel, inadequate skills, decaying infrastructures and chronic shortages of essential drugs. Electricity and water supply are irregular and the health sector as a whole is in a dismal state. In 2000, the World Health Organization ranked the performance of Nigeria's healthcare system 187th among 191 United Nations member states. Also, a 2003 study revealed that only 4.2 percent of public facilities met internationally accepted standards for essential obstetric care (Harrison, 2009). The weak performance of the health system has been attributed to the country's long-standing problems with governance. Corruption in the political system is

endemic while social development, including the promotion of the health of Nigerian citizens has been more rhetorical than a real aim of the state (Lindroos 2010).

The problem of poor organization and access to maternal health services has always been a major challenge in Nigeria despite the fact that the health care is organized around three tiers: primary, secondary and tertiary care levels. Primary health centres are located in all the local government councils in the country where pregnant women are to receive antenatal care, delivery and postnatal care in the one nearest to them. In case of complications they are referred to secondary care centres managed by states or tertiary centres, managed by the federal government. Unfortunately, the primary health care centers designed for pregnancy related issue are mostly poorly funded and filled with incompetent staff. (Aghoja et al, 2008).

2.3 Trend of Maternal Mortality in Nigeria

Maternal mortality remains a serious concern in Nigeria, especially in the northern region and in the rural south where it is more pronounced (WHO 2015, UNICEF 2015). In 2005, the estimated total of global maternal deaths recorded was 536,000. Nigeria accounted for 10 percent of the world's total maternal deaths in 2010 and mortality rate exceeds 1000 deaths per 100,000 live births and is much higher than the African continent average of 800 deaths per 100,000 live births (Zozulya 2012).

Maternal mortality is the death of a woman while pregnant or within 42 days after termination of pregnancy, irrespective of the duration of the pregnancy, from any cause related to or aggravated by the pregnancy excluding all accidental causes of death (WHO 2010). Because a large number of maternal deaths occur late or later than 42 days after termination of pregnancy, some definitions extend the period up to a year after termination of pregnancy (Koonin et al. 2008, Lindroos 2010).

Maternal deaths or mortality can also be defined as either direct or indirect. Direct maternal deaths result from complications of the pregnancy (pregnancy, labor and post-delivery), from interventions, omissions, incorrect treatment or from a chain of events arising from any of the above. Indirect maternal deaths are due to previously existing diseases or diseases that develop during pregnancy and not due to direct obstetric causes (Oxaal et al. 2006). Pregnant women's perception of maternal health varies and affects how they act and whether or not they seek prompt medical attention during an emergency while some women believe that bleeding during pregnancy is healthy and necessary as it eliminates impurities, other women fear excessive bleeding which they believe can drain the life out of a new mother (Obermeyer 2013). In northern Nigeria, most women were admitted into medical facilities in a critical state due to excess bleeding, having delivered several hours prior at home (Obermeyer 2013. Recognizing the danger of excessive bleeding or postpartum hemorrhage may be confounded by the beliefs that excess bleeding is necessary for the cleansing process, these beliefs contribute to the late recognition of dangerous pregnancies which could lead to morbidity or mortality. (WHO 2015, UNICEF 2015).

The causes of maternal mortality are multifactorial. The medical causes are the direct and indirect causes as shown by the World Health Organizations definition of maternal death. Omoruyi (2011), estimated that in Nigeria, more than 70 percent of maternal deaths could be attributed to five major complications: haemorrhage, infection, unsafe abortion, hypertensive disease of pregnancy and obstructed labour. A joint report by World Health Organisation(WHO), United Nations Children Fund(UNICEF) and World Bank in 2015 says, maternal deaths are not uniform in Nigeria it varies according to geographical zones. It is higher in North East 1549 per 100,000 live birth and lowest in South West 165 per 100,000 live birth, with the present ratio, the fifth target of Millennium

Development Goal (MDG 5) which aims at improving maternal health and reduce maternal mortality by 75% between 1990 and 2015 has not really been effective in this country.

2.4 Socio-Cultural Context of Maternal Health

Culture can be defined as values, beliefs and behaviour that are shared by members of a society which provide direction for people as to what is acceptable or unacceptable in given situations (Nayak et al. 2012). Researches have shown that rural population in Nigeria constitute about 60% of total population and most Nigerians irrespective of where they live are strongly influenced by the cultural and traditional norms of their ethnic origin. (Garces, et al 2012). This explains the differences in sociocultural behavior that affect the lifestyles of entire society which put women at risk, such as poor nutrition, heavy work, powerlessness to make decisions, incorrect information on health services and inadequate service delivery, are mostly avoidable by considering the welfares of the culture in relation to maternal health, this means that there is a link between cultural affairs and maternal health. (Majali,2012

The issue of cultural interference on maternal health has become a catastrophic problem, especially in rural areas In addition, sociocultural factors can influence individual behavior depending on one's social and cultural values which can include; religion, economic status, education, family, age, politics and cultural values. (Majali, 2012) some of which are explained below;

- Cultural practices
- Religion
- Poverty
- Maternal Age
- Education

2.4.1 Cultural Practices and Maternal Health

Nigeria from the onset has been a patriarchy society (male dominance) which is still evident till date especially in the northern and rural areas of Nigeria where gender inequality exists in access to food, work allocations and access to medical services and is compounded by cultural and religious norms. Women living in rural areas tend to engage in more strenuous activities such as farm work and carrying heavy loads from the farm to the house on their heads which could have disastrous effects on the health of both mother and the unborn child. (Chinwe 2012). Also the cultural requirements of Nigerian women include serving and attending to male members of the family and the children. These services include taking care of the children, household chores, fetching water, planting crops, harvesting them and taking care of small animals on the farm Chinwe (2012), argues that these factors contribute to high maternal mortality rates in the rural areas because incessant child birth and strenuous work deteriorate woman's health.

Some cultural practices contribute to child and maternal mortality but are most times neglected. This ranges from harmful traditional practices like female genital mutilation, circumcision infibulation etc. Also some cultural practices put pressure on woman to having male children not only to belong to the husband's lineage but also to secure access to inheritance. For instance, in the old community of Mbaises in Imo state, a woman who has 10 or more children (mostly male) is compensated with a cow on the10th live birth. Such cultural practices can expose women and girls to the health risk of early and frequent pregnancies that can lead to high maternal morbidity and mortality.(Sinha 2008). Food taboos are prevalent in several Nigerian communities, during pregnancy and child birth; women's eating habits are guided by these local taboos which deny the consumption of certain food that can fall within the range of protein, carbohydrate or fruits. For instance, some communities among the Yoruba's prohibit the ingestion of meat, egg, beans or

other protein-containing foods during pregnancy. (Sinha, 2008). Similarly, in some communities of both the eastern and southern parts of Nigeria, pregnant women are discouraged from eating egg as they believe that it reduces contraction strength during labor, hence leading to difficult labor. (Garces, 2012). Other forbidden foods are Okra soup and snail, for fear of excessive salivation of the infant, garden egg for fear of impaired speech in infant; fish for fear of extra digits and plantain for fear of delayed ossification of the anterior fontanels; palm oil for fear of jaundice and certain fruits for fear of baldness (Garces, 2012. Sinha 2008).

2.4.2 Religion and Maternal Health

The predominantly Muslim northern region of Nigeria records some of the highest maternal death rates in comparison to the southern states this is because of their rigid religion and cultural practices which see women as secondary citizen (Federal Ministry of Health 2011)..Contributing to maternal mortality and morbidity is an Islamic culture that undervalues the female gender, encourages a social need for women's reproductive capacities to be under strict male supervision and control, practices purdah (also known as wife seclusion), often restricting medical care of the woman, produces high rates of female illiteracy and encourages early marriages and pregnancies often occurring before pelvic maturity (Wall 2008). Early marriage accounts for about 23% of maternal mortality due to severe haemorrhage resulting from obstructed and prolonged labour. This is because the narrow pelvis of young women results to fistula and often times a still birth which consequently leads to haemorrhage. (Olusegun et al, 2012).

In some societies, the church takes care of the delivery process which may also contribute to maternal mortality due to the incompetence of the workers, some women as well as their relative prefer going to church because it is believed that the holy environment of the church would protect both mother and child from evil spirits and witchcraft. Also, certain religions do not believe in

blood transfusions and most times this leads to the death of mothers after childbirth (Chukuezi 2010). In several contexts, women preferred to deliver at home and call in a missionary midwife where they will be in a familiar and convenient setting. During a homebirth, a woman would not need to arrange for child care or transportation, could rest in her own bed after delivery and be catered for by her family and friends.(Garces et al.,2012).

The perception that birth is a natural life event rather than a medical procedure emerged as a common belief amongst many women therefore they saw no rationale for delivering at a facility and paying to do so is considered illogical and superfluous. Giving birth in a religion's environment played an important role as first-line providers for many women. (Chinwe 2012), women emphasized the close bond they felt with the missionary midwives, due to their status in the community and the trust they developed over years of experience. This relationship often prompted women to desire home-based births attended to by missionary midwives rather than medical personnel. Women perceived these missionary midwives as providing high quality delivery care, often emphasizing the supportive and emotional role that they play. A lot of women believed that these missionary midwives have innate skills given to them by God and are more dependable than facility-based health workers. (Chinwe, 2012).

2.4.3 Poverty and Maternal Health

Direct costs associated with maternal health care services are very high for many Nigerian women, considering the poverty level in the country many cannot afford to pay their medical bills as such they prefer to stay at home and look for the services of traditional birth attendants who charge less or in some cases free of charge (Ajaebu, 2013). Low-resource households may have trouble acquiring funds to pay for facility-based care at the time-of-service, particularly those families who rely on seasonal labor, borrowing money was also difficult as few moneylenders lent to the

poor, and if they did, exorbitant interest rates could make the favour turn sour. (Ajaebu, 2013). Research has shown that poorer mothers in Nigeria are less inclined to seek obstetric care from health facilities for various reasons which may put them at risk of developing a lifelong illness or condition. In comparison, a large number of rich women across the world welcome surgical interventions in childbirth even if it is not strictly necessary. Mpembeni (2012).

Poverty has a grave impact on maternal deaths and the decisions women make in utilizing health care services (Graham et al. 2004). Poor pregnant women die more disproportionately than those who are more financially stable due to the fact that poorer people are less likely to get medical care or go to a healthcare facility because of financial constrain, they prefer to go for cheap traditional care but, for their well to do counterpart obstetric treatments, particularly caesarean section (CS), are a matter of responding to the modern way delivery (Prata, et al 2009). Demographic and Health Survey (NHS 2008) data on place of delivery shows that poor women are less likely to give birth in a healthcare facility with skilled healthcare providers. In addition, 30 percent of Nigerian women identified lack of money to pay for health care as a major obstacle to accessing health care. Another 24 percent identified the distance to a healthcare facility and another 24 percent listed the cost of transportation as the obstacle (NPC 2008).

2.4.4 Maternal Age and Maternal Mortality

Higher mortality rates have been observed among women who have babies at high and low extremes of maternal age (women younger than 20 and above 40 years of age), In fact, pregnancy is the highest cause of death in women ages 15-19 years of age in Nigeria (World Bank 2016). This is because the reproductive organs of women within that age group are not mature enough to carry a pregnancy. Women ages 15-19 are two times more likely to die from pregnancy or childbirth as women over 20 years of age while women less than 15 years are 5 times more likely

to develop complicated pregnancies leading to death (UNFPA 2014). Teenagers frequently have adverse social consequences, especially regarding educational attainment, since women who become mothers in their teens are more likely to curtail their education as soon as they become mothers. Every year at least two million women under the age of 19 die from complications resulting from unsafe abortions in the developing world (WHO 2016). Globally, 72 percent of all deaths in women under age 19 are attributed to complications of unsafe abortions with complications such as cervical tearing, hemorrhage, pelvic infection, infertility and death (Zabin and Kiragu 2011).

Ujah et al. (2005), in a seventeen-year review of factors contributing to maternal mortality in North-Central Nigeria found a bimodal pattern of maternal deaths occurring at both extremes of the reproductive age range. They found that the greatest risk of maternal death was among early teenagers and older women. They also found that ethnic group of the women was also an important risk factor for maternal mortality.

2.4.5 Education and Maternal Health

A strong body of evidence indicates that educational level is one of the measures for assessing socioeconomic status and also an important predictor of health status. Low education levels are linked with poor health, more stress and lower self-confidence whereas, higher education predicts good health. (Aminu 2011). Attainment of better education can increase income and empower individuals to effectively promote their own health, it is one of the factors for early childhood development that has a determining influence on subsequent life and the decision an individual makes in life. We can only act on the things we know, hence, a woman with little or no education has limited knowledge about life but are at risk of obesity, malnutrition, mental health problems, heart disease and criminality throughout their life. (UNICEF 2005).

Moreover, increasing poverty in Nigeria has become a barrier to education for many Nigerian women thereby economically disempowering them in the society. About 38 percent of Nigerian women had no education at all, 48.6 percent had primary education and 45.7 percent had secondary education or higher (NPC 2015).

2.5 Hindrances to the Utilization of Maternal Health Care Services

2.5.1 Inadequate Number of Trained Health Personnel

In the past years, Nigeria has invested in the training and re-training of doctors, nurses and midwives to meet the needs of the population. Despite this positive trend, the doctor-patient population ratio is still one to six thousand (1 to 6000); as opposes to the one doctor to 650 patient (I to 650) recommended by the WHO in 2010. The doctor-patient population ratio is even worse in 24 of the 44 nations in sub-Saharan African including Nigeria where there is an estimated 10 doctors for 100,000 people (Weeks cited in Ndep, 2014). These nations also have the following in common; high fertility rates, low GDPs and high MMR. It has been argued that the higher a nation's GDP, the more quality healthcare is made available and better access to higher quality healthcare by larger proportion of the citizen.(Weeks cited in Ndep, 2014).

Previous study by Shamaki and Katiman (2013) indicates that most health facilities and qualified personnel in Nigeria are concentrated only in the urban center while leaving the rural areas at the mercy of unqualified health personnel which make deliveries very worrisome and also the attitude of the health workers is very bad to the patients A lot of women felt disenfranchised by the attitude of the health workers towards them and preferred to deliver at home than to go to the health facility.

2.5.2 Decision to seek for medical care

Decision to seek maternal health care is very complex and distressing and a lot of women had to die because decisions had not been taken whether she should go or not. The amounts of time,

money, information, authority and decision making a woman have at their disposal are very essential for their wellbeing (Sundari, 2002). Decisions to seek medical care are often made not by a woman on her own but by her husband or his family (e.g. mothers-in law, senior sister amongst others) as well as community members. However, many women may already be aware of the danger and signs of obstetric complications but cannot seek for medical care automatically until permission is granted, Women's autonomy in deciding to seek health care can be hampered by their economic dependence and the prohibitive costs of emergency intervention. If the community is asked for help, community leaders may make a decision which overrides the husband's wishes. Women's autonomy can differ according to their age and seniority within the family. For example, pregnant teenagers may be dependent on the decisions of older members of the extended family for economic reasons, where this happens she has no right to take decision on her own concerning accessing maternal health facilities. (Prevention of Maternal Mortality Network,(2012).

2.5.3 Illiteracy

Education has been described as a .medication against fatalism in that women who are educated are less likely to accept dangerous practices that will expose them to dangerous complications during pregnancy or labour. For instance, among the Hausa people of Nigeria 'girishi'- this is a traditional surgical operation to treat obstructed labour by cutting the vagina with an unsterilized blade which is commonly performed on uneducated women, educated women rarely accept the practice (Royston, 2009)..Uneducated women are less likely to seek the help of professional health services because they are probably less aware of what is available and probably find the culture of health services more alienating and frightening. This explain the reason for high child and maternal

mortality in the northern region since they have low female literacy level and fewer trained personnel (Royston, 2009).

Approximately, one-thirds of all uneducated Nigerian women deliver outside of health facilities and without medically skilled attendants present. (NPC, 2013).

2.6 Urban-Rural Differences in Maternal Mortality Rate

Access to healthcare services which includes prenatal care, childbirth and postnatal care, is largely determined by geographical location, cost, proximity of the health facility, affordability of healthcare services, quality of service, level of education and gender (Filipi et al. 2016). Research have shown that approximately 71 percent of Nigerian rural settlement have a primary healthcare facility within a 5km radius to their homes but many of these facilities are not functional due to lack of equipment and essential supplies, inaccessible due to distance and bad roads and unqualified staff (Federal Ministry of Health 2011)..Consequently, rural and urban differences in wealth or financial capability, distance between homes and hospitals, educational levels and culture are important factors in maternal mortality. Studies show large rural-urban disparities in maternal mortality with a 1997 Multiple Indicator Cluster Survey finding a significantly higher rural mortality rate of 828 versus an urban rate of 531 (Federal Office of Statistics 2009).

Rural areas in developing countries such as Nigeria tend to receive less healthcare attention compared to the urban areas. For instance, India and Nigeria, the two countries with the highest maternal mortality rates in the world, have large rural populations, 73.9 percent and 59.5 percent respectively, as well as highly under-served rural communities with regards to healthcare service (Wall 2008; World Bank 1995). As with many health outcomes, mothers in the poor rural areas are at increased risk of developing illnesses and complicated pregnancies, have poorer nutrition, and face more challenges in accessing timely healthcare compared to their wealthier counterparts

located in the rich urban centers. Out of the world's estimated annual 130 million births, 60 percent of it occur at home each year and the pregnancy outcomes appear considerably worse than births that occur in a medical facility (Garces, et al 2012). Thorough investigations have shown that most of these home births were conducted in rural communities due to sociocultural beliefs as many were attended by family members (Garces et al., 2012).. The few healthcare facilities located in rural areas are often poorly equipped and poorly-staffed and inaccessible due to distance, bad roads, and high cost of transportation. Nyirenda (2012) indicates that the higher maternal mortality rate has been observed in the rural areas.

Apparently, Cultural factors greatly affect the utilization of maternity care services in rural communities. For instance, Azuh (2012) reports that in many parts of rural villages in Nigeria women's decision making power is extremely limited, particularly in matters of reproduction and sexuality. Azuh further ascertains that issues such as low status of women and husband's domination all worsen the ugly and poor utilization of health care services. Similarly, Hubert (2013) asserts that high levels of maternal mortality are strongly correlated with high levels of social inequality, especially unequal access to health services. He argued that most of the maternal deaths could have been prevented as well if the women have had adequate prenatal care.

2.7 Review of relevant theories

2.7.1 Human Ecology Model

Human ecology theory was first associated with Ernest Haeckel (1969), a German zoologist who explain how human interaction provide a way of making sense of events that have happened in the past thereby, allowing us to make predictions about what may happen in the future. Human ecology theory is a way of looking at the interactions of humans with their environments and considering

this relationship as a system where biological, social, and physical aspects of the organism are considered within the context of their environments. This theory focus on how the natural and human environments influence our behavior and how individual and families in turn, influence these environments, individual and the environment are viewed as being interconnected in an active process of mutual influence and change The theorists outline an ecosystem, most particularly a human ecosystem or a family ecosystem, as being composed of three organizing concepts: humans, their environment, and the interactions between them. The humans can be any group of individuals dependent on the environment for their subsistence. The environment includes the natural environment, which is made up of the .atmosphere, climate, plants, and microorganisms that support life. Another environment is the natural and human-built environments which include roads, machines, shelter, material goods and the social- cultural environment, human beings; cultural constructs such as language, law, values; also social and economic institutions such as our market economy and regulatory systems (Filipi et al. 2006).

The ecosystem interacts at the boundaries of these systems as they interface, but also can occur within any part of an ecosystem that causes a change in or acts upon any other part of the system. Change in any part of the system affects the system as a whole and its other subparts, creating the need for adaptation of the entire system, rather than minor attention to only one aspect of it.

Below are the relevance of human ecology theory as outlined by Bubolz and Sontag (1993);

- It helps to understand the processes by which families function and adapt and how they ensure survival, improve their quality of life, and sustain their natural resources

- It helps to determine ways by which families allocate and manage resources to meet needs and goals of individuals and families as a group and how their decisions affect the quality of life.
- It gives us insight into how various kinds and levels of environments affect human development and how family system adapt when one or more of its members make transitions into other environmental settings, such as day care, schools and hospitals.
- It provides understanding on how to create, manage, or enhance environments to improve both the quality of life for humans, and to conserve the environment and resources necessary for life.
- It helps to show changes that are necessary to improve human lives and how families and family professionals contribute to the process of change.

2.7.2 Social construction of maternal health

This was developed by Berger and Luckman (1966), social constructionism concerns itself with the social construction of reality, this approach holds that reality is not naturally given rather socially produced (Alvesson and Skoldberg 2015). The social constructionist approach holds the basic assumption that knowledge is subjectively constructed from the socially embedded reality and based on the shared signs and symbols that are recognized by members of a particular culture (Grbich 2013). According to social constructionism, knowledge is the outcome of the interactions among individuals and also involves examining the way people interpret and make sense of their experiences in the world in which they live and how the contexts of events and situation have impacted on constructed understanding (Grbich 2013).

2.7.3 Health Belief Model

The Health Belief Model was developed in the 1950s by a group of American Public Health Service who were Social Psychologists (Hochbaum, Rosenstock and Kegels). It was developed to provide concrete explanation and predict health-related behaviours, particularly in the utilization of health services and the way people react to health issues. The health belief model seeks to explain why few people participate in health-related issue to prevent or detect diseases and proposes that a person's health related behaviour and their beliefs about health problem is dependent on some outlined on six outlined concept which are as follows;

- Perceived susceptibility – This is the ability of an individual to believe that he or she has the chances of developing a health problem, this model is of the opinion that individuals who believes that they are likely to develop a particular health problem will engage in behaviours that will reduce their chances of developing the health problem while individual who do not believe that they are likely to have a health problem will engage in risky and unhealthy health behaviours. Individuals who are aware of their chances of developing a health problem will voluntarily improve their health seeking behaviour in a facility believed to be more potent (orthodox or traditional).
- Perceived Severity – This is an individual belief about how serious or deadly a health problem is and its potential consequences. The health belief model predicts that an individual who believe that a particular health problem is serious or deadly is more likely to take pragmatic steps to preventing the health problem from occurring or re-occurring, this beliefs helps to shape and improve their health seeking behaviour.
- Perceived benefit – This refers to an individual's perception of the potency or efficacy of taking an action to preventing or reducing the risk or severity of an illness or disease. The

action an individual takes is dependent on an individual's evaluation of perceived susceptibility and perceived benefit of taking the available or recommended action, such individual is likely to accept recommended action if it is perceived as beneficial and would produce a positive outcome this is because human beings will choose a behaviour that brings more gain than loss to them

- Perceived barriers – This refers to an individual's beliefs about the obstacles involved in undertaking the recommended action such barriers may be physical, environmental, financial, social, gender, unavailable resources etc. An individual uses is logical sense to compare and contrast the effectiveness of the recommended action against the perception that it may expensive, dangerous, unpleasant, far distance, time-consuming or inconvenient.
- Cues to action – This refers to things that prompted or triggers an individual to take the recommended action, such things differs from one person to another that is, what may trigger one person might not trigger another. Cues may be internal such as pain or external such as encouragement from elders or people that you value or the experience and testimony of other people who have gone through similar challenges and have overcome.
- Self-efficacy – This refers to an individual's level of confidence and ability to successfully perform the recommended action, if individual see themselves as incapable of performing the recommended action, then they may avoid taking the action which may hinder or impede their health seeking behaviour. This can be helped through encouragement and support from other people.

Health belief model suggests that women will seek health care if they understand that complications can arise during and after their pregnancy (perceived susceptibility) and that mild

symptoms experienced at the onset of these complication can increase in its severity if appropriate treatment is not sought (perceived severity), health belief model argues that if women do not see bodily changes or symptoms that occur during pregnancy as threatening or risky, there is no stimulus to act on but if they see it as risky they will automatically improve their health seeking behaviour, they also believe that women who see healthcare as having more benefit that outweighs the cost will readily improve their health seeking behaviour (perceived benefit) but will delay in seeking healthcare if there are certain barriers that hinders them like, side effect of caesarean section or pills, far distance, financial constrain, husband's domination etc. Furthermore, when the benefits of seeking prompt health care service outweigh the perceived barriers to taking such actions, women will not delay before they seek good professional medical help. This means that a women will delay in seeking for health care service if in her opinion these barriers outweigh the gain.

Assumptions

This theory assumes that human beings are logical and rational in nature applying it to their thinking pattern and action and will become positive to health-related issues if they

- Believe that a negative health condition can be avoided
- Have a positive expectation that when they take recommended action, it will be possible to address a negative health conditions.
- Believe they can successfully take the recommended action to address their health condition.

Table from "Theory at a Glance: A Guide for Health Promotion Practice" (1997)

Concept	Definition	Application

Perceived Susceptibility	One's opinion of chances of getting a condition	Define population(s) at risk, risk levels; personalize risk based on a person's features or behavior; heighten perceived susceptibility if too low.
Perceived Severity	One's opinion of how serious a condition and its consequences are	Specify consequences of the risk and the condition
Perceived Benefits	One's belief in the efficacy of the advised action to reduce risk or seriousness of impact	Define action to take; how, where, when; clarify the positive effects to be expected.
Perceived Barriers	One's opinion of the tangible and psychological costs of the advised action	Identify and reduce barriers through reassurance, incentives, assistance.
Cues to Action	Strategies to activate "readiness"	Provide how-to information, promote awareness, reminders.

Self-Efficacy	Confidence in one's ability to take action	Provide training, guidance in performing action.

2.8 Theoretical Framework

Human Ecology Model

The human ecology model provides a framework for understanding maternal mortality and its spatial patterns in Nigeria. Used by geographers, social and behavioral scientists to explain the patterns of human interaction with their physical and social environment. It suggests that human health variations over the surface of the earth are due to habitat, population and behavior differences (Meade and Emch 2010. The absence or presence of health facilities differs across space and therefore affects us differently. Human behavior stems from cultural beliefs, values and perceptions which ultimately affect the decisions we make. Similarly, a woman's decision about heath seeking behavior is greatly influenced by their beliefs that stem out of their environment. The type of food they eat, marriage customs, and health seeking behavior whether to use traditional medicine or modern medicine are influenced by cultural beliefs, religious beliefs, level of education or other exposure. For instance when cultural practices and beliefs require a woman to obtain permission from her husband or nearest male relative before seeking or obtaining medical care, it limits the woman's access to timely health.

Social construction of Child and Maternal Health

Social constructionism model is of the believe that, the construction of knowledge about childbirth and maternal health care is influenced by the socio-cultural context of the individual and family interactions between people in the neighborhood and health care centres. This means that the

construction of meaning of childbirth and health care experiences of one person will be different from that of other persons (Bryman 2001).

Perception plays a major role in influencing women's health care seeking behaviour regarding child and maternal health, Thus, health care develop according to her subjective understanding and vary considerably by aggregate and individual socio-economic and cultural contexts. (Baert and Norre 2009). Socio-cultural factors primarily influence decision making on whether to seek care rather than whether women can reach a facility. Hence, socio-cultural factors influence the practice of maternal health care as well as the experiences of care received from previous health centers. (Gabrysch and Campbell 2009)..

The specific perception and experience of childbirth and the maternal health of a mother leads her towards a particular pattern of maternal health care for childbirth and the post-partum period that is, whether and where to seek care, and when and what type of health care to seek. According to Kunst and Houweling (2011) poorer mothers prefer home based childbirth and seem to have an aversion to attempting hospital based childbirth, while richer mothers depend on hospital based childbirth (preferably in a private facility)..The richer women, who work usually work in formal occupations and are often entitled to maternity leave. Thus, everyday life experience within households makes a huge difference among mothers in making decisions about time, place and type of maternal health care during childbirth and the post- partum period. Therefore, the construction of realities varies as people live in varied social contexts where relationship is guided by the social values of people and of those with which they interact (LeCompte and Schensul, 20

CHAPTER THREE

METHODOLOGY

This chapter addresses the methods used in this study in order to provide detailed account of the systematic steps involved in carrying out the research. Some of the things that were addressed include, study area, population study, sample size, sample techniques and so on. It is also concerned with the collection and systematic analysis of data for the purpose of drawing reliable conclusion.

3.1 Research design

The study adopted a quantitative research design, data is collected from respondents through the use of quantitative research instrument known as questionnaire. This involves collection of primary data from the respondents based on their availability with the number in the sample size which is gotten from the population of study. The data collected was used to provide answers to the observable questions and also analyzed for the purpose of drawing a conclusion.

3.2 Study Area

The study area is Ijero, a town in Ekiti State, Southwest Nigeria which is situated in the northwest part of Ekiti State. She has other component town under her control such as Ijurin Ekiti, Ikoro Ekiti, Iroko Ekiti, Ayegunle Ekiti, Ipoti Ekiti, Iloro Ekiti, Temidire Ekiti, Ilukuno Ekiti etc. Ijero Ekiti is bordered by Moba Local government in the north, Irepodun local government in the east and ila orangun in the west. It is largely an agrarian community producing cash crops such as, cocoa, kola, cashew, coffee, nut, timber etc. She also produce crops such as, yam, cassava, cocoyam, tomatoes etc. The main language spoken by the indigenes of Ijero Ekiti is Ekiti dialect and Yoruba

language. This location was purposely chosen because it's a rural area believed to be plagued with high rate of maternal mortality in Nigeria.

3.3 Study Population

The study population comprises women aged 18 - 49years who resides in Ijero-Ekiti. This age bracket consist of reproductive years of women as defined by WHO (2016). Eligible participants include women in their reproductive age who had given birth or are presently given birth and/or were pregnant at the time of this research and resides in Ijero-Ekiti. The reason for the choice of this population is that, experienced mothers, nursing mothers and pregnant women can vividly explain their experience as it relates to this topic.

According to 2006 census, the population of Ijeor-Ekiti is 221,873 out of which 95,365 consist of women (NPC, 2006).

3.4 Sample Size

Using 10 percent of women population in Ijero Ekiti and confidence interval of 95% within an estimated 1.5 percentage error margin, sample size of 143.05 was calculated. However, to allow for even distribution in Ijero community, calculated sample size is rounded up to 150 women who are between the ages of 18 – 49 years.

3.5 Sample Procedure

The sampling technique used in this study was purposive sampling. In purposive sampling, every respondent does not have equal chances of being part of the study population rather, the researcher chooses respondent who best meet the purpose of the study. The adoption of purposive sampling was necessary because this study focus on a particular set of people (women).

Questionnaire was administered to one hundred and fifty purposely selected respondent for the collection of valid information regarding this topic, sociocultural beliefs and health seeking behavior.

3.6. Instrument for data

Questionnaire was used in collecting data, this is a quantitative instrument used for collecting specific information from the respondents to aid in deriving solution to research problem or providing answers to research questions The questionnaire used was a semi structured questionnaire that encompasses both open and close ended questions which has four sections and forty-one questions. The questionnaire was alongside with the research objectives as it examines the demographic characteristics of the respondent, the respondent knowledge on health seeking behavior, sociocultural beliefs and challenges faced by women in the process of seeking healthcare and the solutions to advance child and maternal health in Ijero Ekiti.

3.7 method of data collection

Data was collected from the sampled population, whereby the respondents gave their consent before taking part in the study, so as to fulfill ethical consideration in social research. One hundred and fifty questionnaire was administered to the purposely selected respondent out of which five was missing and one hundred and forty-five was collected. During the collection of this data the researcher employed one research assistants who is a resident of Ijero Ekiti and is good and fluent in Ekiti dialect for better understanding of both the researcher and the respondents.

3.8 method of data analysis

Since quantitative data was gathered, the collected data will be analyzed using the statistical package for social sciences (SPSS), which will be coded for easy transcription and analyzed for

easy understanding in order to draw conclusion pertaining to the study. It runs the data and calculate chi square, T- test, mean, median and mode etc. The software had two views, which are the variable view and data view. The variable view is a platform in which the variables were imputed based on each questions on the questionnaire. After the data was coded, it was inputted in the data view, analyzed, tested and interpreted.

3.9 ethical considerations

In compliance with the ethical standards on research work involving human subjects, this study upheld the principles aimed at protecting the dignity and privacy of every individual who in the course of research work was requested to provide valuable information about the subject of study. This study upheld the following principles:

Confidentiality- All responses giving by the respondents is treated confidentially.

Non-maleficence - There is no risk or harm involved, the research will not cause any harm to those involved.

Voluntariness- It is based on the voluntary participation of the respondents; no one was coerced to be a participant of the study.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

This chapter focuses on the presentation and data analysis of research work on Sociocultural Beliefs and Health Seeking Behavior; a Study of Child and Maternal Health among Mothers in Ijero Ekiti. The researcher presented the results of the analysis of primary data gathered through questionnaire administration to various respondents in tables showing frequencies and percentages. The result and interpretation of the research hypothesis earlier stated in chapter one of the research work were also presented.

4.1 Socio Demographic Characteristics of the Respondents

Table 1: Distribution Showing the Socio Demographic Characteristics of the Respondents

Variables	Frequency	Percent (%)
AGE GROUP		
18-23	18	12.4
24-29	25	17.2
30-35	44	30.3
36-41	36	24.8
42-49	22	15.2
MARITAL STATUS		
Married	105	72.4
Divorced	15	10.3
Widowed	9	6.2
Single Mother	16	11.0
YEARS OF GIVEN BIRTH		
0 – 1 year	29	20.0
1-5 years	48	33.1
6-10 years	34	23.5
10 years above	34	23.5
NUMBER OF CHILDREN		
1	33	22.8
2	28	19.3
3	40	27.6
4	43	29.7
Others	1	0.7
RELIGION		
Christian	83	57.2

Muslim	62	42.8
OCCUPATION		
civil servant	44	30.3
trading	57	39.3
artisan	40	27.6
student	4	2.8
LEVEL OF EDUCATION		
no formal education	19	13.1
primary	32	22.1
secondary	45	31.0
tertiary	49	33.8
TOTAL	**145**	**100.0**

Source: Authors Field Work, 2018

Table.1 presents the demographic distribution of the respondents. The table shows the age distribution of the respondents which depicts that majority 30.3% of the women were within the age range of 30-35 followed by women within the ages 36-41 with a percentage of 24.8%, while 18-23 are 12.4% which was the least. The table also shows the marital status of the respondent, the result depict that majority 72.4% of the respondent are married accounting for about three-quarter of the sampled size, single mother and divorced took 11.0% and 10.3% respectively while widowed was seen to be the least 6.2%.This implies that sampled population are more of married women which will really help to evaluate their knowledge and opinion about health seeking behavior.

The number of years women have been given birth shows that majority 33.1% have been giving birth from (1-5) years ago. As it was also seen that women given birth from 6-10 years and 10 years above has percentages of 23.2% each while (0-1)year was the least with a percentage of 20.0%. Also the number of children of the sampled women reveals that 29.7% of them had four children followed by three children 27.6% while the least was others that has more than four children with a percentage of 0.7%. The percentage distribution of religion of the sampled women also reveals that majority 57.2% of them were Christians while Muslims were 42.8%.

This implies that there are more Christian worshippers than other religion simply because the study took place in a Christian dominated areas However, no one claimed to be a traditional worshipper.

The occupation of sampled women reveals that majority 39.3%)were traders while civil servant was 30.3% and those that works as artisans were 27.6% and the least was student with just 2.8%. From this we can deduce that most of the sampled women were Christians who engage in trading. Also the percentage distribution of sampled women by educational status shows that some of the sampled women had tertiary education. As it was revealed that 33.8% had tertiary education while those with secondary and primary education had 31.0% and 22.1% respectively and 3.1% had no formal education .This implies that selected sampled populations are considerably educated individuals who are graduates from universities, polytechnics and health technology, a key factor that could be assumed to influence their beliefs and knowledge toward health seeking behavior.

4.2 Knowledge of Women about Health Seeking behavior

Table 2 Distribution Showing Knowledge of Women about Health Seeking behavior

Variables	Frequency	Percent (%)
Do you visit the hospital regularly		
Yes	78	53.8
No	67	46.2
How often do you seek healthcare		
once a week	65	44.8
once a month	52	35.9
twice a month	21	14.5
every three month	7	4.8
Where do you seek healthcare during pregnancy		
prayer house	46	31.7
hospital	70	48.3
traditional birth attendant	29	20

Why did you choose where you seek healthcare above		
hospital is reliable and competent	43	29.7
hospital is safe and clean	27	18.6
prayer is potent and powerful	44	30.3
TBA staffs are experienced	31	21.4
How often do women seek health for their children		
once a week	13	9.0
once a month	45	31.0
twice a month	16	11.0
every three month	8	5.5
only when they are sick	63	43.5
Where is the first place you go when your child is ill		
prayer house	43	29.7
hospital	72	49.7
traditional healer/doctor	30	20.7
What do you give your child first, when sick		
prayer water	19	13.1
herbs	49	33.8
modern drugs	77	53.1

Source: Authors Field Work, 2018

Table 2 talks about the knowledge of women about health seeking behavior, it reveals that 53.8%, more than half of the sampled women saw the need to seek health care regularly but the frequency and where to seek healthcare varies, as it was seen that 44.8 % usually seek health in their various places at least once in a week, some 35.9% visit once in a month while only 4.8% goes every three month. As it was also seen that majority 48.3% visit hospital and 31.7% visit prayer house while only 20% seek treatment with the traditional healers/doctors. Also the reasons for their different choice of where they seek healthcare was aş well revealed, the result shows that out of those who chose hospital as their place of seeking for health 29.7% and 18.6% confessed that hospital is reliable, competent, safe and clean and those who chose prayer house 30.3% expressed their confidence in the potency of prayer while 21.4% believe that traditional healer/doctor comprises of personnel who are highly experienced

The frequency at which mothers seek health for their children was as well revealed, findings has it that 43.5%, almost half of the sampled population seek health for their children only when they are sick and 31.0% do that once in a month while only 5.5% seek health for their children once in every three month. This implies that most of the women in Ijero Ekiti do not take preventive measure in treating their children but curative measure was mostly used. The table also shows where sampled women seek health for their children, based on the findings 48.3% seek health in the hospital for their children, while prayer house and traditional centers took 29.7% and 20.7% respectively. Also, 53.1% of sampled women admitted that modern drug will be the first thing to give to their child when sick while 33.8% chose to give them herbs and some also chose to give their children prayer water 13.1%.

Table 3 Knowledge of Women about Health Seeking behavior

Variables	Frequency	Percent (%)
Do you prefer herbs to modern drugs		
Yes	68	46.9
No	77	53.1
If Yes/No, Why?		
Herb is faster but drug is not	32	22.1
Drug is hygienic and measureable but Herb is not	47	32.4
Herb is natural and has no side effect	37	25.5
Herb is bitter and unmeasurable	29	20
Have you ever had complication before		
Yes	59	40.7
No	86	59.3
If yes, how did you handle the complication		
I did deliverance	21	34.4
I went to the hospital	23	37.7
I used herbs	17	27.9
Preferred place to deliver your child		
Prayer house	45	31.03
Hospital	71	48.97

Traditional birth attendant	28	19.31
Native doctor	1	0.69
Is hospital effective for child and maternal care		
Yes	81	55.9
No	64	44.1
If yes/no, Why?		
Hospital is competent and caring	40	27.59
Personnel are sometimes carelessness	18	12.41
Some personnel are insultive	30	20.69
Inadequate facilities	22	15.17
Hospital is the best	35	24.14
Women views on hospital personnel		
Competent and accommodating	74	51.0
Competent and unaccommodating	23	15.9
Incompetent and accommodating	30	20.7
Incompetent and unaccommodating	18	12.4

Source: Authors Field Work, 2018

Table 3 disclose that more than half 53.1% of the sampled respondent preferred modern drugs to herbs. Reasons that was given by some 32.4% of them is that modern drug is hygienic and measureable while (20%) of the sampled population accused herbs of being bitter and consider it unfit for drinking. Those who prefer herbs (46.9%) also gave their reasons. Some of them disclose that herb is derived from nature that is, it is natural 25.5% and has no side effect unlike modern drug while 22.1% saw herbs has been faster than modern drug as it cures from the source or the root of the sickness. When sampled respondent were asked if they ever had complication 59.3% claimed not to have had any complication while 40.7% admitted to have had it and have employed different means in dealing with the situation 37.7% went to the hospital to treat themselves while 34.4% went to church for deliverance and 27.9% used herbs in treating themselves. Furthermore, the table also shows the findings on how effective sampled respondent viewed hospital personnel 55.9% said they are effective while 44.1% said they are not effective. Those who saw them as effective gave their reasons, some saw them as caring, competent and the best while those who view them as not being effective has this to say, ' some hospital

personnel are sometimes careless while some are insultive coupled with the fact that there is inadequate facilities'. All these reasons and some others made them ineffective.

4.3 Challenges of Seeking Healthcare

Table 4 Distribution of the Respondent on the Challenges of Seeking Health

Variables	Frequency	Percent (%)
Does income affect women in seeking health		
Yes	110	75.9
No	35	24.1
If yes/no, Why?		
No money no drug	38	26.2
Without money staffs will insult me	51	35.2
Health is wealth	27	18.6
I can't risk my life	21	14.5
I can't joke with my health	8	5.5
Does residence affect women in seeking health		
Yes	64	44.1
No	80	55.9
If yes/no, Why?		
Hospital is near my house	34	23.6
Hospital is far to my house	47	32.6
Ijero has no adequate facilities	24	16.7
No distance barrier	25	17.4
Hospital is the same everywhere	14	9.7
Age liable to have complication		
18-23	19	13.1
24-29	9	6.2
30-35	14	9.7
36-41	33	22.8
42-49	70	48.3
Does the rich and the poor have equal access to health		
Yes	63	43.5
No	82	56.5
If yes or no, why?		
The rich can afford costly drugs	47	32.4
Equality does not exist	24	16.6
Discrimination exist in Nigeria	24	16.6
Everybody is equal	29	20

No preferential treatment	21	14.5

Source: Authors Field Work, 2018

Table 4 present the distribution showing the factors that hinders the women of Ijero-Ekiti from seeking healthcare. It was revealed that majority 75.9% of the respondent affirm that income is one major factor that hinders them from seeking the appropriate healthcare, some of the reasons given is that, without money they can't buy drugs 26.2% and that the personnel is likely to insult or embarrass them 35.2%. It was also seen from the findings that 24.1% disagree to the fact that income hinders their health seeking behavior. They can't risk their life 14.5% and that health is wealth (18.6%). Still on the same table, 55.9% of the sampled respondent disclose that their place of residence has nothing to do with whether they will seek health or not according to them, hospital is the same everywhere 9.7% and that distance cannot hinder them from seeking healthcare 17.4%. Some 44.1% of the respondent disagree to this notion but believe that residence can also influence their decision to seeking healthcare or not, they argue that in the first place Ijero Ekiti has inadequate health facilities 16.7% and that hospital is far from where they live 32.6%.

The table also shows that age liable to have complications associated to pregnancy related issues is age 42years and above 48.3% of the sampled women reported this while 22.8% said the liable age was 36-41yrs and the least 6.2% most liable age was 24-29years. This implies that most complications occurs among adult women believed to be closer to their menopause stage, this might be because of several deliveries they have had in the past. When asked whether the rich and the poor have equal access to health care more than half 56.5% of the sampled women affirm that there is no equal access to health among the rich and the poor while 43.5% saw equality, among those who saw equality 20% said everybody is equal in the hospital while 14.5% said there is no preferential treatment. However, women who affirm that there is no equality in access to health

argues that the rich can afford costly drugs and costly operation 32.4% in fact, inequality and discrimination pervaded the entire sectors of the country16.6%.in which the health sector is inclusive.

Table 5 Distribution of the Respondent on the Challenges of Seeking Healthcare

Variables	Frequency	Percent (%)
Who decides when and where to seek healthcare		
my husband	61	42.1
my in-law	6	4.1
both of us	38	26.1
my friend	1	0.7
myself	39	27
Hindrance to Health Seeking Behavior		
Distance to the Hospital	8	5.5
Stress in the hospital	20	13.8
Attitude of the personnel	30	20.7
My faith in God	7	4.8
All of the above	28	19.3
None of the above	52	35.9
Rate of child and maternal mortality		
Very low	2	1.4
Low	11	7.6
Moderate	56	38.6
Very high	51	35.2
High	25	17.2
Does Ijero Ekiti has adequate health facilities		
Yes	35	24.1
No	110	75.9
Do you have time to rest		
Yes	131	90.3
No	14	9.7
If No, Why?		
demanding work	7	50
house chores	7	50
In your opinion why do you think women have complications		
No balance diet, poverty and stress	41	28.3
Ignorance and carelessness	28	19.3
Prayerlessness and laziness	28	19.3

God's will	30	20.7
Age at pregnancy	18	12.4
What is the state of your health in general		
Excellent	55	37.9
Better	43	29.7
Good	43	29.7
Average	4	2.8

Source: Authors Field Work, 2018

Table 5 shows the percentage distribution of who decides when and where to seek healthcare. From the findings it was seen that there is a gender imbalance as 42.1% of the sampled women disclosed that the decision of where and when to seek health is the responsibility of their husband while 27% said it is their personal responsibility, it was also confirmed that 26.1% saw it as the responsibility of both parties and only 0.7% chose their friend. This findings attest to the fact that Nigeria is a patriarchal society (male dominance) which is more obvious in the rural society. The table also reveals that the attitude of the personnel is one of the major factors that hinders women health seeking behavior as 20.7% chose it while 11.8% of the sampled women saw hospital as stressful and 19.3% chose all the factors highlighted. However, 35.9% sampled respondent affirm that nothing can hinder their health seeking behavior, this might be as a result of their level of education. When asked about the rate of child and maternal mortality in Ijero Ekiti 38.6% affirm that it is moderate, 35.2% argues that it is very high while only 1.4% said it is very low. Finally, the table also present the percentage distribution of whether Ijero Ekiti has adequate health facilities or not. Amazingly, more than three-quarter of the sampled respondent chose 'no' while only 24.1% said there is adequate health facilities.

When asked if the sampled women had time to rest it was amazing to know that more than ninety percent (90.3%) said they have enough time to rest but only 9.7% said they don't have time to rest due to their work that is demanding 50% and sometimes house chores 50%. When asked about

their views on the causes of complication (28.3%) said it was due to stress while 20.7% are of the opinion that whatever happens to anyone is the will of God and cannot be questioned, prayerlessness, laziness, ignorance and carelessness all took (19.3%) while age at pregnancy was seen as the least major cause of complication as it took just 12.4%. Many of the sampled women were positive about their health as 37.9% affirm that the state of their health is excellent while those who said their health is better and good are (29.7%) each and only (2.8%) said the state of their health is average.

4.4 Cultural and Traditional Practices observed by Women during Pregnancy

Table 6 Distribution Showing the Cultural and Traditional Practices observed by Women during Pregnancy

Cultural practices	Frequency	Percent (%)
Do you have cultural or traditional practices you observe during pregnancy		
Yes	83	57.2
No	62	42.8
no eating snail, walnut and banana		
Yes	63	75.9
No	20	24.1
no walking in the sun and at night		
Yes	57	68.7
No	26	31.3
Sleeping with white cloth and putting safety pin		
Yes	58	69.9
No	25	30.1
Drinking prayer water		
yes	56	67.5
no	27	32.5

Source: Authors Field Work, 2018

Table 6 present the cultural/traditional practices observed by women during pregnancy, it was seen that more than half 57.2% of the sampled population confessed that they engage in diverse forms of cultural/traditional practices while 42.8% said they don't. It was also revealed that most women who observe cultural/traditional practices engage in more than one of those practices as it was seen that 75.9% of the respondent don't eat snail, walnut and banana during pregnancy, 68.7% don't walk in the sun especially by 1.00pm neither do they walk at night while 69.9% usually sleep with white cloth and move around with safety pin on their cloth and 67.5% drink prayer water during pregnancy.

4.5 Solutions to improving Child and Maternal Health

Table 7 Distribution of the Respondent Showing Solutions to Child and Maternal Health

Variables	Frequency	Percent (%)
What can encourage you to visit the hospital		
Income and affordability	30	20.7
Nearness and stress free process	22	15.2
Good personnel attitude	45	31.0
Available free drugs	31	21.4
No need of encouragement	17	11.7
Government role to improve HSB of women		
Free healthcare	47	32.4
Adequate facilities	42	29.0
Public health education	30	20.7
Good personnel	18	12.4
Stress-free process	8	5.5
Government role to reduce Child and maternal mortality		
Encouraging family planning	37	25.5
Free healthcare	29	20
Sensitization and enlightment	32	22.1
Immunization	27	18.6
Government policies	20	13.8
How do you think government can stop or reduce cultural or traditional practices		

They cannot do anything	56	38.6
Public awareness	23	15.9
Enlighten them on its consequences	35	24.1
Sensitization	31	21.4

Source: Authors Field Work, 2018

Table 7 present the percentage distribution showing the suggested means by which child and maternal health can be improved in Ijero Ekiti .When the sampled respondent were asked about what can encourage them to visit the hospital regularly 31% said a good personnel attitude can encourage them to visit the hospital regularly, 20.7% admitted that their income is a significant factor in their quest for seeking heath, also availability of drugs was also mentioned by 21.4% of the sampled women while 11.4% said something contrary to all that have been said. To them, people should not wait for encouragement before seeking health but they should go regularly because a good health is important to live a good life. Also the responsibility of the government in improving child and maternal health was also revealed, from the findings it was observed that 32.4% employ the government to provide free healthcare for mother and child, 29% suggested adequate health facilities that is, equipping the primary healthcare with every necessary equipment while the number of those that suggested public health education and good personnel were 20.7% and 12.4% respectively 5.5% of sampled respondent plead with government to make hospital environment and processes stress-free and convenient for people to easily access it.

The sampled respondent also believe that the government can help to reduce the rate of child and maternal mortality by employing different means like; encouraging family planning 25.5%, by providing free healthcare 20%, sensitization and enlightment 22.1%, through immunization 18.6% and government policies that promote proper spacing 11.8%. When the respondent were asked about what the government can do to reduce cultural/traditional practices observed by

women. It was shocking to know that 38.6% argues that nothing can be done to reduce those cultural beliefs solely because it is embedded in their culture and as sociologist we understand that culture is a way of life, some women gave contrary opinion as it was seen that 24.1% suggested that they should be enlightened on the negative effect of the practices while sensitization and public awareness took 15.9% and 21.4% respectively.

4.6 Testing of Research Hypothesis

The bivariate analysis shows the results of hypothesis raised in this study. Testing for the factors that influence women health seeking behavior. The research Hypothesis generated in the study was tested using a Pearson Chi-Square Statistical Techniques at 0.05 level of significance.

Hypothesis 1

H1; There is no relationship between socio-cultural beliefs and health seeking behavior of women.

H0; There is a relationship between socio-cultural beliefs and health seeking behavior of women.

Table 8.Testing the relationship between Age and Health Seeking Behavior

Variables	**Do you visit the hospital regularly during pregnancy**		**Total**	
	Yes	**No**		
Age				
18-23	5 (6.4)	13 (19.4)	18 (12.4)	
24-29	12 (15.4)	13 (19.4)	25 (17.2)	X^2=12.2241
30-35	32 (41.0)	12 (17.9)	44 (30.3)	Pr=0.016
36-41	19 (24.4)	17 (25.4)	36 (24.8)	
42-49	10 (12.8)	12 (17.9)	22 (15.2)	

Source: Authors Field Work, 2018

The study proceeded to seek for the relationship between the socio demographic factors of sampled women and their health seeking behavior, looking at 'age' as one of the social factors. Findings

shows that women between the ages of 30-35 seek health most as 41% of them seek healthcare followed by age 36-41 with a percentage of 24.4%, women between the ages of 18-23 were seen to seek health less 6.4%.

Decision Rule:

Reject ***Ho*** if the calculated p-value through statistical software is less than 0.05 level of significant, otherwise we do not reject

Conclusion

Since chi-square value 12.2241with p=0.016 (where p<0.05) revealed a significant relationship, we therefore have enough statistical reason to reject Ho and we can conclude that age affect women's health seeking behavior in Ijero Ekiti .

Table 9. Testing the relationship between marital status and Health Seeking Behavior

Variables	Do you visit the hospital regularly during pregnancy		Total	Chi square
	Yes	No		
Marital status				
Married	65(83.3)	10 (14.9)	105 (72.4)	
Divorced	40 (59.7)	3 (3.9)	15 (10.3)	X^2=11.6963
Widowed	12 (17.9)	4 (5.1)	9 (6.2)	Pr=0.008
Single	5 (7.5)	6 (7.7)	16 (11.0)	

Source: Authors Field Work, 2018

Furthermore, the study in its quest to identify various factors influencing women health seeking behavior, the percentage distribution of the relationship between marital status and health seeking behavior was revealed. As it was seen that married women seek health more than others as they account for 83.3% of those who seek healthcare while 7.7% of sampled singles seek health and the least was divorced women with a percentage of (5.1%).

Decision Rule:

Reject ***Ho*** if the calculated p-value through statistical software is less than 0.05 level of significance otherwise we do not reject

Conclusion

Since chi-square value 11.6963 with p=0.008 (where p<0.05) revealed a significant relationship, we therefore have enough statistical reason to reject Ho and we can conclude that marital status of sampled women affect their health seeking behavior in Ijero Ekiti .

Table 10. Testing the relationship between Religion and Health Seeking Behavior

Variables	Do you visit the hospital regularly during pregnancy		Total	
	Yes	No		
Religion				
Christian	55 (70.5)	28 (41.8)	83 (57.2)	X^2=7.3337
Muslim	23 (29.5)	39 (58.2)	62 (42.8)	Pr= 0.062

Source: Authors Field Work, 2018

The percentage of the relationship between religion and health seeking behavior of women was also revealed. Findings had it that the religion to which they belong to does not influence their decision to seek health or not as 41.8% of Christians do not seek health while 58.2% of Muslims also do not seek health.

Decision Rule:

Reject ***Ho*** if the calculated p-value through statistical software is less than 0.05 level of significant, otherwise we do not reject

Conclusion

Since chi-square value 7.3337 with p=0.062 (where p>0.05) revealed no significant relationship, we therefore have enough statistical reason to accept Ho and reject H1. Therefore, we can conclude that the religious beliefs of sampled women does not affect their health seeking behavior in Ijero Ekiti.

Table 11. Testing the relationship between Level of Education and Health Seeking Behavior

Variables	Do you visit the hospital regularly during pregnancy		Total	Chi square
	Yes	No		
Level of education				
No formal Education	3 (3.9)	16 (23.9)	19 (13.1)	
Primary	1 (1.3)	31 (46.3)	32 (22.1)	X^2= 86.2371
Secondary	25 (32.1)	20 (29.9)	45 (31.0)	Pr=0.000
Tertiary	49 (62.8)	0 (0.0)	49 (33.8)	

Source: Authors Field Work, 2018

Findings also shows the relationship between level of education and health seeking behavior. It was reported that majority of those who seek healthcare have attended tertiary education 62.8% while those who had secondary and primary education took 32.1% and 1.3% respectively and only 3.8% seek health among those who are illiterate.

Decision Rule:

Reject ***Ho*** if the calculated p-value through statistical software is less than 0.05 level of significant, otherwise we do not reject.

Conclusion

Since chi-square value 86.2371 with p=0.000 (where p<0.05) revealed a significant relationship, we therefore have enough statistical reason to reject H0. Therefore, we conclude that education has a strong and significant relationship on the health seeking behavior of women in Ijero Ekiti.

Table 12. Testing the relationship between Income and Health Seeking Behavior

Variables	Do you visit the hospital regularly during pregnancy		Total	Chi square
	Yes	No		
Does income affect women to seek health				
Yes	56 (71.8)	54 (80.6)	110 (75.9)	X^2=1.5249
No	22 (28.2)	13 (19.4)	35 (24.1)	Pr=0.217

Source: Authors Field Work, 2018

From the table above, it was revealed that income do not affect the health seeking behavior of women. As it was seen that 71.8% of those who believe in the influence of income on health seeking behavior seek health while 80.6% do not. Likewise, 19.4% of those who do not believe in the influence of income do not seek healthcare while (28.1%) seek healthcare.

Conclusion

Since chi-square value 1.5249 with p=0.217 (where p>0.05) revealed no significant relationship, we therefore have enough statistical reason to accept Ho and reject H1. Therefore, we can conclude that the income of sampled women does not affect their health seeking behavior in Ijero Ekiti

Table 13. Testing the relationship between Residence and Health Seeking Behavior

Does residence affect women to seek health				X^2 = 5.2457
Yes	29 (37.2)	36 (53.7)	64 (44.8)	Pr = 0.073
No	49 (62.8)	31 (46.3)	80 (55.2)	

Source: Authors Field Work, 2018

It was also reported that residence do not affect the health seeking behavior of women. As it was seen that (37.2%) of those who believe in the influence of residence on health seeking behavior

seek health while (53.7%) do not. Likewise, (46.3%) of those who do not believe in the influence of residence do not seek healthcare while (62.8%) seek healthcare.

Decision Rule: Reject ***Ho*** if the calculated p-value through statistical software is less than 0.05 level of significant, otherwise we do not reject

Conclusion

Since chi-square value 5.2457 with p=0.073 (where p>0.05) revealed no significant relationship, we therefore have enough statistical reason to accept Ho and reject H1. Therefore, we can conclude that the residence of sampled women does not affect their health seeking behavior in Ijero Ekiti

Table 14. Testing the relationship between Cultural beliefs and Health Seeking Behavior

Variables	Do you visit the hospital regularly during pregnancy		Total	Chi square
	Yes	No		
Do you engage in Cultural/Traditional/ Practices				
Yes	33(39.8%)	45(72.6%)	78(53.8%)	X^2=15.381
No	50(60.2%)	17(27.4%)	67(46.2%)	Pr= 0.000
No eating of snail, walnut and banana				
Yes	25(39.7%)	53(54.6%)	78(53.8%)	X^2=8.924
No	38(60.3%)	29(35.4%)	67(46.2%)	Pr= 0.003
no walking in the sun and at night				
Yes	24(42.9%)	54(60.7%)	78(53.8%)	X^2=4.390
No	32(57.1%)	35(39.3%)	67(46.2%)	Pr=0.036
Sleeping with white cloth and putting safety pin				
Yes	23(39.0%)	55(64.0%)	78(53.8%)	X^2=8.778
No	36(61.0%)	31(36.0%)	67(46.2%)	Pr=0.003
Drinking prayer water				
yes	19(33.9%)	59(66.3%)	78(53.8%)	X^2=14.484
no	37(66.1%)	30(33.7%)	67(46.2%)	Pr=0.000

Source: Authors Field Work, 2018

Table 15 shows the percentage distribution of the relationship between cultural beliefs and health seeking behavior of women. It was reported that out of those who claim to engage in cultural practices during pregnancy only 39.8% seek healthcare while 72.6% do not seek healthcare. Likewise, 60.2% of those who have no cultural practices seek healthcare while 27.4% do not. The table further reveals the various beliefs observed by respondent during pregnancy as it was seen that 54.6% 0f those who do not eat walnut, snail and banana during pregnancy do not regularly seek health in the hospital while only 39.7% seek health. 60.3% of those who do not observe this particular cultural beliefs seek health while 35.4% do not.

Furthermore, 60.7% of those who do not walk in the sun or at night don't seek health while 42.9% seek health also, 57.1% of those who do not believe in it seek health and 39.3% do not, 64% of those who usually sleep with white cloth and move around with safety pin on their cloth do not seek health care while 34% seek health. Out of those who do not believe in this 61% seek health while 36% do not.66.3% of those who affirm to drinking prayer water during pregnancy do not seek health care while 33.9% do. Out of those who do not believe in drinking prayer water 66.1% seek health while 33.7% do not.It was also seen that most of them engage in more than one cultural practices.

Decision Rule:

Reject ***Ho*** if the calculated p-value through statistical software is less than 0.05 level of significant, otherwise we do not reject.

Conclusion

Since all the p values are less than ($p<0.05$) which reveals a significant relationship, we therefore have enough statistical reason to reject Ho. Therefore, we conclude that Cultural beliefs have a strong and significant relationship on the health seeking behavior of women in Ijero Ekiti.

Hypothesis 2

H0; There is no relationship between socio-cultural beliefs and the rate of maternal mortality in Ijero Ekiti

H1; There is a relationship between socio-cultural beliefs and the rate of maternal mortality in Ijero Ekiti

Table 15. Testing the influence of Socio-cultural beliefs on the rate of Child and Maternal Mortality in Ijero Ekiti

Variables	**What do you think is the rate of child and maternal mortality**					**Total**	**Chi square**
	Very low	Low	Moderate	Very high	High		
Do you engage in Cultural or Traditional Practices							
Yes	1 (1.2%)	4 (4.8%)	24 (28.9%)	33 (39.8%)	21 (25.3%)	83 (57.2%)	X^2=15.210 Pr=0.004
No	1 (1.6%)	7 (11.3%)	32 (51.8%)	18 (29.0%)	4 (6.5%)	62 (42.8%)	

Table 16 reveals how sociocultural beliefs was found to influence the rate of child and maternal mortality in Ijero Ekiti. As it was seen that the chi square and p values are X^2=15.210 and Pr=0.004 respectively. We therefore, reject **H0** and accept **H1**

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 Summary

The overall aim of this study is to examine the socio-cultural context surrounding the health seeking behavior of women regarding child and maternal health and how this enhance maternal mortality and morbidity in Ijero-Ekiti. This chapter is the last chapter in this project work and focuses on the summary of the research analysis. It is the conclusion of the project work and the recommendation from the result of the research which will help in formulating better policy for the improvement of the health sector and Nigeria in general.

5.2. Discussion of findings

The results showing the demographic characteristics of the respondent reveals that most of the sampled women 70.3% are 30 years and above, most of whom are married 72.4% with 3-4 children 57.3%. More than half 57.2% of the sampled respondent are Christians who engage in trading 39.3% and are considerably educated individuals as most of them reached tertiary 33.8% and secondary level 31.0%.

Although, more than half 53.8% of the sampled women saw the need to seek health regularly but the frequency and where to seek healthcare varies, 48.3% chose to seek health in the hospital because they felt it was reliable and safer, others had a contrary opinion as they either chose prayer house 31.7% or traditional birth attendant 20.0%. The findings also shows that majority 43.5% of the sampled women seek healthcare for their children only when they are sick and that the first place they will take them to when sick is the hospital 49.7% and the first thing they will give them is modern drug 53.1%. It was also reported that 53% of the sampled women preferred modern

drugs to herbs because some of them felt it was hygienic and measureable while others preferred herbs because it is natural and has no side effect. Also 40% confessed to have had complications before and have employed different means to deal with the situation. Almost half 48.3% of the respondent agrees that people who are 42 years and above are the most liable to have complications associated with pregnancy related issues. It was also revealed that majority 75.9% of the sampled women affirm that income is one major factor that hinders them from seeking healthcare but argues that place of residence has nothing to do with whether they will seek healthcare or not. More than half 56.5% of the sampled women also said that inequality in access to health facilities exist between the rich and the poor.

The patriarchal nature of our society was confirmed in this thesis as 42.1% of the population confessed that the decision of where and when to seek healthcare is their husbands' while 26% see it as the responsibilities of both parties. When the respondent were asked about what can hinder them from seeking healthcare, 20% of them said the attitude of the personnel can be an hindrance. Amazingly 36% said nothing at all can hinder them from seeking healthcare. Some of the sampled women 39% are of the opinion that the rate of child and maternal mortality is very high while 35% felt it is moderate. It was also reported that 75.9%, more than three-quarter of the sampled population admitted that Ijero Ekiti has inadequate medical facilities that could be used to take care of patient. Also, 57.2%, of the sampled population confessed that they engage in one or more cultural/traditional practices during pregnancy. Finally respondent suggested diverse ways to improving child and maternal health, from the findings it was observed that 32.4% employ the government to provide free healthcare for mother and child, 29% suggested adequate health facilities that is, equipping the primary healthcare with every necessary equipment while the number of those that suggested public health education were 20.7% while

5.5% plead with government to make hospital environment and processes stress-free and convenient for people to easily access it. When the respondent were asked about what the government can do to stop or reduce cultural/traditional practices observed by women. It was shocking to know that 38.6% argues that nothing can be done to reduce those cultural beliefs solely because it is embedded in their culture and as sociologist we understand that culture is a way of life, some women gave a contrary opinion as it was seen that 24.1% suggested that they should be enlightened on the negative effect of the practices while sensitization and public awareness took 15.9% and 21.4% respectively.

The findings of the bivariate analysis which shows the results of hypothesis tested in this study was also revealed. The study was interested to know the relationship between sociocultural beliefs, demographic factors and health seeking behavior. Age as one of the tested social factors shows that women age 30 and above 70.3% were seen to seek health more and that age of respondent affects their health seeking behavior in Ijero Ekiti as the chi square and p values are 12.2241 and 0.016 respectively. Percentage distribution of the relationship between marital status and health seeking behavior was also shown. As it was seen that married women seek health more as they account for 83.3% of those who seek healthcare, having a chi square and p value of (X^2-11.6963, Pr=0.008). This shows that there is a significant relationship between marital status and health seeking behaiour. The findings also reveals the relationship between religion and health seeking behavior of women (chi square 7.3337 and p value Pr= 0.062) It was seen that religion to which they belong to does not really influence their decision to seek health. The hypothesis also shows the relationship between residence and health seeking behavior with a chi square and p value of (X^2= 5.2457, Pr=0.073). This show that residence has no influence on health seeking behavior of women in Ijero-Ekiti.

Findings also reveals the relationship between level of education and health seeking behavior which has a chi square of 86.2371 with a p value of 0.000. Hence, education have significant relationship on the health seeking behavior of women in Ijero Ekiti, Findings also shows how sociocultural beliefs was found to influence the rate of child and maternal mortality. Cultural beliefs like, no eating of snail, banana and walnut (X^2=8.924, Pr= 0.003), no walking in the sun (X^2=4.390, Pr= 0.036), sleeping with white cloth and putting safety pin (X^2=8.778, Pr=0.003), drinking prayer water (X^2=14.484, Pr=0.000). This shows that cultural beliefs has a strong and significant relationship on the health seeking behavior of women.

5.2 Conclusion.

From this study, it was concluded that even though there are lots of factors that predisposes women to the danger of death associated with pregnancy related issues, the power of knowledge through education is one major aspect by which this can be reduced .As it was seen in this study that the geographical location to which people live has no effect neither do their religion but the knowledge base of people determines their attitude towards health seeking behavior. Other Socio demographic factors that influences women towards seeking proper healthcare are; marital status, age etc. It was also seen that cultural beliefs has a significant relationship with health seeking behavior which oftentimes leads to child and maternal mortality. Thus, this study has been able to establish the fact that sociocultural beliefs and some socio demographic factors are determinant factors that influences health seeking behavior while religion, residence and income do not have any influence on the health seeking behavior of women in Ijero Ekiti.

5.3 Recommendation

1. The government should specifically improve the standard of primary healthcare by providing adequate and modern health facilities so that women can easily access health care since it is the primary health care that is closer to the women.
2. Government should also improve the standard of the educational sector and give women better chances of been educated so that their decision towards health will be based on logic rather than cultural or superstitious beliefs.
3. Cultural beliefs about pregnancy should be discouraged via public enlightment and education. It was found that women because of their notion on pregnancies made hospital their secondary option by going there late therefore, most women miss out of intended benefits of preventing adverse pregnancy outcome with early antenatal care
4. There is need to improve the implementation of public health interventions in terms of coverage and effectiveness, to provide prompt and adequate medical attention and referral when it is needed.
5. Women should be given autonomy to decide on their own where and when they want to seek healthcare instead of the husband whose decision might not be favorable to the woman.
6. Finally, there must be strong political will on the part of government at all levels that will help in reducing maternal mortality in Nigeria.

Reference

Abdukarim, I. (2008) "Health-Nigeria: Little Progress on Maternal Mortality". Source:http://www.ipsnew.net/G:/health2/HEALth-NIGERIA.Retrieved August 9th, 2008

Abubakar, A., Van Baar, A., Fischer, R., Bomu, G., Gona, J. K., Newton, C. R. (2013).sociocultural determinants of health-seeking behaviour on the Kenyan coast: A qualitative study.

Afonja, S. (2011) Women Power and Authority in Traditional Yoruba Society. In: Dube, L., Leacock, E. and Ardener, S., Eds., Visibility and Power, Bergin and Garvey, South Hadley, 136-157.

Ahmed, S. S., Islam, F. A., & Barket-e-Khuda, (2013). Neonatal Morbidity and care seeking behavior among rural Bangladesh. *Journal of Tropical Paediatrics. 47(2). 98-105.*

Ajiboye, O.E. and Adebayo, K.A. (2012) Socio-Cultural Factors Affecting Pregnancy Outcome among the Ogun Speaking People of Badagry Area of Lagos State, Nigeria. International Journal of Humanities & Social Science, 2,

Akande, T.M and Owoyemi, J. O. (2009) Healthcare Seeking Behaviour in Anyigba, North Central,Nigeria. *Research Journal of Medical Sciences, 3(2): 47-51.*

Azuh D (2012) Socio demographic factors influencing health programme usage by pregnant mothers in Nigeria: Implications for policy action, demography and social statistics program. Covenant University, Ogun sate, Nigeria

Azuh D., Fayomi O., and Ajayi L.,(2015) Socio-Cultural Factors of Gender Roles in Women's Healthcare Utilization in Southwest Nigeria. Open *Journal of Social Sciences, 2015. 3(04): p. 105.*

Bennett KJ, Powell MP, Probst JC. Relative financial burden of health care expenditures. Soc Work Public Health 2010; 25(1):6-16.

Chuku SN (2010) Low birth weight in Nigeria: Does antenatal care matter? Research for Masters of Arts in development studies. Institute of Social Studies, Graduate School of Development, The Hague The Netherlands, November 2008.

Contributing to Maternal Mortality in North-Central Nigeria: A Seventeen-year Review African *Journal Reproduction Health Vol.9, No3, pp 27-40*

Chiwuzie, J., & Okolocha, C. (2011). Traditional belief systems and maternal mortality in a semi-urban community in southern Nigeria. African *Journal of Reproductive Healt 5(1), 75-82*

Chukuezi, C. (2010) Socio-cultural Factors Associated with Maternal Mortality in Nigeria.Research *Journal Or Social Sciences, 1(5): 22-26.*

Demographic Health Survey (DHS), "Measure DHS stat-compiler database," 2015. Retrieved from http://www.statcompiler.com 27th October, 2017. [4]

Dyson, T. and Moore, M. (2013) On Kinship Structure, Female Autonomy and Demographic Behaviour in India. Population and Development Review, 9, 35-60. **http://dx.doi.org/10.2307/1972894**

Fawole OA (2016) sociocultural factors affecting perception of Ill-Health in Nigeria. Ilorin *Journal of Sociology 2 (2), 245-257.*

Federal Ministry of Health (2011) Nature, Strategic Framework on the Health and Development Adolescents and Young people in Nigeria. Federal Ministry of Health, Abuja. [2] Nigeria Demographic and Health Survey (NDHS) (2000) Nigeria: DHS, 1999—Final Report. Measure DHS,

Filippi, V.; Ronsmans, C.; Campbell, O. (2013). "Maternal Health in Poor Countries":The Broader Context and a Call for Action. Lancet. Vol.368 (9546). 2(1): 535–541

Gabrysch, S. and Campbell, O.M.R. (2009) Still Too Far to Walk: Literature Review of the Determinants of Delivery Service Use. BMC Pregnancy and Childbirth, 9, 34. **http://dx.doi.org/10.1186/1471 2393-9-34 [38]**

Garces A e'all (2012) Home birth attendants in Low Income Countries: Who are they and what do theydo? BMC Pregnancy and Childbirth 2012, Open Access 12 (34), 1 - 9.

Greenaway ES, Leon J, Baker DP (2012) Understanding the association between maternal education and use of health services in Ghana: Exploring the role of health knowledge.NIH Public Acces 44 (6), 733–747

Harrison, K.A.,(2009) The struggle to Reduce High Maternal Mortality in Nigeria African *Journal of Reproductive Health Vol.13*

Helman, C.G. (2008). Culture, health and illness (4th edn.). Oxford, UK: Butterworth-Heineman PLoS *ONE, 8(11), e71998. Doi: 10.1371/journal.pone.0071998.*

Hc (2008) Maternal health: Fifth Report of Session 2007–08. Committee, I. D. London,Authority of theHouse of Commons. I.

Hubert C (2013) Maternal mortality trends in Mexico: State differences. Population Research Center,Chubert@Prc.Utexas.Edu. Texas, University of Texas at Austin. Ensor

Hughes, Jessica (2014). Gender, Equity and Indigenous Women's Health in the Americas. The Genderand Healn th Unit, Pan-American Health Organisation. Washington, DC www.paho.org/English/AD/GE/IndigenousWomenHughes0904.pdf (accessed 28 June 2007). 45

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/ La Revue Africaine de la Sante Vol.12, No.2,pp.132-140*

Idowu, E. B. (2011). African traditional religion: A definition. Fountain Publication.

Ivey, G., & Meyers, T. (2008). The psychology of bewitchment (Part I): A phenomenological study of the experience of bewitchment. South African *Journal of Psychology, 38(1): 54-74.*

Iyalomhe G. B. S. (2016). Compliance to antihypertensive therapy. Nig. Clin. Rev. J. 63: 12-16. University

Iyalomhe G. B.S., & Iyalomhe S. I. (2012). Health-Seeking Behavior of Rural Dwellers in Southern Nigeria: Implications for Healthcare Professionals. *International Journal of Tropical Disease & Health 2(2): 62-71.*

Johson Grob(2013).Maternal Child Health;Inter disciplinary aspects within the perspective of global health. Germany:University of Gottinge.

K. Nwachukwu, "Health Care Seeking Behaviour among Market Traders in Ibarapa Central Local Government, Nigeria," The Internet Journal of Health, vol/issue: 9(2), pp. 1-7, 2011. [16]

Lawóyin, 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, 299-318.* http://dx.doi.org/10.1057/palgrave.jphp.3200143 [40]

Lindroos, A. 2010. Antenatal Care and Maternal Mortality in Nigeria. Public Health Program exchange to Nigeria

Majali V (2012) The socio-cultural factors affecting the participation of women in agricultural development: Khezana Village in Alice District. (Master thesis). University of Fort Hare.

McCarthy, J. and Maine, D. (1967). "A framework for analyzing the determinants of maternal mortality":Implications for Research and Programmes.

Micheal IK (2012) Curbing maternal and child mortality: The Nigerian experience. International *Journal of Nursing and Midwifery 4 (3), 33-39*

Mitali, D. (2013)."Unraveling the web of maternal mortality". Unpublished Thesis, University of North Carolina.

M. Adeyemo, A. Oluwatosin, T. Yekinni, "Home Management and prevention of malaria among under five children: Experiences of mothers in Egbedore Local Government Area, Osun State Nigeria,"*African Journal of Biomedical Research, vol/issue: 17(2), pp. 271-281, 2014. [5]*

Mojekwu, J.N.(2012) Maternal Mortality: Natural Risk to Women, *Ghana Journal of Development Studies, vol.2,No.1, pp 129-141.*

M. T. Akande and J. Owoyemi, "Health Seeking Behaviour in Anyigba, North- Central, Nigeria," *Research Journal of Medical Science, vol/issue: 3(2), pp. 47-51, 2009.*

National Population Commission (NPC) [Nigeria] and ORC Macro. Nigeria Demographic and Health Survey 2003 (NDHS), 2004: April 2004 Calverton, Maryland

National Population Commission (2013). "Nigerian demographical health survey report".

Nayak MG, Sharada, George A (2012) Socio-cultural perspectives on Health and Illness. *Nitte University Journal of Health Sciences- NUJHS 2 (3) September, 61-67 Olusegun OL, Ibe RT,*

Network. Wydra K. And Lawoyin, T.O, Lawoyin O,O.C, Adewole D.A, (2007) Men's Perception of Maternal Mortality in *Nigeria Journal of Public Health Policy, Vol.28, No.3, pp.299-318*

Niklaus, D. L., Sabine M. A., Engelbert, M., Jozien, M. B., & Wolf, L. (2010). Bridging the gap: how traditional healers interact with their patients. A comparative study in Cameroon. Tropical Medicine and International Health, 15(9), 1099–1108.

Nyirenda O. (2012).Maternal Mortality. Retrieved from http//www. business.co.tz/19:20pm

Osken, P.(1993). The Hosken Report: Genital and Sexual Mutilation of Publishers.2008.

O. Bábatunde, O. Imran A. Oladosu, et al., "Help Seeking Behaviour among Women currently leakingurine in Nigeria," Dove press Journals, vol/issue: 1(2), pp. 9-11, 2012.v

Ogujuyigbe, O. P., & 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.*

Ogunlesi TA, Olanrewaju DM. Socio-demographic Factors and Appropriate Health Care seeking Behavior for Childhood Illnesses. J Trop Pediatr 2010;.56(6):379385.

Okafor, B. E. (2009). The relation between demographic factors and attitudes about seeking professional counseling among adult Nigerians living in the United States. PhD Thesis, University of Akron, USA.

Olujimi, J. (2006). Significant factors affecting patronage of health facilities by rural dwellers in Owo Region. Nigeria. Soc. Sci., 1(3), 206-215.

Okereke, H.; Kanu, I.; Nwachukwu, N.; Anyanwu, E.; Ehiri, J. and Merrick, J. (2005). "Maternal and Child Health Prospects in Nigeria. *Internet Journal of Nursing Science. 4(2): 45 – 48. View*

Okeshola, F.B. and Ismail, T.S. (2013) Determinants of Home Delivery among Hausa in Kaduna South Local Government Area of Kaduna State, Nigeria. *American International Journal of Contemporary Research, 3, 78.*

Omotosho, O. (2010). Health-seeking behavior among the rural dwellers in Ekiti State, Nigeria. Int. Multi Disciplinary J., 4(2), 125-138. 64.

Pathfinder International (2013) Reproductive health knowledge and practices in northern Nigeria: Challenging misconceptions, the reproductive health/family planning service delivery project in Northern Nigeria Funds from David and Lucile PackardFoundation

Saudia, T. L., Kinney, M. R., Brown, K. C., & Young-Ward, L. (2001). Health locus of control and helpfulness of prayer. *Journal of Social Research. 20(1):60-5.*

Smith, F. (2011). "Mortality Ratio". Journal of Women's Health. 6(2): 67 – 73.

Sunday Punch (2012), Surulere Gets Maternal and Child Care Centre, February 5, 2012, Vol. 18, No.19676, p66

United Nations (2011). The Millennium Development Goals Report. New York: UN.United Nations Children's Fund. The state of the world's children 2009: maternal and newborn health. New York: UNICEF; 2009.

Uthman, O.A. 2009. A multilevel analysis of individual and community effect on chronic childhood malnutrition in rural Nigeria. *Journal of Tropical Pediatrics 55(2): 109 115.*

Uzochukwu, B. S. C., & Akpala, O. E. (2014). Socio-economic differences and health seeking behaviour for the diagnosis and treatment of malaria: a case study of four local government areas operating the Bamako initiative programme in south-east Nigeria. Rural and Remote Health, 6, 563.

Ward, H., Mertens, T., & Thomas, C. (2004). Health seeking behaviour and the control of sexually transmitted disease in Health Policy and planning; 12:19-28

World Health Organisation (2012, May). Maternal mortality: fact sheet No 348.WHO.Retrieved July, 30 2012, from http://www.who.int/mediacentre/factsheets/fs348/en/

World Health Organization. Trends in maternal mortality: 1990 to 2010. WHO, UNICEF, UNFPA and The World Bank estimates. Geneva:

WHO;2012.Availablefrom:unfpa.org/webdav/site/global/shared/documents/publications/2012/Tends_in_maternalmorality_A4-1.pdf Accessed on 5 January 2014

WHO.HealthStatisticsandHealthInformationsystem..www.int/healthinfo/statistics/morchildmortlity/en/index.html. Accessed on June 2008

Zozulya M. (2010) Maternal Mortality in Nigeria: An Indication of Women"s Status. A Consultancy Africa Intelligence Publication. Source: http://www.consultancyafrica.com. Retrieved August, 2010.

APPENDIX

FEDERAL UNIVERSITY OYE EKITI

QUESTIONNAIRE

PARTICIPANTS SEMI-STRUCTURED QUESTIONNAIRE

Topic: Socio-Cultural beliefs and Health Seeking Behaviour; a study of child and maternal health in Ijero-Ekiti.

I am Adeniran Abimbola Adebamigbe, an undergraduate student of Sociology department, Federal university Oyè ekiti, Nigeria. Iam conducting a research on the above topic and you have been purposely selected to take part in the study for being a nursing mother who resides in Ijero-Ekiti. Your honest answers will be highly appreciated.

SECTION A

Socio-Demographic Characteristics

1. Age..... (a) 18-23 (b) 24-29 (c) 30-35 (d) 36-41 (e) 42 -49

2. Marital Status..... (a) Married (b) Divorced (c) Widowed (d) Single (e) Others, specify..... .....

3. How long have you been given birth.....(a) less than a year (b) a year to five years (c) six to ten years (d) over ten years (e) others, specify .....

4. Number of children. ..... (a) 1 (b) 2 (c) 3 (d) 4 (e) Others specify. .....

5. Religion..... (a) Christian (b) Muslim (c) traditional (d) Others, Specify.....

.6 Occupations..... (a) Civil servant (b) Trading (c) Artisan (d) Student (e) others, specify.....

7. Level of Education..... (a) No formal education (b) Primary (c) Secondary (d) Tertiary (e) Others, specify.....

SECTION B

Perception of women about health seeking behaviour.

8i. Do you visit the hospital regularly? (a) Yes (b) No

8ii How often do you seek health care during and after pregnant? (a) once a week (b) once a month (c) Twice a month (d) every three month (e) others, specify .....

9. Where do you seek health care most during and after pregnancy? (a) Prayer house (b) Hospitals (c) Traditional birth attendant (d) Native doctors (e) others, specify.....

10. Why do you choose that option in **NO 9** above?.....

11. How often do you seek health for your child(ren)? ? (a) once a week (b) once a month (c) Twice a month (d) every three month (e) others, specify .....

12. Where is the first place you will go when your child(ren) is ill? (a) Prayer house (b) Hospitals (c) Traditional birth attendant (d) Native doctors (e) others, specify.....

13. What will you give your child(ren) first if he/she suffers from disease like measles? (a) Prayer water (b) Herbs (c) Modern drugs (d) others, specify.....

14. Do you prefer herbs to modern drugs? (a) Yes (b) No

15. If **YES/NO, Why?** .....

16. Have you ever had complication during or after pregnancy? (a) Yes (b) No

17. If **Yes**, how did you handle ths complication? .....

18 Where do you prefer to deliver your child? (a) Prayer house (b) Hospitals (c) Traditional birth attendant (d) Native doctors (e) others, specify.....

19. Do you think hospital facilities has been effective for child and maternal care (a) Yes (b) No

20. If **Yes/No, Why?.** .....

21. How do you view hospital personnel? (a) Competent and accommodating (b) Competent and unaccommodating (c) Incompetent and accommodating (d) Incompetent and unaccommodating.

SECTION C;

Socio-cultural beliefs and challenges faced by women in the process of seeking health care.

22. Does income plays any role in your ability to seek health care ? (a) Yes (b) No

23. If **Yes, How**?. .....

24. Do you think your place of residence hinders your health seeking behaviour?. (a) Yes (b) No

25. If **Yes/No, How**?. .....

26. What age do you think is liable to have complications most during and after pregnancy? (a) 18-23 (b) 24-29 (c) 30-35 (d) 36-41 (e) 42 -49.

27. Do you think the rich and the poor have equal access to health facilities? (a) Yes (b) No

28. If **YES/NO, Why?. .....**

29. Who decide when and where to seek health? (a) My husband (b) My in-laws (c) Both of us (d) My friends (e) Myself.

30. What can hinder you from seeking health care in the hospital during and after pregnancy? (a) Distance to the hospital (b) Stress in the hospital (c) Attitude of the personnel (d) My faith in God (e) All of the above (f) None of the above.

31. What do you think is the rate of child and maternal mortality among rural dwellers? (a) Very low (b) Low (c) Moderate (d) Very high (e) High.

32. Do you think Ijero-Ekiti have adequate health facilities? (a) Yes (b) No.

33. Do you have cultural/traditional practices you observe during pregnancy (such as not eating some foods, what you cannot do etc.)?. Pls. list them; i.....

ii..... Iii.....

34. Do you have time to rest? (a) Yes (b) No

35. If No, what do you think is the reason for not having time to rest and to take care of yourself? .....

36. In your opinion, why do you think women have complications in pregnancy? .....

37. In general, how is your health? (a) Excellent (b) Better (c) Good (d) Average (e) Poor

SECTION D

Solutions to advance child and maternal health in Ijero-Ekiti ?

38. What can encourage you to visit the hospital regularly ....
.....

39. How can the government help to improve the health seeking behaviour of women and their child(ren)? .....

40. What do you think the government can do to reduce the rate of child and maternal mortality in Ijero-Ekiti and Nigeria at large? ....
.....

41. How do you think government can stop or reduce the cultural/traditional beliefs that hinders the health seeking behaviour of women and their child(ren)?..... .....
.....