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Exploring Male Partners and Health Workers' Views on Women's Utilisation of Maternal Healthcare Services in Bauchi State, Nigeria

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ABSTRACT

Healthcare services at Maternal healthcare facilities operate to provide safe delivery for women of childbearing age. The numerous maternal deaths remain a concern, even though the government maintains maternity healthcare facilities. All literature studies show that health services usage remains low in rural regions, particularly Northern Nigeria. This study delved into exploring male partners' and health workers' views on women's utilisation of maternal healthcare services in Bauchi state, Nigeria. The study adopted a case study qualitative research design. A purposive sampling technique was used to select five married men and two skilled birth attendants, who were interviewed using a semi-structured interview guide. The data collected were transcribed and translated from Hausa to English. Braun and Clarke's (2006) Thematic Data Analytical technique was used to analyse the data with Computer-Assisted Qualitative Data Analysis Software (CAQDAS), MAXQDA 2024. Three themes emerged from the analysis: maternal healthcare factors, women's use of maternal healthcare, and women's issues. There was a staff shortage, an unfavourable staff attitude, and a distance from the health centres. In contrast, the maternal healthcare centres were not in good condition to attract reproductive women to the healthcare centre. Reproductive women experienced financial challenges and inadequate spousal support and mostly used healthcare during emergencies. Hence, it was recommended that health institutions, NGOs, and policymakers should partner to educate communities about home and self-delivery, including the potential risks and benefits.

Keywords: Maternal Health Care, Reproductive Women, Skilled Birth Attendants, Male Partners

INTRODUCTION

Maternal healthcare encompasses the health status of women within their reproductive age range. Antenatal Care (ANC) can address complications that may arise and screen pregnant women and their unborn children for actual and potential issues as the pregnancy progresses (Downe et al., 2019). Addressing maternal healthcare is crucial for national thriving,

particularly in achieving MDG 4, which aims to reduce child mortality. Neglecting maternal healthcare can have severe implications. Inadequate and prompt attention to severe bleeding post-birth may result in the loss of women's lives. Infections after childbirth can be prevented through proper hygiene, recognising early signs of disease, and prompt treatment, thereby detecting and treating potentially fatal complications before they occur (WHO, 2019). Expanding initiatives to reduce maternal mortality is crucial for enhancing overall health and well-being. Every pregnancy and birth is unique, highlighting the need to address inequalities affecting maternal sexual and reproductive health and rights to ensure all women have access to high-quality maternity care that is respectful (WHO, 2023b).

Women's experiences before delivery, their overall health, and lifestyle choices can influence pregnancy fertility, maternal health, and the likelihood of infants developing chronic conditions (WHO, 2022a). Thus, pregnant women need to have their health checked for potential challenges and problems, engaging in early treatment and signposting. This type of care ensures a smooth delivery experience through adequate preparation balanced with necessary precautions. Throughout pregnancy, women must receive high-quality antenatal care for a healthy pregnancy for both mother and baby, ensuring an efficient transition to positive labour and childbirth (WHO, 2022a). Emphasising the vitality of antenatal care for every pregnant mother is essential. Attending antenatal care provides advantages such as quality information on what to do, how to do it, what to avoid, what to practice, and channels of doing it, among others. Early detection and reduction of risk factors are facilitated by antenatal care, making it easier to identify and manage obstetric complications and infections (Mohamoud et al., 2022). The phases of maternal healthcare extend beyond before and during childbirth to cover after birth. Antenatal and postpartum care services are proximate determinants of outcomes for mothers, enabling early detection of at-risk mothers and providing prevention services (Dairo & Atanlogun, 2018). Furthermore, the risk of death is higher in the first week after birth, emphasising the importance of the health of both mothers and their babies (WHO, 2022a). The immediate postnatal period is crucial, yet postnatal care has received little attention in Nigeria despite its significance for children's survival (Somefun & Ibisomi, 2016a). Mothers who deliver at maternal healthcare centres may have reasonable expectations about their health and the well-being of their newborns, possibly not seeing the need to return for check-ups.

The majority of worldwide maternal mortality occurs in low-income countries (WHO, 2023). Global data from the World Health Organisation indicates pregnancy-related mortality claims 536,000 women every year, with pregnancy complications affecting nearly 10 million women based on their annual reports (WHO, 2019a). The mortality rate of women from preventable pregnancy and childbirth complications stood at 810 fatalities per day, while the global maternal mortality rate (MMR) recorded a 38% reduction between 2000 and 2017 (WHO, 2018). Discrepancies in MMR reveal distinctions between developed and developing nations. The MMR exceeded 1000 in 2017 in low-income countries, while high-income nations recorded only 11 deaths per 100,000 live births (WHO, 2021). Developing countries, which include both low-income and middle-income regions, represent 94% of total maternal mortality rates as per WHO (2021) statistical data.

The Nigerian health sector needs to take seriously the growing problem of maternal deaths that prove worrisome to healthcare officials. Women fail to attend postnatal check-ups at a rate of 62.9%, according to the National Bureau of Statistics (NBS) and the United Nations Children's

Fund (UNICEF) 2018 data. Postnatal care utilisation through maternal healthcare services reaches only 58.9% in urban areas. In comparison, it reaches 27.8% in rural areas per National Post Natal Care (PNC) data (National Bureau of Statistics (NBS) and UNICEF, 2018). Women in rural areas do not frequently use maternal healthcare centres for antenatal and postnatal services since 81% of northwest Nigerian women skip postnatal check-ups, while southwest Nigeria only sees 24% of women having them (NBS and UNICEF, 2018; World Health Organization (WHO), UNICEF, UNFPA, 2015).

This study aimed to investigate the utilisation of maternal healthcare centres in Bauchi State, given the persistently high maternal mortality rate despite the presence of such facilities staffed by skilled health workers. Notably, in Nigeria, 41% of women did not deliver in Western maternal healthcare settings (Dahiru & Oche, 2015), and the northern part of the country, including Bauchi State, exhibits elevated maternal mortality rates (Kana et al., 2015). Despite governmental efforts to provide maternal healthcare and address the lack of awareness about the importance of utilising healthcare facilities, there has not been a proportional increase in the expected utilisation among reproductive women. This study identifies research gaps, revealing a scarcity of studies on utilising maternal healthcare centres, specifically in Bauchi State. The existing studies in the state predominantly employed quantitative research methods, with only a limited number of qualitative studies available.

Moreover, the few qualitative studies primarily focused on home visits, general health, and child health, which differ from the objectives of this study. Consequently, there is a pressing need to investigate maternal healthcare utilisation in Bauchi State. Several underlying factors influence women's utilisation of maternal healthcare centres. To comprehensively grasp women's experiences, this study also sought perspectives from other key groups, including male partners of reproductive women and skilled health workers. By incorporating these diverse viewpoints, the study aims to create a comprehensive understanding of the factors influencing the utilisation of Western maternal healthcare services in Bauchi State.

- **Research Question:** What are the perspectives of maternal stakeholders on the factors influencing women's utilisation of maternal health services in Bauchi State, Nigeria.

METHODOLOGY

Research Approach

This study adopted a qualitative research approach. The study focused on the views of husbands and healthcare workers regarding women's use of maternal healthcare services in Bauchi State, Nigeria. The study adopted a case study method to examine what influenced reproductive women in utilising community healthcare centres. A purposive sampling technique was used to select the participants with in-depth knowledge of the topic. Data was collected from 7 participants (5 male partners and 2 health workers) through a semi-structured interview guide. The male participants, who were husbands and heads of their families, were identified with the assistance of community leaders. The inclusion of skilled birth attendants was crucial, as they play a key role in delivering maternal health care to pregnant women. The two selected attendants were directly involved in maternal health services at local healthcare centres. The researcher took a debriefing approach, regularly meeting with the committee that helped facilitate the study. Participants were reassured that their responses were strictly for research purposes, and they were informed about the confidentiality of their responses, with

no names attached to the excerpts. The researcher conducted a pilot study to identify and address potential issues with participants.

Ethical approval was secured from the University of Northampton (UoN), and clearance from the Bauchi State Health Research Ethics Committee (BASHREC) to access the study sites was obtained. After submitting all the required documents for ethical clearance, BASHREC granted us the go-ahead to start collecting data. We received full ethical approval from the University of Northampton, which helped us create a participant information sheet (PIS) and a consent form for the study. Additionally, we got permission from community leaders in these wards through the gatekeepers. Thematic Analysis technique developed by Braun and Clarke (2006) was used to dive into the data gathered from the participants.

RESULTS

Theme 1: Maternal Healthcare Factor

The theme refers to the healthcare system's challenges, problems, or shortcomings that hinder women's effectiveness in utilising maternal healthcare centres.

Theme 1.1: Staff Shortage:

The theme shows the inadequate number of appropriate health workers available for work in healthcare centres. A health worker expressed dissatisfaction with the rural area's healthcare services. According to the participant:

> *To be candid with you, the services in the rural area are boring. This is because we get two or three health personnel in the clinic, and it runs all the services to meet the health needs of the entire community with few or limited staff. It makes it difficult for the staff to work efficiently (Interview with Health Worker, Participant 1)*

In addition, the participant emphasised the shortage of human resources in different levels of hospitals and advocated for training Traditional Birth Attendants (TBAs) as a community-centric solution to address gaps in maternal healthcare, saying, "There is a shortage of human resources in tertiary, secondary, and primary hospitals. Therefore, it is essential to train the TBAs because they play a key role in our communities."

Similarly, another healthcare worker revealed significant gaps in personnel and expertise needed to cater to the medical requirements of the community. The health worker stated:

> *We lack the human resources to meet this community's medical needs or demands. As you can see, only three are working here: the security guard, the cleaner, and me. The security guard keeps watch of the facility at night while the cleaner comes three times a week to clean the facility (Interview with Health Worker, Participant 2)*

Buttressing the response above, the participant sheds light on the challenging circumstances he faced as a single health worker responsible for the medical care of an entire community, "I am the only trained health worker providing medical care to the community's entire population." A male participant highlighted the challenges and potential limitations of healthcare services, particularly in terms of resource shortages and referral systems for

complex cases, in connection with the emotional toll and significant loss associated with the death of a newborn child:

> *My wife has given birth to about five children now, though one was born at the healthcare centre, but not in this community. We were referred to another health facility because of the shortage of human resources and referral services in case of complications. …My wife delivered the baby after about a day of painful labour at the healthcare centre. The child only lived for six hours, after which he sadly gave up the ghost (Interview with Male Participant, M2).*

The participant underscored the general problem of a shortage of human resources in healthcare facilities, using the specific example of a health centre that experienced declining staffing levels over the years. A health worker mentioned the challenges in the healthcare sector, emphasising the impact of understaffing on patient experiences and the workload of healthcare professionals.

> *We have a small number of health personnel to meet the daily health needs of patients. Some are retired, and some are dead without the government replacing professionals to fill the vacancy, from primary healthcare to tertiary institutions. (Interview with Health Worker, Participant 2)*

A health worker drew attention to an unequal distribution of health workers based on gender, which has consequences for both access to healthcare services and gender equality. "Conversely, the government does not send women nurses or female health workers to remote areas away from their husbands, so most health workers in remote areas are men. Female health workers are found in or around city centres" (Interview with Health Worker, Participant 1). The findings showed staffing challenges in rural healthcare, a shortage of human resources across tiers, the impact of the lack of human resources on maternal and child health, overburdened healthcare staff, and gender disparities in the distribution of healthcare workers.

Theme 1.2: Staff Attitude:

The theme refers to the behaviour and overall approach exhibited by health workers with the patients who utilise the healthcare facilities. A male participant addressed concerns about the lack of respect for women by healthcare staff, emphasising the emotional impact of such experiences and advocating for a more respectful and patient-centered approach in healthcare interactions:

> *The other issue is the health staff's lack of respect for our women. This is another painful experience; why would someone feel superior simply because they are a health worker? I do not want a situation where my wife would come back and tell me someone at the hospital disrespected her (Interview with Male Participant, M2)*

Another male participant conveyed negative experiences of women in healthcare centres, emphasising issues such as inadequate facilities, poor reception, and lack of respect for older people. According to the participant:

> *Most testimonies from these women are discouraging to many women who have never experienced any healthcare treatment at healthcare centres. They complain of inadequate facilities, poor reception at the healthcare centre, and lack of respect for older people or the elderly. These are very terrible practices that tend to hurt our women whenever they go to the health centres, especially those centres that are located in the cities (Interview with Male Participant, M4)*

Another male participant complained about perceived disrespect towards individuals with limited formal education at the health centre.

> *My wife complained bitterly about how she was treated at the health centre. She said most of the workers spoke to them without regard because they were illiterates with no formal education; they had not been handled the way educated women were. My wife does not want to go back to the health centre because of this reason and other healthcare practices which our wives find uncomfortable whenever they visit the hospital (Interview with Male Participant, M1)*

Another male participant raised concerns about the behaviour of young medical personnel, highlighting perceived arrogance, a lack of respect, and a deviation from cultural expectations regarding interactions with older community members.:

> *Sometimes, the medical personnel are very young and do not know what they are doing. In the case of what is happening, these little children are feeling too big most of the time when they meet our women; they expect our women to salute them or even give them a way to pass before them simply because they are medical personnel. What a shame (Interview with Male Participant, M4)*

A health worker emphasised the absence of corrupt practices in their clinic and the proper handling of free drugs:

> *…whenever there are free supplies of drugs, we disburse these drugs accordingly. For example, immunisation, ANC, and any under-five services are free. Health committees oversee the disbursement of these free drugs, and representatives are sent to, if not all, of the clinics to monitor what the health workers are doing (Interview with Health Worker, Participant 2)*

On the other hand, the health worker underscored the influence of past negative experiences with health personnel as a reason for some women's non-utilisation of maternal health services:

> *Well, it could be because of what they (patients) experienced. We go for sensitisation and creating awareness about maternal health service (MHS) use in the community. The few women I had an opportunity to chat with told me that some do not utilise MHSs because of the negative attitude of the health personnel they have come in contact with.*

The findings showed a lack of respect for women by health staff, discouraging testimonies from women, discontent with treatment at health centres, young medical personnel, and a lack of care. They also showed the response from health workers, sensitisation efforts, and the impact on promoting maternal health services.

Theme 1.3: Distance of Healthcare Centres:

This theme shows how far or near maternal healthcare is to the community members. A male participant highlighted the speaker's challenges in accessing a health facility due to distance and associated transportation costs. He raised broader considerations about the intersection of financial capacity and healthcare accessibility, highlighting potential disparities in access based on socioeconomic factors:

> *The health facility is far from my place. It would cost me eight hundred naira for transportation to and from the health centre. I believe it is accessible to the people around the facility and to those who are financially strong (Interview with Male Participant, M2)*

In addition, the participant underscored the complexity of reasons for not accessing healthcare services, with a specific emphasis on proximity as a major barrier., a response that suggests a need for strategies to improve the accessibility of healthcare services, especially concerning travel distances. According to the participant:

> *The reasons are enormous; it is not like we hate the healthcare centres, but certain factors prevent us from accessing the services; firstly, proximity is a big issue; one has to travel a long distance to access these services.*

Another male participant highlighted the distance of the healthcare centre to his residence alongside the cost of transportation:

> *It is pretty far from my place. It would cost me a thousand naira for transportation to and from the healthcare facility. Still, I believe it is accessible to those living close to the health centre or those with the means of transport no matter the distance (Interview with Male Participant, M3)*

The findings showed that despite the challenges posed by the distance, there is a recognition that those living close to the health centre or individuals with the financial means to cover transportation costs may find it more accessible.

Theme 1.4: State of Maternal Healthcare:

This theme describes the condition or status of healthcare services provided to pregnant women, mothers, and newborns within a specific region or community. A male participant interviewed affirmed the existence of a healthcare facility in the community, indicated his knowledge about it, and highlighted its long-standing presence, "Yes, there is a healthcare facility in my community. I know quite much about it, and it has been in existence long before now" (Interview with Male Participant, M2). The participant highlighted establishing a healthcare centre in a neighbouring community during a democratic regime, with efforts to

engage the community and publicise the project. The participant mentioned the inadequacy of facilities in the healthcare centre:

> *The mass mobilisation was done before establishing the healthcare centre in the neighbouring community, and it was done during the democratic regime. Every project bid was publicised in the media so the government could score political points. Few people enjoyed the services when it was newly established. Secondly, the facilities are inadequate (Interview with Male Participant, M2).*

A health worker interviewed acknowledged the small size of the healthcare facility in Kadage Village, emphasising its role in meeting the basic and daily medical needs of the local community, "This healthcare facility is a small one to meet the basic and daily medical needs of the Kadage Village people," (M1). Another male participant highlighted concerns about limited access to drugs and the inconsistent availability of health providers in the community. The participant underscored the importance of reliable healthcare services and raised questions about the reasons behind these challenges, advocating for potential improvements in healthcare delivery:

> *Most of the time, drugs used to treat common diseases are hard to come by. Is there a reason why the health provider is not always around? How would I know? I know he is not always available, and I am not the only person who has observed it. (Interview with Male Participant, M2)*

Another male participant interviewed communicated a personal perspective on healthcare facilities, stating that they were not helpful to him because they did not utilise them: "In my case, these facilities are not helpful because I do not utilise them" (M3). The first health worker interviewed discussed the surplus of medical drugs, extended storage periods, efforts to revive a healthcare facility after twelve years, and the current underutilisation of the facility. He emphasised the importance of aligning healthcare services with the needs and preferences of the community to ensure effective and sustainable healthcare delivery:

> *Most times, the medical drugs supplied do not get exhausted within the stipulated time frame, so the drugs end up in the store for a year or more. After twelve years, it was revived and brought to life to benefit the community's people. The facility is there without people to utilise it (Interview with Health Worker, Participant 2)*

In addition, the participant highlighted the abandonment of the healthcare facility due to a lack of community patronage, leading to the government's decision to discontinue allocating resources:

> *The facility was once abandoned due to a lack of patronage by the community's people. The government felt it could not continue to spend money and waste its resources on such a community that does not need these services.*

The findings showed mass mobilisation and initial utilisation of maternal healthcare, concerns about inadequate facilities in the healthcare centre, difficulties in accessing drugs for common

diseases and inconsistent availability of health providers, underutilisation of healthcare facilities, expiration of medical drugs, and abandonment and lack of patronage.

Theme 2: Women's Issues

Women's Issues typically refer to matters or concerns that specifically affect women individually or personally. Two sub-themes emerged under this theme.

Theme 2.1: Economic Challenge:

Economic challenge refers to difficulties, obstacles, or hardships that individuals, communities, or societies face in managing their financial resources, sustaining livelihoods, and addressing economic needs. A male participant highlighted the interconnected challenges of geographical distance and financial constraints that can impede healthcare access.

> *The health facility is far from my place. It would cost me eight hundred naira for transportation to and from the health centre. I believe it is accessible to the people around the facility and to those who are financially strong (Interview with Male Participant, M2)*

Similarly, a male participant highlighted the multifaceted nature of healthcare accessibility, incorporating geographical, economic, and individual factors. The perception of accessibility is not uniform and is influenced by the specific circumstances of individuals within the community:

> *It is quite far from my place. It would cost me a thousand naira for transportation to and from the healthcare facility. Still, I believe it is accessible to those living close to the health centre or those with the means of transport no matter the distance (Interview with Male Participant, M3)*

Another male participant spoke on the intersection of economic factors, healthcare costs, and decision-making within the farming community. The perceived financial challenges contribute to a preference for home delivery, emphasising the need for solutions that make healthcare services more accessible and affordable for individuals with limited financial means:

> *You know we are farmers and do not have any other source of income. Hospital services are costly; if your wife delivers in any healthcare facility, it will cost you at least twenty thousand naira (#20000). This amount is a fortune for most of us. Some of us cannot raise that much within a year, so this is one of the reasons we prefer delivering at home (Interview with Male Participant, M4)*

Another male participant mentioned the dynamic nature of healthcare access decisions, influenced by personal resources, transportation availability, and economic considerations; he demonstrated a practical approach to ensuring their spouse can access healthcare services in a manner that is both feasible and economical:

> *Well, that depends on one's strength. When I had a motorcycle, I used to take her myself to the hospital, but today, the bike is not there. I only give her money to access the services of the healthcare centre. This is more economical than going there together with her in that situation (Interview with Male Participant, M1)*

A health worker interviewed underscored the importance of understanding and adapting to the local context in healthcare delivery. He mentioned the adaptive measures taken by healthcare staff, along with community-wide communication, indicate a collaboration:

> *The few patients utilising these services always complain about the items they have been asked to bring for delivery, such as bleach, pads, and the like. Therefore, the staff only tells the patients to wash their old wrappers and come with them, and then they provide the pad for cleaning the child and the bleach to disinfect the surface after delivery. By so doing, they tell their fellow women to come to the clinic for ANC and delivery (Interview with Health Worker, Participant 2)*

The findings showed that the geographical distance of the healthcare centres, financial constraints for transportation, preference for home deliveries, patients utilising healthcare services expressing concerns about the items requested for delivery, and economic considerations play a role in the choice for home deliveries.

Theme 2.2: Women's Attitude to Maternal Healthcare:

The theme concerns women's general behaviours, beliefs, and perceptions of healthcare and medical services. A health worker interviewed spoke on the connection between the timing of healthcare seeking during childbirth and maternal deaths. He emphasised the need for addressing behavioural factors and potential barriers to ensure that mothers seek medical assistance promptly, ultimately improving maternal and child health outcomes:

> *What leads to these deaths sometimes is the negligence of the mothers. They stay at home during labour and only come to the clinic only when they cannot give birth by themselves due to complications (Interview with Health Worker, Participant 2)*

The participant emphasised the importance of continuous ANC and the potential risks associated with assuming a static standard presentation. He underscored the need for education, communication, and community health strategies to promote consistent antenatal care and improve maternal and child health outcomes:

> *Sometimes, the presentation of the unborn child may not be usual, and the mothers may not be aware. When they come for ANC at some point and are told that the child is average, they never return to the clinic again, not knowing that the child's positioning may likely change and lead to delayed labour and uterine death before the patient is brought to the clinic.*

By addressing financial barriers and encouraging clinic visits, the participant fostered a supportive environment for maternal healthcare within the community. "In my experience, I have used my money to provide the necessary items needed during labour to encourage these women to come to the clinic." The findings showed the emphasis of the health worker that maternal deaths are sometimes linked to maternal negligence, as mothers tend to stay at home during labour and only seek clinical assistance when complications arise. Additionally, the health worker notes that some mothers may not be aware of abnormal presentations of the unborn child, leading to delayed labour and potential risks.

Them 3: Women's Use of Maternal Healthcare

This theme refers to the participants' views on how pregnant women access and receive essential healthcare services during pregnancy, childbirth, and postpartum in community healthcare centres. Two sub-themes emerged under this theme (Figure)

Theme 3.1: Emergent Use:

The theme refers to community members' utilisation of maternal medical services when they are in urgent and critical situations related to pregnancy and childbirth. A male participant spoke on a cautious and selective approach to healthcare services. He acknowledged the benefits of hospitals while expressing a preference for home remedies using a pragmatic approach to seeking professional medical assistance when needed:

> *We do not like going to healthcare centres for any medication or treatment. It is only utilised when necessary. When all options at home are exhausted, and there is no relief, we rush to the hospital. The hospital has been beneficial. Today, we don't have to go a far distance to access these essential healthcare services (Interview with Male Participant, M1)*

A male participant spoke about the expertise of TBAs in managing childbirth complications with traditional methods. He also said the awareness of the limitations and a collaborative approach with modern healthcare is recognised when necessary; balancing traditional practices with timely referrals to hospitals contributes to comprehensive maternal healthcare:

> *If there are complications, the TBA takes care of that by the use of herbs, but if the complication is something that the TBA cannot manage, she advises we take the pregnant woman to the hospital services (Interview with Male Participant, M5)*

Another male participant spoke about the community's reluctance to visit healthcare centres, indicating a need for targeted efforts in community engagement, trust-building, and health education:

> *We do not like going to healthcare centres for any medication or treatment. It is only utilised when necessary. When all options at home are exhausted, and there is no relief, we rush to the hospital. The hospital has been beneficial (Interview with Male Participant, M2)*

Another male participant indicated a pattern where hospital visits are often prompted by severe complications during childbirth, leading to challenges in reaching the hospital in time:

> *We go to the hospital mostly when there is a complication that cannot be managed at home. Most of the time, women who are taken to the healthcare facility for delivery end up delivering on the way to the hospital (Interview with Male Participant, M4)*

A male health worker highlighted a prevalent trend of limited utilisation of maternal healthcare services, with women predominantly staying at home during pregnancy, seeking professional assistance primarily in response to complications: "But in terms of utilising maternal healthcare

services, it is not encouraging. Most of these women stay at home from conception to delivery. The few that come around are due to complications during childbirth" (Interview with Health Worker, Participant 2). The findings showed women's reluctance to seek healthcare at maternal healthcare unless necessary, the role of Traditional Birth Attendants (TBAs) in managing complications using herbs, visitation to hospital primarily driven by complications that cannot be managed at home, and limited utilisation of maternal healthcare services.

Theme 3.2: Women's Enlightenment:

This theme explores the role of women's enlightenment in shaping their healthcare decisions, particularly in the context of pregnancy. A male participant suggested a pragmatic and informed approach to healthcare, recognising both traditional and modern practices. The decision to choose herbal solutions or hospital delivery seems to be influenced by factors such as enlightenment, individual preferences, and perhaps the specific needs of each pregnancy: "Well, I cannot say there is nothing as such, but we do not rely entirely on herbal solutions to every pregnancy-related problem because there is enlightenment. This is why one of my children was delivered in the hospital" (Interview with Male Participant, M1).

Another male participant highlighted the family structure, the number of children among the wives, and the community-wide practice of attending ANC while opting for non-hospital deliveries. The healthcare choices align with cultural and community norms, showcasing the influence of local practices on maternal healthcare decisions within the family and the broader community:

> *I have four wives. My first wife has eight children, the second has five, the third has four, and the last has five. None of them went to the hospital for delivery but went for antenatal care at one point or the other (Interview with Male Participant, M2)*

Another male participant spoke on the combination of modern healthcare practices, such as regular antenatal care and adherence to professional advice, with an awareness of traditional dietary methods. The family dynamic includes a collaborative effort in household tasks, reflecting a holistic approach to maternal care that considers both the health and well-being of the pregnant wife:

> *My wife goes to the maternity for antenatal care. We follow the advice of health care professionals. However, we know both traditional and modern types of food are prepared to provide blood and nutrition to women. I relieve my wife from any hard work that requires much energy. She is only allowed to cook food for the family, which is less stressful, and sometimes her co-wives assist (Interview with Male Participant, M1)*

> *I encourage my wives to go for antenatal care at the maternity unit because I know the advantages of utilising the modern healthcare system. We try to adhere to the instructions of the healthcare extension workers. However, we are familiar with both traditional and modern maternal services. We tend to abide by this advice. I ensure my wife doesn't get engaged in any hard work that may disturb her. She is only allowed to cook food for the family, which is less stressful, and sometimes her co-wives or her mother-in-law (Interview with Male Participant, M2)*

The findings showed the male participants' expression of the approach to maternal healthcare, acknowledging both traditional and modern practices. While some have relied on herbal solutions in the past, there is a growing awareness and reliance on modern healthcare facilities. Participants highlighted instances where their wives went for antenatal care in maternity facilities, demonstrating a willingness to incorporate modern healthcare practices. The participants emphasise the importance of following healthcare professionals' advice, ensuring their wives' well-being during pregnancy, and balancing traditional and modern approaches to maternal services. The findings showed participants' approach to maternal healthcare, growing awareness and reliance on modern healthcare facilities, integration of contemporary healthcare practices like wives seeking antenatal care and willingness to embrace modern maternal healthcare, the importance of healthcare professionals' advice, and balancing traditional and modern approaches.

DISCUSSION OF FINDINGS

The findings show inadequate staff numbers as a factor affecting the utilisation of maternal health services by women of reproductive age. This finding agrees with Olusegun, Thomas, and Michael (2019), who found that the inadequate number of qualified health workers, among other challenges, discouraged maternal service utilisation. This type of experience quickly spreads, with patients sharing experiences, especially the unpalatable ones, with their friends and relatives, who may not see the need for the patronage of the maternal health centres when the need arises. Insufficient health workers can lead to restricted access to maternal healthcare services, particularly in remote areas. Women may encounter difficulties in obtaining vital prenatal care, skilled assistance during delivery, and postpartum support.

This finding shows the negative attitudes of the healthcare workers. This finding agrees with Sadiq-Umar (2017), who found that most women quit Antenatal care for home delivery because of the negative attitude of the health workers. Negative attitudes from healthcare staff can undermine trust and confidence in the healthcare system. Such attitudes can cause women to hesitate in seeking care, leading to delayed or inadequate maternal healthcare utilisation. Moreover, women may develop increased fear and anxiety about healthcare visits if they anticipate encountering disrespectful or dismissive behaviour from staff. This emotional distress can discourage women from seeking necessary maternal healthcare.

The findings from this study showed that the proximity of the healthcare centre was an issue, as the participants said they had to travel a long distance to access maternal healthcare services. Hence, distance limits women's utilisation of maternal healthcare. This finding agrees with Ajayi, Ahinkorah, and Seidu (2022), who established that many women with low socioeconomic status in rural areas live far away from the healthcare centres, which requires them to travel far to utilise the healthcare facilities. The challenge extends beyond the considerable distance to healthcare centres; there is also the issue of transportation, which is closely tied to financial constraints. The finding showed the participants' dissatisfaction with community healthcare, while they preferred public and private healthcare in the cities with better quality of service. This finding agrees with the results from (Okedo-Alex et al. 2021), who compared users' satisfaction with the quality of service in private and public maternal healthcare centres. Community members may develop skepticism toward seeking medical assistance, causing delays in obtaining necessary care and exacerbating existing health conditions.

In this study, the participants acknowledged their poor financial capability, a factor they considered to be significantly underestimated. This finding is consistent with scholars (1) who, from their study, found that most women did not have a dependable source of income to meet their needs. Women showed how they needed to pay for transport fares because of the distance of the healthcare centres from their residences. This finding also aligns with Sodimu (2021), who found that people with low socioeconomic status tend to consider the patronage of maternal health services too expensive and, thereby, opt for a cheaper alternative, mostly traditional health care. Utilising traditional health services may be easily chosen considering other benefits and low service costs. Such benefits include the proximity of the TBAs to the community members, female-to-female interaction, and cheap healthcare costs. The non-institutional places covered outside the formal health care system, where skilled health workers and self-delivery locations are mostly at home, fall under this classification. The finding agrees with the position of Shamaki and Buang (2019), who described this phenomenon as pregnant women engaging in self-delivery at home and seeking assistance afterward for cleaning and placenta removal. The reason was based on the perception of child delivery as a normal process when women were expected to display their endurance as long as they were not sick during the pregnancy. Women are believed to have sufficient natural strength to endure the pregnancy experience. A factor that may cause a deviation from the women's choice of institutional delivery may be rapid labour.

Recommendations

1. Management and leaders of maternal healthcare centres should organise periodic training that promotes attitudinal changes and professionalism among healthcare workers.
2. NGOs should collaborate with educational institutions to establish satellite campuses, training programmes, or partnerships to produce healthcare professionals committed to rural practice. Such collaboration can help create a pipeline of professionals who understand and are invested in rural healthcare.
3. Policies should recognise the importance of spousal support during maternal healthcare. Health institutions, NGOs, and policymakers can partner to emphasise the positive impact of involved fathers.
4. Governmental and non-governmental organisations should educate communities about home and self-delivery, including the potential risks and benefits.
5. To address community concerns, the government should prioritise improving the quality of maternal healthcare services in Western healthcare centres. This may involve facility improvements, cultural competence training for healthcare providers, and respectful maternity care.

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