

# Healthcare Seeking Behavior and Utilization of Maternal Healthcare Services among Women of Reproductive Age in Northwest, Nigeria

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## Abstract

*Maternal health outcomes and indicators in Northwest, Nigeria are some of the worst in the world, with many women and girls losing their lives or becoming incapacitated as a result of pregnancy and childbirth complications. Maternal morbidities and mortalities are preventable with the availability and regular utilization of functional maternal healthcare services. As one of the major determinants of the utilization of maternal healthcare services, maternal health seeking behavior goes beyond individual decision, but a complexity of socio-cultural and economic factors determining women's utilization of such services in the Northwest. Relying on literature on the health seeking behavior of women in the region, this paper offers theoretical and contextual explanations for women's low utilization of maternal healthcare services in the region. The Northwest region is a predominantly Hausa and Muslim society, with a culture that is entwined and guided by the Islamic injunctions. Lack of autonomy in decision making, high adherence to cultural belief and practices, illiteracy, distance and poor access to maternal healthcare services are among the major factors impeding utilization of maternal healthcare services among women in the region. The paper thus, recommends that, in addition to making education more accessible to lactating women, interventions towards increasing utilization of maternal healthcare services must inevitably target husbands, being the key actor in determining healthcare seeking behavior within the households.*

**Keywords:** *Maternal Health, Healthcare, Behavior, Northwest, Nigeria.*

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## Introduction

Globally, maternal health indicators are among the health indicators that reflect the greatest disparity between developed and developing countries (World Bank Report, 2013; African Progress Panel, 2010). Poor maternal health is said to be an indicator and cause of extreme poverty, which is why United Nations (UN) through the Millennium Development Goals (MDGs) (World Health Organization, 2005) and later the Sustainable Development Goals (SDGs) adopted improving maternal health with the target of a global estimated Maternal Mortality Rate (MMR) of fewer than 70 maternal deaths per 100,000 live birth by 2030. Yet Nigeria is still a long way from the said target, with a MMR of 512 per 100,000 live birth (National Population Council, 2019). Nigeria has an annual estimate of 40,000 maternal deaths, accounting for 14% of the global burden of maternal mortality,

which makes it the second largest contributor to maternal mortality after India (African Population and Health Center, 2017).

Maternal mortality is said to be the extreme consequence of poor maternal health, yet despite the grim statistics, maternal mortality is just an aspect. For each death, 30 to 50 women suffers from maternal morbidities (World Health Organization, 2013; Koblinsky, Chowdhury & Ronsmans, 2012). Pregnancy and childbirth continue to be a major source of death and disabilities among women of reproductive health in developing societies, northwest Nigeria inclusive. Pregnancy is a natural process, however, many pregnancies often end up with life threatening, high risk, and at times - chronic or other serious health complications. The situation is worst in Northern Nigeria, which despite the global decline in maternal mortality, the MMR across four states (Katsina, Zamfara, Yobe and Jigawa) in the northwest and northeast Nigeria was estimated to be 1,271 per 100, 000 lives (Doctor, Findley & Afenyadu 2012), further declining to 1,012 per 100,000 live birth for Jigawa state, which is still higher than the national average (Sharma, Brown, Kainuwa, Leight, & Nyqvist, 2017).

The leading causes of maternal deaths in northern Nigeria are hemorrhage (heavy bleeding), sepsis (infection), unsafe abortion, eclampsia (hypertensive disorders), obstructed labor, malaria and anemia (Federal Government of Nigeria and UNDP, 2013). It was reported Nigeria has the prevalence of Obstetric fistula at 3.2 per 1000 birth with an estimates of 13,000 new cases annually (FMoH, 2019). The cases of Vesico-Vaginal Fistula (VVF) are attributed to early marriage and pregnancy which is more prevalent in the northern parts of Nigeria (Amodu, Salami and Richter, 2018; Ijaiya et al, 2014). Apart from VVF and RVF, cases of eclampsia and pregnancy induced hypertension are also high (Yarzever, 2013), which has serious physical and psychological consequences on affected women.

A look at all the causes of maternal mortality and morbidity will show that they are all preventable only if women had access to timely obstetric and maternal healthcare and utilize the services. The problems of maternal morbidity and maternal mortality are particularly acute, among the rural women and women in northern Nigeria (African Population and Health Research Center (APHRC) 2017; Hassan, 2016; Yar'zever 2014; Basirka, 2012; Wall, 1998). Pregnancy and childbirth has been known to be influenced by the social settings in which it took place because societies vary in the way they treat pregnancy and also, in their ability to deal with the complications that often come with it (Wall, 1998). The Hausa society is a pro-natalist society where children are seen as a gift from God, as such

pregnancy is often seen as miraculous - something no human can control. Moreover, traditionally, certain actions or herbs have always used to ensure successful pregnancy.

Data from NDHS (2018) shows that while there has been a steady increase since 2008 on the number of women receiving ANC from a skilled provider in Nigeria, there are still 46.1% in the North West who did not. For delivery care, while 82% births in the South East were in a health facility, only 16% reported having skilled assistance during birth in the North West. As for the postnatal care, which is the period where complications are most likely to arise, 76.8% of women in the North West region had no postnatal care, while only 19.2% did not in the South West (NPC, 2019). Considering the fact that the same DHS shows that the lifetime risk of maternal death in Nigeria indicates that 1 in every 30 women will die as a result of pregnancy complications, being pregnant is dangerous in northern Nigeria. In most cases, maternal morbidity or pregnancy related complications does not only affect the physical condition of a woman but also her sexual, psychological, social and economic wellbeing (UNFPA, 2013).

This paper offers theoretical and contextual explanations on maternal health seeking behavior in Northwest Nigeria, taking into consideration, the socio-cultural complexity of the region, thereby offering recommendations to tackle the issue.

### **Theoretical Underpinnings**

The Anderson socio-behavioral model was first developed by Anderson (1968), but was first modified in 1973. Initially, the model was developed to study the healthcare seeking behavior of the whole family, however due to the criticism about the heterogeneity of family members; the model was later adapted to focus on the individual rather than the family as a unit of analysis. Since 1973, the model has been modified to accommodate its criticism. However, the core assumption for Anderson (1968) socio-behavioral model is that, the decision to patronize a particular medical channel (whether the healthcare facilities or the traditional healthcare services) is influenced by a variety of socio-economic variables, sex, age, the social status of women, the type of illness, access to services and perceived quality of the service. For him, three variables influence the use of healthcare services:

1. Predisposing factors include race, age, and health beliefs.
2. Enabling factors include family support, access to health insurance and the individual's community.
3. Need represents both perceived and actual need for healthcare services.

The model was also criticized for not paying enough attention to culture and social interaction but Anderson modified the model in 1995 and argued that those factors are included in the predisposing characteristics component, he also included demographic factors such as sex, marital status and past illness; and social structure which are, are education, ethnicity, occupation, family size, religion and residential mobility including social networks and culture (Andersen, 1995). Culture encompasses an individual's value concerning health, attitudes and the individual's knowledge of the condition. The enabling factors were also expanded to include community factors. Family factors include income, health insurance, type of service regularly used; access to regular source (e.g. hours of availability, distance to source, waiting lists). Andersen suggests that quality of social networks, or social support, are also part of the enabling factors. Community factors are the ratios of health personnel and facilities to the population, differences in the price of health services, region of the country, and the rural or urban character of the region. These groups of factors are significant, especially for health care utilization in developing societies such as northwest Nigeria. The third variable 'Need', can be differentiated into perceived need and evaluated need. Perceived needs are the personally experienced need while evaluated needs are the professionally established need. The perceived need is an interaction of probable biologically active disease and the perception of the patient influenced by health beliefs, experience, etc.

The 1995 version of Anderson's model has been criticized for its lack of dynamic character. Another criticism was the overemphasis of the need and at the expense of health beliefs and social structure. However, Anderson argues 'need' itself is a social construct. That is why it is split into perceived and evaluated. The Anderson model best describe utilization of maternal healthcare in north west Nigeria as all those variables are significant in influencing whether a pregnant woman would either have ANC, delivery care and PNC in healthcare facilities or visit a TBA or none.

## **Salient Issues in Healthcare Seeking Behavior and Utilization of Maternal Healthcare Services**

### **Maternal Healthcare**

Maternal healthcare encompasses the healthcare a mother receives during pregnancy, delivery and postnatal periods, from trained healthcare providers. It has been described as the overall comprehensive wellbeing of women at the stage of pregnancy and children below the age of five years (Olonade, Olawande, & Imhonopi, 2019). It includes antenatal care (ANC); Delivery care includes delivery

by skilled birth assistants and availability of emergency obstetric care and postnatal care.

**Antenatal care:** This encompasses early detection and treatment of diseases and complication in pregnant women; immunization and micronutrient supplementation; birth preparedness and complication preparedness; health counseling including information and sensitization on proper nutrition and sanitation. Early detection of complications during ANC leads to timely treatment and referral which can a long way in reducing the risk of maternal morbidity. ANC does not only identify risks and mal-presentation, provides information on recognition of danger signs and symptoms but also play a critical role in establishing confidence between the woman, the family and the healthcare provider (Inam & Khan, 2002).

In Nigeria, the ANC policy was adopted after the World Health Organization approach, which rather than advocating for higher frequency of antenatal visit, emphasized the quality of care during each visit. For the WHO, At least four ANC visits are recommended for women with no complication. During the 2008 NDHS, it was found that, it was found that 58% of women received ANC from a skilled health care provider, 3% received ANC from TBAs and 38% did not receive ANC at all. It was also found out that mother's level of education is related to the use of skilled ANC and women with their first birth received more ANC from a skilled health provider than women with higher birth order. However, there is little improvement in the ANC utilization in the 2013 NDHS, 34% women in Nigeria who had no ANC during pregnancy, the situation is worst in the North West region as 55.4% of women who delivered during the five years preceding the national demographic health survey, had no ANC compared to the 4.2% and 5.7% in the South East and South West respectively.

**Delivery care:** Delivery care includes delivery by skilled birth assistants and availability of emergency obstetric care. Skill birth assistants include doctors, mid wives and nurses who were educated and trained in skills required to manage normal pregnancies, childbirth and the immediate postpartum periods, including trained traditional birth attendants (TBAs). The conditions for delivery care are: first should be assisted by trained health workers who are able to identify the signs of complications and act appropriately when a problem occurs. Second referral facilities should be available to deal with obstetrics emergencies once they have been identified, and on arrival at the referral facility, women should be observed immediately. In addition, for delivery care to be effective there is also the need to

have a transport system that will get the women to the facilities in time (Thaddeus & Maine, 1994).

However, in developing countries, there are several socio-economic and institutional factors militating against the effectiveness of delivery care. These include: inadequate supply of equipment, materials and drug; inadequate blood supply and the absence of blood bank in most maternities and surgical consumables (Griffiths & Stephenson, 2001). In addition, the inability of the health personnel to incorporate the preferences of women such as childbirth in a squatting position rather than the norm in the hospital which is laying down are also contributing factors to the ineffectiveness of delivery care in the Northern parts of Nigeria (Kisseka, 1992). Medical evidence has shown that the squatting position also has its advantages which include: it is could be more comfortable and relieve backache, widens pelvic outlet and it may enhance rotation and descent in a difficult birth (Fraser, Cooper & Nolte, 2006). According to NPC (2014), only 38% of women in Nigeria had their childbirth by skilled birth assistants, 36% of which are in health facilities. Four in five births in the South West and South East are attended by a skilled health provider as compared to the 12% in the North West region; only 12.9% of women who delivered in Kano state for instance were delivered by skilled birth provider.

**Postnatal care:** Postnatal care includes postnatal checkups; immunization for both the mother and the new born; and family planning services and counseling for those who have experience obstetric complications. Postnatal period is defined by the World Health Organization (1998) as the period beginning one hour after delivery of the placenta and continuing till six weeks after delivery. It is recommended that a woman and the child she bore are assessed within the first hour of birth and again after discharge for births in a health facility. The first assessment should target the first 24 hours after delivery for births that occur not in health facilities. Follow up contacts are also recommended at least 2-3days, 6-7days and at 6weeks. However, according to a report from Safe Motherhood (2002), the majority of women in developing countries receive almost no postpartum care after delivery as only 5% of women in sub-Saharan Africa received postnatal care (Safe Motherhood, 2002).

### **Health seeking behavior**

*Health seeking behavior refers to the actions an individual or group of individuals takes towards being healthy and maintaining that health. Igun (1988), describe health seeking behavior from two major perspectives; the first is viewing it in as a 'single still picture of events', in other words, seeking for factors which may*

*influence decisions and actions during a particular illness episode. The second sees health seeking behavior as a process which unfolds during a particular illness episode. Whether as an event or a process, it all boils down to taking actions using things at one's disposal to seek and maintain health. Erinosh (1998), on one hand, refers to health seeking behavior as the interplay between socio-cultural, economic, psychological and spatial factors on one hand and the patterns of utilization of health services on the other. Thus, health seeking behavior is the "way by which symptoms are perceived, evaluated and acted upon by a person who recognizes pain, discomfort and other signs of organic malfunction" (Mechanic, 1960).*

*Health seeking behavior are influenced by a complex web of determinants (Culture, economics, access, perceptions, knowledge, belief in efficacy, age, gender roles, and social roles) and it is difficult to isolate the most influential determinants in the decision to utilize health care. prevention and treatment of illness (Rebhan, 2015). These determinants may be similar across the globe but they have unique interactions, manifestations and influence on individual's or group's lives depending on the individual's or group's peculiarities (Prosser, 2007).*

### ***Maternal mortality***

Maternal mortality according to the World Health Organization (2019), is the death of a woman during pregnancy, delivery or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. Maternal mortality is among the health indicators that reflect the greatest disparity between rich and poor. The main causes of maternal mortality are severe bleeding, infection, unsafe abortion, eclampsia, and obstructed labor. While every woman is at risk for experiencing sudden and unexpected complications during pregnancy, childbirth and following delivery, adequate antenatal, obstetric and post-natal care can reduce the risk of death considerably.

### ***Maternal morbidity***

Maternal morbidity is complex and difficult to define not as clear as mortality. It ranges from mild, to acute and could also be chronic depending on the criteria adopted by the researcher (Hassan, 2016). The complexity of the definition of maternal morbidity is connected to the difficulties in its diagnosis. However, maternal morbidity according to Koblinsky et al (2012), is "an overarching" term that describes the physical or mental or disabilities associated directly with pregnancy and child birth which can be classified into two (2) categories: acute

maternal morbidity and obstetric complications. Acute maternal morbidity refers to the acute problems suffered during pregnancy up to 42 days, which is the standard postpartum period. Other researchers may refer to this category as ‘Absolute Maternal Indications (AMIs)’, ‘Severe Acute Maternal Morbidities (SAMMs)’ or “near miss” which is a term that is used for women who survived acute and severe pregnancy complications and escape death by receiving timely, appropriate care. They include obstetric fistula, uterine prolapse, chronic urinary tract infection and uterine rupture. Obstetric complications on the other hand, refers to complications that may directly cause maternal mortality, not only do these complications leads to death but also cause serious chronic maternal morbidity such as those described above (McCarthy and Maine, 1992). These complicated cases include ante partum or postpartum hemorrhage, prolonged or obstructed labor, postpartum sepsis, complications of abortion, pre-eclampsia and eclampsia (United Nations Children Fund; WHO; UNFPA, 1997) including caesarean delivery. These complications can occur at any time during pregnancy or childbirth, often without warning and requiring immediate access to emergency obstetric care for its management (Safe motherhood Reports, 1997).

### **Women health seeking behavior in the Northwest, Nigeria**

Hausa culture is rooted in their religion which is Islam, which is reflected in their health seeking behavior. However, it is also shaped by certain traditional beliefs and practices as well as commonly accepted cultural understanding on the nature of disease and illness. Pregnancy therefore is often regarded as a natural process but very serious and life threatening. In fact, pregnant women are said to have one leg on earth and the other in heaven; implying that anything can happen in pregnancy. As a result, it is a general belief that nothing can be done except to wait for God’s will. Pregnancies among Hausa women tend to occur at a younger age because of early marriage. Early marriage among Hausa women is quite common despite the increase in girl child enrolment in formal schools. Some of the reasons given for early marriage include the desired to avoid dishonoring the family name by ensuring that the girl child was not had sexual relations before marriage; low level of girl child enrolment in schools, economic reasons resulting from dowry; including the need to reduce the burden on the parents (Shehu, 1992).

Before pregnancy, there is what is termed as the *gishiri disease*. The word *gishiri* is usually used to describe a wide range of ailments related to the reproductive system. Studies have shown that the following symptoms resulting from specific medical conditions have been erroneously classified as the *gishiri disease*, they include: pruritis vulvae, amenorrhoea (absence of menstruation, infertility,

obstructed labor, painful intercourse, vaginal atresia, imperforated hymen and menopausal syndrome. Other symptoms which are associated with anemia and malaria such as headaches, fainting attacks and oedema are also considered as signs of *gishiri*. During pregnancy, certain physiological changes that occur such as hypertrophy of the vaginal muscle coat, the softening of the pelvic floor, the increased vaginal discharge are all attributed to the disease. Hausa women's health seeking behavior is also influenced by male dominance in decision making. A woman choice is dependent on male partner as she needs his permission for spatial mobility even in the case of obstetric emergencies (Kisseka et al, 1992). This is also connected to the aversion of a male health worker seeing a woman's nakedness.

According to Adamu (2010), there also some specific dos and do nots of pregnancy among Hausa women; some of which include: sleeping on the right hand side rather than on the back; eating beans and vegetable; drinking lots of water; and exercise. The do not of pregnancy include: going out at night; laughing at an ugly person; taking sugary things; and taking water that is very cold.

TBAs are called *anguwanzoma* in Hausa language. Their main function is to assist women during delivery. They however, also provide ANC and PNC services. In a study that involves 15 TBAs and 165 women within the reproductive years, it was discovered that TBAs place a significant in maternal healthcare. The TBAs provide ANC medicine and during labor encourage women to deliver in squatting position as they believe that only this position brings about faster delivery. They also advice women not to push too hard so that they won't have *episiotomy* (tear). If that should happen, the TBAs advise the women to treat it with hot water. After delivery, they perform the ritual disposal of the placenta and the treatment of the umbilical cord (Muazu, 1992).

### **Factors affecting the utilization of maternal health services in Northwest, Nigeria**

**Poverty:** Poverty is one of the major factor predisposing women to maternal morbidity. Approximately 99% of maternal deaths occur in poor countries and it is even higher among women living in the rural areas compared to those who reside in the urban areas (Kristof & WuDunn, 2009). Poverty is wide spread in West Africa especially the northern part of Nigeria where majority are Hausas. This is most especially for the Hausa women. In some societies, women are not given equal opportunities that men have to education and economic liberation because in such societies it is believed that exposing women to western education is a waste of resources when in the long run she will be under the protection of a husband

(Okoye, 2011). Poverty limits women's access to quality life. It affects women accessibility to healthcare and exposes women to malnutrition, disease, unhygienic environment such as overcrowding and unclean water, and accessibility to information including limiting women's of getting educated. In addition, poverty also has grievous effect on the entire household of the ill (OECD reports, 2003). The cost of health care services is associated with maternal and infant mortality as it is the cause of the health care service that determines where women deliver their babies. Women from lower socio-economic status and poor educational background can hardly afford modern health care services (Adamu & Salihu, 2000). According to the UNDP human development report, 2006, a significant amount of Nigerian women delivers without the help of medical care providers because they can't afford their services as 12% of the poorest 20% of Nigerian women have no access to skilled medical care during child birth (UNDP, 2006).

**Distance from health facilities:** Shehu (1992) argued that the distance to the hospital is a major deterrent in hospital attendance and delivery having found that distance account for 42.3% of the maternal deaths in Usman Dan fodio Teaching Hospital (UDUTH) between April and July 1987. In a study conducted in Abidjan, Ivory Coast in 1986, it was found out that the maternal mortality rate for women who has been refers to the urban zones are 2000/ 100,000 deliveries and 3000/100,000 deliveries for those suburban areas and 6000/ 100,000 in the rural areas. Another study in Aden hospital, where 73% of maternal deaths were women from the rural areas who had a long way to travel, show clearly acute is the problem in the rural areas. 10% of these women were died on arrival and another 15% died within an hour of arrival.

**Mother's level of education:** Education is an important factor which determines development in general. It is associated with fertility, use of health care facilities and use of contraceptives. For every one thousand girls who get an additional year of education, two fewer women will die in childbirth (World Bank Reports, undated). Generally, in the northern Nigeria, there are high percentages of women who do not have access to education beyond secondary level, especially in the rural areas; even at the primary school level, difference exists between girls and boys in favor of boys (DFID, 2002). According to NPC (2013), women with no education marry earlier; at least 6 years earlier than those who have had at least secondary school education, with their median age at 15.5 years and 21.5 years respectively. Also the Contraceptive Prevalence Rate (CPR) of women with no education is far lower than women with at least secondary education with 3% and 37% respectively.

Many researchers have also attributed maternal ill health and death to illiteracy. This is because according to Rayston (1989) educated women are likely to have more understanding of the physiology of reproduction and are less likely to accept the complications and risks of pregnancy as inevitable when compared with the uneducated or illiterate women. Educated women are also more likely to utilize modern health care facilities than those who are not. Education is directly connected to utilization of ante-natal care (ANC) services; as 97% of all women with more than secondary education received care from a skilled health worker compared with 38% of those with no education (NPC, 2013). There is also found a positive association between educational attainment and the decision of whether to opt for hospital delivery or home delivery (Bala, 2009). Education also empowers women, educated women are more likely to have paid jobs, that enables them to afford health care when needed (Kristoff & WuDunn, 2009). However, in some societies, women are not given equal opportunities as men; in terms of education and economic liberation. In such societies, it is believed that exposing women to western education is a waste of resources, when in the long run she will be under the protection of a husband (Okoye, 2011).

**Women's lack of decision-making power within the family:** The significant role men play, as the sole providers and head of the family, in patriarchal societies such as the Hausa society; gives them strong dominance and control over household decision making (Duse & Muhammed, 2006; Wall, 1998). This dominance extends over to their health seeking behaviour, as men decide whether their wife/wives will patronize orthodox healthcare services or not. In a study of factors associated with maternal mortality in three remote villages of Gwaram Local Government Area in Jigawa State, Northern Nigeria; it was found that husband's permission is necessary before a woman can utilize the health facilities and in situation whereby this permission is delayed or denied, the woman stands the risk of maternal morbidity or in extreme cases, maternal mortality. The study also found out that in most cases, husbands often deny granting such permission because of the financial cost of patronizing such facilities (Basirka, 2012). In another study also conducted in the northern parts of Nigeria, Borno state to be precise, Abdulkarim, Kawuwa and Kullima(2008) found out that, husband's refusal to allow their wives to attend clinics is among the factors responsible for the prevalence of maternal mortality in the area.

**Aversion to hospitals:** Another problem responsible for the escalation of cases of maternal morbidity is the reluctance of women, especially those from the rural areas to patronize modern healthcare facilities. Women at times, prefer to deliver at

home. The risk is that, home delivery can result in complications which more often than not, require emergency obstetric care. This avoidance can be the result of the fear of caesarean delivery, or the loss of child during a previous caesarean delivery, which is associated with mother's fear of repeated occurrence (Konje, Obisesan and Ladipo, 1990). The avoidance of hospital is also attributable to religious or cultural beliefs. In some societies such as the Hausa society, modesty or what is referred to as '*kunya*' can prevent a pregnant woman from seeking antenatal care or delivering in hospital, especially for first pregnancy (Wall, 1998). At times this aversion is because of the fear of exposing genitals to strangers, especially the opposite sex.

**Institutional determinants:** Accessibility to maternal healthcare facilities is a factor inhibiting qualitative maternal health, especially in this part of the world. Accessibility in this regard encompasses availability of service, knowledge of service, financial strength, quality of care, or proximity to qualitative healthcare (McCarthy & Maine, 1992; Maine, 1991). The healthcare, a woman receives during pregnancy, delivery and postpartum is very crucial to the survival and wellbeing of both mother and child, because early detection of problems, results in more timely treatments and referrals (NPC, 2009). Nigeria's high rate of maternal, new born and child mortality including morbidities; is associated with lack of emergency obstetric care, inadequate health facilities, lack of transportation to institutional care, inability to pay for health services and resistances among rural population to modern health care as well as cultural attitude and practices that discriminate against women and girls (UNICEF, 2009). According to the WHO (2012) facts sheet Reports, more than 99% of cases of maternal mortalities and maternal morbidities occur in developing countries and more than half of that occur in sub-Saharan countries indicating that lack of adequate and available health resources is a major factor. The Nigeria health system has a weak referral system (FMoH, 2010). The referral system between the various types of facilities is non-functional or ineffective. This weak referral system usually leads to the inappropriateness of the use of referral hospital and self-referrals in developing countries. This usually result in theoretical explanations of maternal healthcare seeking behavior.

## **Conclusion and Recommendations**

Factors such as age; age at first marriage; education; lack of autonomy in decision making; proximity to the healthcare facilities and financial constraint affects maternal health seeking behavior and utilization of maternal healthcare facilities. Poverty and limited access to appropriate mat care pose major challenges to improving maternal health and reducing maternal mortality. Improving education of women is important both from long term perspectives of enhancing decision

making, and acquisition of knowledge and positive attitude towards utilization of maternal healthcare; including their health seeking behavior. Interventions towards increasing utilization of maternal healthcare services must inevitably target husbands, being key actors in determining healthcare seeking behavior within the households.

## References

- Abdulkarim, M., Kawuwa, M.B., & Kullima, A. (2008), Community Perception of Maternal Mortality in Northeastern Nigeria. *African Journal of Reproductive Health*. Vol. 12 (3):27-34  
<http://www.jstor.org/stable/20617073?origin=JSTOR-pdf>
- Adamu, Y. M. (2010). *Maternal mortality in northern Nigeria: a case study of Kano state*. PhD thesis. VDM publishing house Ltd.
- Adamu, Y. M., Salihu, H. M., Satiakumar, N. and Alexander G. R. (2003). Maternal mortality in northern Nigeria: a population based study. *European journal of obstetrics and gynecology and reproductive biology* 109:153-159.
- African Population and Health Research Center (APHRC) (2017). *Maternal health in Nigeria: Facts and figures*. Nairobi: APHRC
- African Progress Panel (2010). *Maternal Health: Investing in the Lifeline of Healthy Societies and Economies*. [www.africaprogresspanel.org](http://www.africaprogresspanel.org) Retrieved on June 11, 2019
- Anderson, Ronald M. (1995). Revisiting the behavioral model and access to medical care: does it really matter? *Journal of Health and Social Behavior*. Vol.36(March):1-10. American Sociological Association. <http://www.jstor.org/stable/2137284>
- Andersen, R. (1968). *A behavioral Model of Families' Use of Health Services*. Research Series No. 25. Chicago, IL: Center for Health Administration Studies, University of Chicago.
- Anderson, R. & Newman, J. (1973), Societal and individual determinants of medical care utilization in the United States. *Milbank memorial fund quarterly health*. Vol. 51(1):95-124
- Amodu, O. C., Salami, B. O. & Richter, M. S. (2018). Obstetric Fistula in Nigeria: A critical discourse analysis. *BMC Pregnancy and Childbirth* Vol 18:269  
<https://doi.org/10.1186/s12884-018-1907-x> Retrieved on March 21, 2021
- Bala, B, S. (2009). *Constraints to accessing obstetric care and the psycho-social consequences of obstetric fistula: study of three VVF centers in North-Western Nigeria*. Being a PhD in demography proposal for the department of sociology, faculty of social and management science. Bayero University, Kano.

- Basirka, I. A., (2012), *A Study of Factors Associated with Maternal Mortality in Three Remote Villages of Gwaram Local Government Area, Jigawa State (2006-2010)*. Being a dissertation submitted to the Department of Sociology, Bayero University, Kano in partial fulfillment of the requirement for the award of award of Masters of science (M.Sc.) Sociology with specialization in Demography.
- Doctor, Findley and Afenyadu, Doctor, H.V.; Findley, S.E.; & Afenyadu, G.Y. (2012), Estimating maternal mortality level in rural northern Nigeria by the sisterhood method. *International journal of population research*. Vol. 2012, article ID 464657.
- Duze, M. C. and Mohammed, I. Z. (2006). Male knowledge, attitudes, and family planning practices in northern Nigeria. *African Journal of Reproductive Health*. Vol.10(3):53-65.
- Erinosh, A. Olayiwola. (1998), *Health Sociology*. Ibadan: Sam Bookman.
- Federal Ministry of Health (FMoH) [Nigeria] (2019), *National Strategic Framework for the Elimination of Obstetric Fistula in Nigeria 2019-2023*. UNFPA Nigeria.
- Fraser, D. M., Cooper, M. A. and Nolte, A. G. (2006), *Myles Textbook for Midwives-African edition*. Edinburgh: Elsevier limited.
- Hassan, H. K. (2016), *Maternal health and morbidity among Hausa women in Kumbotso Local Government area, Kano state*. Being a project submitted to the Department of Sociology, Faculty of Social Management Science, Bayero University, Kano. Nigeria. For the award of BSc degree in Sociology.
- Igun, U. A. (1988). *Medical Sociology- An introduction*. Ibadan: Shaneson Limited
- Ijaiya, M. A., Rahman, A. G., Aboyeji, A. P., Olatinwo, A. W., Esuga, S. A., Ogah, O. K., Raji, H. O., Adebara, I. O., Akintobi, A. S., Adediran, A. S. & Adewole, A. A. (2010), *Vesicovaginal Fistula: A review of Nigerian Experience*. *West African Journal of Medicine*. 29(5):293-8 doi:104314/wajm.v29i5.68247
- Inam, S. N. B. & Khan, S. (2002). Importance of Antenatal Care in Reduction of Maternal Morbidity and Mortality. *Journal of Pakistan medical association*. [www.jpma.org.pk/full\\_article\\_text](http://www.jpma.org.pk/full_article_text) Retrieved January 16<sup>th</sup> 2015.
- Kisekka, M. and Otesanya, B. (1998), *Sexually Transmitted Diseases as a Gender Issue: Example from Nigeria and Uganda*. Paper presented at the AFARD/AAWORD third general assembly, Dakar, Senegal.
- Kisekka, M. N. (1992), *Women's health issues in Nigeria*. Zaria: Tamaza publishing company limited.
- Kisseka et al, 1992 in Kisekka, M. and Otesanya, B. (1998), *Sexually Transmitted Diseases as a Gender Issue: Example from Nigeria and Uganda*. Paper

- presented at the AFARD/AAWORD third general assembly, Dakar, Senegal.
- Koblinsky, M., Chowdhury, M.E. & Ronsmans, C. (2012). Maternal Morbidity and Disability And Their Consequences: Neglected Agenda In Maternal Health. *Journal for health, population and nutrition*. Vol.30(3):124-130. Available <http://www.ncbi.nlm.nih.gov> Retrieved: 28<sup>th</sup> of August, 2013.
- Konje, J. C., Obisesan, K.A.; & Ladipo, O. A. I. (1992). Obstructed labor in Ibadan. *International Journal of Gynecology obstetrics*. Vol.39:17–21.
- Kristof, N. D. & WuDunn, S. (2009), *Half the sky: turning oppression into opportunity for women worldwide*. New York: Alfred A. Knopf.
- Maine, D. (1991) cited in Seyfried, L. (2011). *Family Planning and Maternal Health: The Effect of Family Planning on Maternal Health in the Republic of Congo*. Being a thesis submitted to the Graduate school of Arts and sciences of Georgetown university in the partial fulfillment for the degree of Master of public policy. Washington DC.
- McCarthy, J. & Maine, D. (1992). A framework for analyzing the determinants of maternal mortality: implications for research and programs. *Studies in Family Planning* 23, 1:23-33.
- National Population Commission (NPC) (Nigeria) and ICF International (2014), *Nigerian Demographic Health Survey (NDHS) 2013*. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF International.
- National Population Commission (NPC) (Nigeria) and ICF International (2009), *Nigerian Demographic Health Survey (NDHS) 2008*. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF International.
- Olonade, O., Olawande, T. I., Alabi, O. J. & Imhonopi, D. (2019), Maternal mortality and Maternal Health Care in Nigeria: Implications for Socio-economic Development. Open Access *Maced J MedSci*.2019 Mar 14. doi: 10.3889/oamjms.2019.041
- Ononokpono, D. N. & Odimegwu, C. O. (2014), Determinants of Maternal Healthcare Utilization in Nigeria: A Multilevel Approach. *The Pan Medical Journal*, 2014;17(supp1):2 doi:10.1164/pamj.supp.2014.17.1.3596
- Organization for economic co-operation and development (OECD) (2003), *Poverty and Health in Developing Countries: Key Actions*. [www.oecd.org/publications/pol\\_brief](http://www.oecd.org/publications/pol_brief) retrieved February 17, 2013.
- Prosser, T. (2007), *Utilization of Health and Medical Services: Factors Influencing Healthcare Seeking Behavior and Unmet Health Needs in Rural Areas of Kenya*. Perth: Edith Cowan University.
- Rebhan, D. P. (2013). *Health Care Utilization: Understanding and applying theories and models of health care seeking behavior*. Case Western Reserve

- University. Retrieved on September 27, 2013 from <http://www.cwru.edu/med/epidbio/mphp439/healthcareutil.pdf>
- Safe motherhood (2002). *Improve accessed to quality maternal health services*. Retrieved from [www.safemotherhood.org.html](http://www.safemotherhood.org.html)
- Sharma, V. Brown, W. Kainuwa, M. A. Leight, J. & Nyqvist, M. B. (2017). High Maternal Mortality in Jigawa State, Northern Nigeria estimated using the sisterhood method. *BMC Pregnancy and Childbirth*. 17:163 DOI 10.1186/s12884-017-1341-5
- Shehu, D. G. (1992), *Socio cultural factors in the causation of maternal morbidity and mortality in Sokoto* in Kisseka, M. N. (1992), *Women health issues in Nigeria*. Zaria: Tamaza publishing limited.
- Thaddeus, S. & Maine, D. (1994), Too Far to Walk: Maternal Mortality in Context. *Social Science and Medicine*, 1994, 38:1091-1110
- UNFPA (2013). *Adolescent pregnancy: A review of evidence*. New York: UNFPA
- United Nations Development Programs (2006). Human development report 2007/2008. Available at <http://hdr.undp/hdr2006/report.cfm> accessed in January, 2014
- Wall, L. L. (1998). Dead mothers and injured wives: the social context of maternal morbidity and mortality among the Hausa of northern Nigeria. *Studies in Family Planning*. Vol.29:341–59.
- World Health Organization (2019). Trends in Maternal Mortality 2000 to 2017: estimates by WHO, UNICEF, UNFPA, World Bank Group and United Nations Population Division. Geneva
- World Health Organization (2012). Maternal mortality: fact sheet N<sup>o</sup> 348". Available at <http://www.who.int/mediacentre/factsheets/fs348/en/> retrieved August, 2013.
- World Health Organization (2006), Measuring progress towards the health Millennium Development Goals. Available at [www.who.int/mdg/](http://www.who.int/mdg/). Retrieved February, 2013.
- World Health Organization and Millennium Development Goals, (2005) Geneva: WHO
- World Health Organization (2005). Make every mother and child count. Geneva: WHO
- Yahaya M. K. (2002). Analysis of Women's Reproductive Health Situation in Bida Emirate of Niger State, Nigeria *African Journal of Reproductive Health* Vol. 6, No. 1 (Apr.,2002)pp. 50-64 Published by: Women's Health and Action Research Centre (WHARC). Available at <http://www.jstor.org/stable/3583146> .Accessed: 28/08/2013 17:20

- Yar'zever, I. B. (2011), *A comparative study of the socio-cultural factors associated with maternal mortality in urban and rural areas in Kano*. Being a PhD proposal for the Department of Sociology, Faculty of Social and Management science, Bayero, University of Kano.
- Yar'zever, I. B. (2014), Temporal Analysis of Maternal Mortality in Kano State, Northern Nigeria: A Six Year Review. *American Journal of Public Research*. Vol. 2 (2) pp 62-67
- Yusuf M. A. (2005), Pattern of Maternal Morbidity and Mortality in Kano State: A geographical analysis. *Journal of Social and Management Science*.9 (special edition) 2005, 196-221.