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Underutilization of Maternal Health Care Facilities In Semi-Urban Community Of Southern Nigeria

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Abstract
This study investigated different socioeconomic and cultural related factors that limit pregnant women from accessing maternal health care services. Both qualitative and quantitative research methods were utilized. 192 respondents were chosen in a cross-sectional survey and 8 In-Depth Interviews (IDIS) were conducted with 24 respondents. The study revealed that there was a link between the belief system of women who are married to traditionalists/herbalists and the use of maternal health care facilities in Nigeria. Respondents with higher education and income earnings were more disposed to accessing Maternal Health Care (MHC) than those with lower education and income earnings. Government inadequacies and lifestyles of pregnant mothers portend great danger to the lives and health of women of reproductive age. The study recommended a widespread education of women in the reproductive age.

Keywords: Socioeconomic-Factors, Cultural-Practices, Government-Inadequacies, Underutilization, Maternal-Care.

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I. INTRODUCTION

High maternal mortality is one of the major public health problems in Nigeria. The Maternal Mortality Ratio (MMR), (defined as the number of women who die during pregnancy and childbirth per 100, 000 live births), ranges from 16 in the developed countries to 220 in South Asia, and 500 in Sub-Sahara Africa (World Health Organization [WHO], 2012). The barriers to the utilization of maternal health care (UMHC) facilities have a direct bearing on maternal and infant morbidity and mortality (Obasi, 2013). This feature is noticeable in most third-world countries, including Nigeria, down to the rural areas. Lack of access to and the utilization of health care services for delivery are among the main reasons for the high maternal and neonatal mortality rates in these developing nations (Govindasamy & Ramesh, 1997). Poor maternal health status in Nigeria is largely attributable to poor antenatal care (ANC) practice, lack of access to and the use of unskilled attendants at birth, and a weak healthcare delivery system. Factors that prevent women from receiving or seeking health care during pregnancy and childbirth include inadequate services, poverty, distance, lack of information, and cultural practices (UNICEF, 2012; Onwuama, 2011). The utilization of maternal care facilities, however, varies between countries with a great underutilization potential among pregnant women in low-income countries of Africa and Asia, which may be due to many factors, such as age, education, medical insurance, clinical risk factors, and the supply of health care (for example, clinic availability, distance to a facility) (Raine, 2007).

Using the estimates from Nigeria's Demographic and health survey in the year 2008, and as supported by the account of the National Planning Commission, there are higher maternal mortality rates in the Northern part of Nigeria compared to their southern counterparts, owing to the high level of illiteracy, poverty, unfavorable socio-cultural practices, limited social amenities, environmental factors, and so on, that is prevalent in Northern Nigeria (Adedini, 2014).

The underutilization of maternal health care facilities has become a national imperative because it relates to the health conditions of women and children. The barriers that threaten women's exposure and access to health care facilities are multi-dimensional and are proliferating, making necessary the need to understand those barriers and the means of transferring them (Obasi, 2013). Data from the Demographic and Health Survey conducted in Bangladesh, India, Pakistan, Kenya, Nigeria, and Tanzania, show that more than half of the births in these countries were delivered outside a health facility (Tey & Lai, 2013).

Several studies have shown that women's age, marital status, parity, level of education, family size, women's occupation, husbands' occupation, and the head of the household, can influence the choice for the place of delivery (Anwar et al., 2007), and have noted that educated women are more likely to use skilled birth

attendants than uneducated women. A study in Bangladesh found that 74% of women with more than ten years of education used skilled birth attendants during delivery compared to 18% who are uneducated (Anwar et al., 2007). Maternal Education is the most important determinant of health services use (Ensor & Cooper, 2004).

Several studies conducted in developing countries on the demographic and socio-cultural factors influencing the use of maternal health care facilities have shown that factors like maternal age, number of living children, education, place of residence, occupation, religion, and ethnicity, are significantly associated with the use of antenatal care (Celik & Hotchkiss, 2000). Maternal and neonatal morbidity and mortality rates in Nigeria are among the highest in the world and can be attributed to a range of socioeconomic, political, and demographic factors. Given the diverse challenges that pregnant women face throughout the continuum of care, a broad range of measures is needed, to improve women's health (Maternal & Child Health Integrated Program [MCHIP], 2015). There has been an acceleration of efforts to improve the availability, accessibility, and quality of maternal health services, and develop policies in support of facility-based birth with a skilled provider (MCHIP, 2015).

It is estimated that about 90% of maternal deaths could be prevented with timely medical intervention (Thaddeus & Maine, 1994). The chances of death decrease are considerable if women receive skilled maternal health care during delivery (WHO, 1991). Ensuring the availability of appropriate and adequate services, and quick access to services when obstetric emergencies arise is one of the most important aspects of safe motherhood programs in developing countries (Bloom et al 1999; WHO 1991). Women should have adequate knowledge about pregnancy-related care and should be able to recognize the importance of antenatal care and its usage.

Therefore, a better understanding of the factors influencing the low utilization of maternal health care services is urgently required to improve women's health. However, the present study was carried out to assess factors influencing underutilization of maternal health care facilities in Nigeria, since research about adequate utilization of maternal health care has focused upon western populations; there have been few studies among African samples – especially residents of Nsukka – a semi-urban community in southern Nigeria. The study will interrogate the following (i) What are the causes of underutilization of maternal health care facilities in Nsukka, Nigeria? (ii) What are the strategies that are needed to enhance the utilization of maternal health care facilities?

II. LITERATURE REVIEW AND THEORETICAL FRAMEWORK

This study anchors its theoretical framework on ecological theory and social theory. The theories were adopted to anchor this study because they are broader in concept and captures virtually all the areas touched in this study. The ecological theory propounded by (Tansley, 1935) assumes that human needs and problems are generated by the transactions between people and their environments. In other words, to understand a woman's problems of underutilization of maternal health care facilities, there is the need to understand her environmental context. According to (Pies et al, 2008), an ecological model suggests a need for an expanded approach to improve maternal and child health, one that emphasizes not only risk reduction during pregnancy but also health promotion and optimization across the life course. The environment has an impact on the actions, beliefs, and choices of the individual. It follows, therefore, that the problems women face in the areas of maternal health arise from life transactions, environmental forces, and interpersonal pressures. (UNICEF, 2012), identified the gap between the availability and use of maternal health care facilities. (Warren, 2010: 39), concludes that increasing the availability of services and equipment, does not guarantee that women will use them.

Social theories are analytical frameworks or paradigms used to examine social phenomena. The term 'social theory' encompasses ideas about 'how societies change and develop, about methods of explaining social behaviour, about power and social structure, gender and ethnicity, modernity and 'civilization', revolutions and 'utopias' (Harrington, 2005). The social theory explains socioeconomic and cultural factors influencing the underutilization of maternal health care facilities. It was used by Elem and Nwabah (2016) to explain pregnant women's patronage of primary health care in the reduction of maternal mortality in River State, Nigeria. Pregnancy, birth, and transition to motherhood are physiological processes; however, they are also socially and culturally shaped and managed, forming a major component in the lives of individual women, families, and communities (McCourt, 2014). Social theory captures the fact that some factors are responsible for the underutilization of maternal health care among semi-urban residents. Social theory helps to analyze and explain the social determinants of health-seeking behaviour and how socio-economic conditions, life chances; access to knowledge and power can shape health status and wellbeing (McCourt, 2014).

III. DATA AND METHODS

This study was carried out to understand socioeconomic and cultural factors that influence underutilization of the maternal health care facilities using a mixed model in a semi-urban community in Southern Nigeria. The descriptive, cross-sectional, quantitative, and qualitative designs were involved. The cross-sectional survey design was appropriate in a study of the underutilization of maternal health care facilities

because it sought to understand the attitude, opinion, and perception of women on a matter that concerns their health. The qualitative approach (in-depth interview) was utilized as a supplementary data source.

The study was carried out in the Nsukka Area of Enugu State, Nigeria. Nsukka is a semi-urban area and the residents have access to government, mission-owned and private hospitals, clinics, and pharmacies, where maternal health care can be accessed. Nsukka was selected as the study area because it is a town that houses the highest number of hospitals and clinics in the Nsukka North Senatorial district. The people of Nsukka are selective in their choice of the utilization of maternal health care programmes available to them, due to their cultural and religious virtues. The people do not usually avail themselves to some of the programmes that constitute maternal health care programme, such as an aspect of family planning (for example, the use of contraceptives of any kind is seriously frowned at by majority of them, knowing that it constitutes one of the major programmes in maternal health care settings. This is an aspect of their cultural and religious belief, hence, the choice of this study area.

The study involved all married women aged 15-49 years, who had given birth to a baby in Nsukka town. Twenty-four (24) participants were selected for the In-depth Interview (IDI), using a purposive sampling technique. The In-depth interview participants were selected by the principal investigator. Six (6) women were selected from each of the four communities for the In-depth interviews and 2 IDIs were conducted in each Community with 3 women in a team. Some of these discussions (IDIS) were held within the church premises, while others preferred their community hall. Informed oral consent was obtained from all the study participants, and they were assured of anonymity and confidentiality.

The sample size for the quantitative data was selected through the simple random sampling technique, using the balloting process. Through these methods, research zones made up of communities, streets, and villages were selected. The twenty-one communities in the senatorial zone were clustered under four constituencies. The selected communities include Ovoko (Nsukka North), Nru (Nsukka Central), and Eha-Alumona (Nsukka East), and Lejja (Nsukka South). In selecting the respondents, the dwelling houses within the community were counted and numbered for the purpose of this research. The appropriate Kth interval was used in selecting the sample household, where respondents were selected. The respondents were distributed proportionately to the population of women aged 15 – 49 years in each of the sample communities.

Both qualitative and quantitative methods were employed in this study. The quantitative method sought to identify the socio-demographic characteristics of the respondents, and also, the information on the underutilization of maternal health care facilities. The In-depth Interview (IDI) as a qualitative instrument was used to understand the state of maternal health care and the attitudes of women in accessing health facilities during pregnancy and childbirth. While the questionnaire administration guaranteed anonymity of the respondents and enhanced information delivery, the in-depth interview (IDI) allowed for further probe on certain issues.

Data collection for the study took place from October to December 2017. Two research assistants were recruited and trained for this research. One of them was specifically trained in qualitative data collection methods. We conducted in-depth one-on-one interviews with 24 women who had given birth to a baby. Interviews with women were conducted in a confidential place mostly on the church premises and community halls at each of the four selected communities. All interviews were conducted in the local language and were audio-recorded.

The IDIs utilized the respondents who are vast with the traditions and norms of the community. The respondents in this category include the community women leaders, the presidents of Christian women's organizations, and chairwomen of notable organizations or the "Umuadas" (women leaders of some sort). Qualitative information was received from this category of leaders who are usually too few to constitute any distinct discussion group.

The researcher involved those who possessed at least a first degree in the field of social sciences and had previous experience in data collections. The questionnaire was subjected to some necessary tests. The researcher randomly selected respondents from the population and administered the questionnaire to them. This was done to explore any difficulties that may arise in the actual data collection process.

We adopted multiple steps to analyze the data. First, the lead researcher (CNN) transcribed verbatim each audio-recorded interview conducted in the local language and then translated the interview into English and saved it as a Microsoft word document. Second, the research assistant (CU) cross-checked the local language translation against the audio recording and the transcription. CNN then manually coded all transcripts. Since the study was descriptive, we applied an inductive thematic approach for data analysis. Data from the questionnaire were computer-processed using the Statistical Package for Social Sciences (SPSS). The data from the IDI were edited and analyzed manually, using codes. The codes were merged into categories and the themes were determined, based on the combination of similar categories.

Approval was obtained from the University of Nigeria Teaching Hospital Health Research Ethics Committee with registration number- NHREC/05/01/2008B-FWA00002458-1RB00002323. Verbal informed

consent was given by the respondents, before the in-depth interviews, and after ensuring anonymity and confidentiality.

The study has some limitations, it coincided with the time when the Boko Haram victims from the North-Eastern part of the country, were returning home to the Southern part in their droves, for safety. Most citizens of southern Nigeria were apprehensive of the situation and were suspicious in entertaining any question from unknown persons. In another instance, the study involved all women that were of childbearing age (15-49 years), and the group of the younger ones may not have enough experience about their cultural practices and past events, among others. All these may have some form of effect on their responses and can lead to wrong conclusions.

IV. RESULTS

Demographic characteristic:

The predictive factors studied were age, occupation, education, economic status of the women, and cultural factors. As shown in Table I, more than half of the study participants (52.6%) fell within the age of 35-43 years. Only 19 women (9.9%) of the population were within the ages of 15 – 25 years. Because of the different experiences and influences, maternal age plays an important role in maternal health care underutilization.

Table I: The socio-demographic characteristics of the respondents:

Age group (by years)	**Frequency**	**Percentage**
15 – 25	19	9.9
26 – 34	44	22.9
35 – 43	101	52.6
44 and above	28	14.6
Total	**192**	**100.0**
Religion		
Christianity	189	98.4
Islam	2	1.0
African Traditional Religion	1	.5
Total	**192**	**100.0**
Academic qualification		
First School Leaving Certificate (FSLC)	62	32.3
Senior School Certificate Education (SSCE)	84	43.8
Ordinary National Diploma	37	19.3
High National Diploma/Degree	9	4.7
Total	**192**	**100.0**
Occupation of Respondents		
Farming	70	36.5
Civil Servants	42	21.9
Business	46	24.0
Artisan	34	17.7
Total	**192**	**100.0**

In addition, most of the respondents (43.8%) were holders of the Senior School Certificate Examination (SSCE), which was followed by those who possessed the First School Leaving Certificate (FSLC) (32.3%). Only 4.7% were holders of Higher National Diploma (HND) or degree certificates. This result showed that the majority of the women studied, possessed lower educational qualifications.

Socioeconomic Factors:

In this study, the occupation of women showed that the majority of them (36.5%) were farmers, while 24% were businesswomen. The majority of the women (7.3%) who were engaged in business activities received antenatal care services very often, more than any other group in this category, whereas, in the farming group, (7.9%) of the women did not receive ANC Services. This shows that the greater percentage of women who did not receive ANC Services were engaged in farming activities, and this probably shows that they were farmers who were somehow living in poverty. However, the study revealed that women with higher income earners are more likely to access maternal health care facilities than those with lower levels of income ($p \geq 0.000$).

As illustrated in Table 1, the respondents were between the ages of 15 – 44 years and above. About Fifty-three percent (52.9%) of the women, constituted the age group that received ANC services the most in this study, and they fell within the age bracket of 35 – 43 years. Interestingly, the older group also constituted the

highest percentage of those who did not attend (9.9%). Maternal age plays an important role in maternal health care utilization, though the direction of the effect is often contradictory (Burgard, 2004; Reynolds, Wong & Tucker, 2006). It has been noted that some studies show a lack of association between maternal age and health service utilization (Celik & Hotchkiss, 2000) or higher utilization for younger women than older ones (Magadi et al, 2007).

Cultural and Religious Factors:

Cultural factors are factors that overlap in influencing the health-seeking behaviour of women. In this study, a greater percentage of the women (81.2%) believed that the cultural practices of people, contribute to the problems of underutilization of maternal health care services. About 19% of the mothers did not agree that culture has any effect on the utilization of maternal health care. Out of those who agreed that culture contributes to the underutilization of maternal health care services, 15.7% of them did not access ANC services not even once, while 23% accessed it often.

This shows that the majority of the study population knows the dangers inherent in the cultural practices of a people, like that of the Nsukka geopolitical zone. The routine checkups and visits to health care institutions by women are not a norm in developing countries, especially in Africa (Jadesse, 2015). Though socio-cultural factors play an important role in influencing the health-seeking behaviour of women, economic factors (for example, the ability to afford treatment and care) are also a crucial factor that affects the health-seeking tendency of women (Jadesse, 2015).

Table 2: Religious and cultural influences on the utilization of maternal health care facilities.

Cultural Practices	**How Often do you Attend ANC Services**				
Contribute to UMHC	**Not at all**	**Not often**	**Often**	**Very often**	**Total**
Yes	30	49	44	32	155
	25.7%	25.7%	23.0%	16.8%	81.2%
No	6	8	13	9	36
	3.1%	4.2%	6.8%	4.7%	18.8%
Total	**36**	**57**	**57**	**41**	**191**
	18.8%	**29.8%**	**29.8%**	**21.5%**	**100.0%**
Religious Belief System Contribute to UMHC					
Yes	24	43	41	29	137
	12.6%	22.5%	21.5%	15.2%	71.7%
No	12	14	16	12	54
	6.3%	7.3%	8.4%	6.3%	28.3%
	36	**57**	**57**	**41**	**191**
Total	**18.8%**	**29.8%**	**29.8%**	**21.7%**	**100.0%**

As shown in table 2; the majority of the study population, 71.7%, agreed that religious belief system contributes to the problems experienced in the non-utilization of maternal health care services, while only 28% of them disagreed, saying that religious belief had no effect on maternal health care utilization. About 19% of these women had not received ANC services previously. The people's common belief more often than not, contributes to their health challenges, hence, their non-utilization of maternal health care facilities (Agbo, 2011). The people's indifference to some maternal health care programmes, such as contraceptives in the family planning programme, leaves much to be desired.

Individual lifestyles and government inadequacies:

Table 3, shows that two-third of the respondents (75%) were of the view that individual lifestyles constitute a serious problem to maternal health care, especially as it involved the maternal nutrition and hygienic conditions of mothers. In regards to the effects of lifestyles on maternal health care, the vast majority (42.7%) supported the opinion that unhealthy nutrition affects women's health, followed by those who said that "negligence to good hygiene" (42.2%), also affects mothers' health.

Table 3: Individual lifestyles and government inadequacies hinder access to Maternal Health Care (MHC).

Lifestyles can hinder MHC	**Frequency**	**Percentage**
Yes	144	75.0
No	48	25.0
Total	**192**	**100.0**
Effects of Lifestyles on MHC		
Abuse of Substance	6	3.1
Unhealthy nutrition	82	42.7
Stress	23	12.0
Negligence to good hygiene	81	42.2
Total	**192**	**100.0**
Government inadequacies can hinder MHC		
Yes	148	77.1
No	44	22.9
Total	**192**	**100.0**
Effects of Government inadequacies on MHC		
Inconsistence of Government policies & programmes	21	14.8
Ill-equipped MHC facilities	88	59.5
Incompetent and inadequate personnel	39	26.4
Total	**148**	**100.0**

Most people realize that what they eat usually affects their health. Nutrition is an important component of wellness and is strongly associated with the physical activities of pregnant mothers. The lifestyles of pregnant mothers can affect their unborn babies and this may include the mother's drinking and smoking habits, and unhealthy nutrition. Harmful drinking of alcohol and the state of being dependent on alcohol cause enormous damage to the health and well-being of pregnant mothers. There is a dose-response relationship between alcohol consumption and a variety of physical effects, psychological and psychiatric disorders, and social damage (Anderson, 1993).

More than two-thirds of the sample population (77.1%) felt that the government's inadequacies are one of the problems confronting the smooth running of maternal health in the country. As shown in Table 3, the majority of the respondents (59.5%) believed that ill-equipped facilities were the most outstanding effects of government inadequacies on MHC. While 26.4% opted for incompetent and inadequate personnel as another challenge facing the use of maternal health care services in Nigeria, 14.8% agreed that the inconsistency of government policies and programmes, constitute the problems of the nation's health system.

V. DISCUSSION

The major and consistent determinant of using maternal health care facilities is the level of education of expectant mothers (Ajaegbu, 2013). In a study on maternal mortality in Addis Ababa, women who did not receive maternity care services were often poor, illiterates, and unmarried with limited knowledge of maternal care services (Adiba, 2000). A woman that is not educated is likely to be unaware of the benefits of using maternal health services.

There is a link between the socioeconomic status of women, and the use of maternal health care facilities. Several studies have been conducted worldwide on the factors affecting delivery in health facilities and some issues were observed. The issues of risk and vulnerability, such as lack of money, lack of transport, staff attitudes, location, and the perception of poor quality of health services, cultural practices, and the pattern of the household, were perceived as key determinants of the place of delivery (Mrisho et al, 2007; Magoma et al, 2010).

Generally, the above assertions appear to agree with one of the answers given by an in-depth interview (IDI) participant in Nru Community, on the accessibility of maternal health care facilities. The woman declared thus;

We do not go to receive ANC Services until what will take us there manifests itself. We can only go to receive ANC services when we are sick or have pregnancy problems. However, this is largely due to a lack of money for drugs and transportation.

This reason corroborates with the study conducted by (Gwamaka, 2012) in Tanzania, who found out that the reasons given by respondents for not having accessed ANC Services or being delivered in health facilities showed that 79 (39.1%) of them delivered in other places, because they were unable to afford the

transportation cost to health facilities and 68 (34%), was due to the long distance from their homes to health facilities. Other responses were as follows: 22 (6.9%), unfriendly services due to bad behaviors' of the health providers, 13 (6.4%), the presence of traditional birth attendants, and only one respondent had nobody to escort her to a health facility. Many of the IDI participants in this study believed that they could only receive ANC Services when they had pregnancy problems, otherwise, it will be an exercise in futility, since they were healthy. This shows that women with this kind of belief or understanding may not know when they will have pregnancy complications that may result in death or cesarean operation.

The present study shows that the older respondents received ANC services more than the younger ones. Also, the greater percentage of women in this study who did not receive ANC services belonged to the category of older women. Therefore, there was no relationship between the age of the respondents and antenatal care utilization. This contradiction also manifested in the responses of the IDI participants. One of the female IDI participants from Ovoko said;

Many of us in this community depend on the nearby chemist shops for our antenatal drugs, and a lot of others depend on herbal medicine, and they are working for us. These means are cheaper and less stressful (Woman farmer, 31 years)

Another 38 year old female IDI participant in Lejja community said: Our mothers and grandmothers did not deliver in any health facility. They did not receive hospital treatments during pregnancy, and they were strong and delivered safely. We are not used to having our babies delivered in a clinic or hospital; it means disrespect to our orientations and norms (Woman, 44 years).

A woman leader in the same Lejja community responded to the above comments: In her words: "Receiving antenatal services is based on choice and necessity. Those who choose not to receive have other alternatives, such as chemist shops or traditional birth attendants, and those who accepted the service, know the importance of their actions. For me, I believe in receiving ANC services, because many pregnancy issues cannot be handled locally or by the traditional birth attendants."

According to one 48 – year – old woman from Eha-alumona,

During my first pregnancy, I registered for antenatal in the third month of my pregnancy where lack of experience clouded the whole idea, even a baby's kick in my stomach meant going for antenatal. The second and third pregnancies changed my story because I had safe facility deliveries, and was feeling very strong and healthy because I had the experience, and therefore, I was no longer afraid.

Knowledge about antenatal care services according to the women was ostensibly acquired from their mothers and grandmothers. According to one female IDI participant; "during the process of socialization, mothers pass on these pieces of information in bits, to their girls, who eventually grow and get married with this knowledge."

The IDI responses collected from all the study zones revealed a strong belief that attending to antenatal care services was good, but contentious among the age groups. However, the contentions among the participants were for various reasons. Overall, younger mothers appeared to be more supportive of maternal health care facilities or receiving ANC services. The older mothers thought they had gotten many years of experience and could withstand any pain during delivery; therefore, they failed to give their full support to ANC services.

It was discovered in other studies that the people of Nsukka still adhere to the dictates of their age-long culture and tradition, where contraceptives of any kind are an abomination and are offensive to the gods of the land, which attract severe consequences and punishments from the gods (Chiwuzie & Okolocha, 2001). It is even unspeakable to suggest the use of contraceptive measures to a married couple who is an ardent believer in this culture and tradition. Some women have conditioned their minds not to accept any measures put in place to improve the health status of women because their minds have been eluded by religious fanaticism or obnoxious cultural practices.

When these religious and cultural challenges were further explored through the In-depth Interview (IDI), women shared their respective challenges, showing that there are still cultural practices that tend to limit the ability of women from accessing maternal health care facilities. According to a 47-year-old female participant in Ovoko community (A primary school headmistress),

Accessing or not accessing maternal health care depends on Someone's (a woman's) belief system. This is my fifth pregnancy and I am accessing Maternal Health Care (MHC), in defiance of my husband's order which says "I must not receive hospital treatment, but herbal care". My husband believes in consulting the oracle for a safe delivery instead of seeking medical care, but this runs contrary to my own belief. My insistence on MHC lies in my rights and faith and it is working wonderfully for me.

Another woman from Nru– Nsukka autonomous community believed that women who come from real Christian families are more likely to access MHC than those who are culturally inclined to traditions. In her words:

Many of these women (wives) who are married to herbalists or traditionalists, chief priests, and those who are servants of known deities, prefer to receive herbal concoctions as a means of antenatal care. They cannot reverse this trend, if they do; they will die-one of the chief priests declared.

It is a well-known fact in the social and medical parlance that these women will not die if they accessed maternal health care or deliver in a health facility. The traditionalists use a threat to coerce their households and other members, into their cultural practices. This threat can only be effective on those who have no faith and education. Several cultural and religious factors explain why millions of women in the world lack access to adequate care during pregnancy.

Moreover, in many parts of Nigeria, women's decision-making power is limited, especially concerning the issue of reproduction. Some of the zones (communities) designated for this study are strongly influenced by the cultural and traditional norms of their historical origins. Men of all classes, both old and the young, have historically acted as the family heads and providers of family needs, as well as controlling women's decisions on maternal health care services.

These gender inequalities are perpetuated by social norms and culture, and reflect the differences in power between men and women, both within the household and in the wider society (Pathfinder International, 2013). Women depend more on male partners for health management in terms of seeking access to available health care services (Miltra, 1998). In a survey conducted in Senegal, researchers found that in more than half of the cases, decisions on care-seeking for women were made by the husband (Ensor & Cooper, 2004).

The blame for the inadequacies in our hospitals as a result of the epileptic health system in Nigeria has often been shifted to the government of Nigeria. The government has been accused of being insensitive to the health of Nigerians, especially the health of women who are the mothers of Nations. Studies have shown that the availability and accessibility of health care facilities portend great danger to the Nigerian populace and the Nation's health industry. The availability of health care facilities is a serious problem, as there is a gross deficiency in the distribution of health facilities (Ibekwe, 2010). Many communities in Nigeria do not have hospitals, and when they do, they do not have qualified medical practitioners that take care of patients. However, the fact that health facilities physically exist in the case of the bricks and mortar does not necessarily mean they are functional (Lanre-Abbas, 2008). Many hospitals in Nigeria are poorly equipped and lack essential supplies and quality staff. The prevailing socio-economic problems in the country are still persistent and are yet to be addressed due to the Boko Haram insurgency, coupled with the oil glut in the international market.

When this issue of incompetent and inadequate personnel was further explored in the interviews, it was reported that a long wait during the ANC services, was linked to women's lack of interest in accessing MHC facilities in Nigeria. An In-depth interview with a woman from the Lejja community, age 48, illustrates the situation clearly:

In my third pregnancy, I woke up around 6:30 am to see my doctor. I trekked halfway to save money, and then, entered a bus to the hospital with the hope of seeing my doctor early and going back to my shop, but the doctor came around 12noon. I saw the doctor around 4 pm and collected my drugs around 5 pm. That day, there was no food for us in the house, because everybody depended on the day's sale which was not achievable due to the long wait at the facility and my absence in the shop. That day was a bad experience and has affected my interest in accessing MHC for now.

According to National Population Commission [NPC] (2008), this kind of experience may account for the reason why only 35% of the deliveries in the year 2008 in Nigeria, took place in health facilities. When some women take the decision to seek medical attention, and remember their past experiences in terms of long waiting times and unfriendly interactions with the nurses and other health workers, the attitudes of the medical personnel demoralize them from accessing MHC facilities in Nigeria. Most women are aware of the benefit of using modern maternal health services, but staff attitude towards mothers, deter them from the use of MHC facilities. Many lives that could have been saved are lost, because of staff attitude and system failure.

Another In-depth interview participant from Nru – a community in Nsukka, aged 51, had this to add. "In my first delivery, I was seriously maltreated by a midwife who scolded me like her maid, slapped me, and threatened to abandon me when I was in pain. I thought I was going to die, but God saved me. After that day, I swore never to use facility delivery again." Similar experiences abound, and that is the reason some uneducated pregnant women shy away from health facility delivery. The attitude of many nurses/midwives towards pregnant women and those in labor is poor. In the course of their professional duty as nurses/midwives, they act inappropriately towards the woman in labor (Lanre-Abbas, 2008). Some pregnant women prefer to seek treatment from traditional healers, rather than the western style health care facilities, largely because they found formalities like queuing for card registration, physical examination, and so on in the latter, cumbersome, strange, and seemingly alienating. The Nigerian health system as a whole has been plagued by the problems of quality service, including the unfriendly attitudes of staff to patients, inadequate skills, decaying infrastructures, a chronic shortage of essential drugs, and the well-known out-of-stock syndrome (Hodges, 2001). All these have affected MHC in Nigeria, and have continued to militate against the successful utilization of maternal health

care facilities. Governments and health professionals in Nigeria must address the socio-cultural factors and government inadequacies that inhibit the utilization of health care facilities, and communities should increase the acceptance of, and demand for hospital deliveries.

VI. CONCLUSIONS

This study examined numerous factors that limit the ability of women from accessing maternal health care facilities in Nigeria. In the study, it was revealed that several socioeconomic and cultural factors explain why pregnant women from Nsukka, Nigeria, lack access to adequate care during pregnancy. Those with lower levels of education and low-income earnings were less disposed to ANC practices than those with higher education and income earnings. The unfriendly attitudes of the health workers and the ill-equipped facilities in the health settings are among the factors militating against the successful implementation of maternal health care programmes in Nsukka-Nigeria. However, a stronger political commitment by the government to equip the Nation's hospitals, improve ANC services, and tackle traditional beliefs and practices among women in Nsukka Nigeria, will enhance maternal health care services in the country.

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