

# The Influence of Cultural Beliefs and Practices on Access and Use of Family Planning Facilities among Yoruba Women of Nigeria

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**Abstract:** The significance of mothers to the overall sustenance of maternal health care cannot be overemphasized, despite this fact; however, there is an increasing gap between the developed and the developing countries in terms of morbidity and mortality and mothers' survival at prenatal, delivery and postnatal periods. In spite of the great efforts that have been put forth to achieve the 8<sup>th</sup> "Millennium Development Goals", much work is yet to be done to assuring maternal health for women especially in Sub Saharan Africa

The study involved a survey of 196 women aged 15-45+ years in Ido/Osi LGA in Ekiti of Nigeria which established maternal health seeking as inseparable from the socio-economic and cultural contexts in which they occur. Employing field methods from medical sociology and demography, the study argues that maternal health seeking transcends the boundaries of either of these disciplines and that their comprehensive understanding entails the collaboration of both. Its specific objectives encompassed: the influence of cultural beliefs and practices on access and use of family planning facilities among Yoruba women of Nigeria

(1) An investigation of the influence of cultural beliefs and practices on maternal health seeking (2) Examination of the relationship between the social demographic characteristics of women and maternal health seeking and; (3) An assessment of the impact of the existing social structure on maternal health seeking.

The model of behavioral change in public health, rational choice theory, location theory and feminist theory enable the study to highlight the links between socio-cultural variables and maternal health seeking by showing the strength of their separate and collective relationships.

Data were collected by triangulation of in-depth interviews and the survey questionnaire. The qualitative data were analyzed through manual content analysis to identify the socio-cultural variables associated with factors affecting maternal health seeking; quantitative data were analyzed by using frequency distributions tables for univariate while cross tabulation was used with the aid of SPSS version 22 for bivariate analysis, Microsoft Excel 2013 for the charts and STATA version 12 for the T-Test.

The result of the survey reveals that factors such as socio-economic, beliefs and cultural practices of the Yoruba people, to a large extent affect maternal health seeking. Some of the specific findings include: Patriarchy to great extent has a strong impact on maternal health seeking; majority of women in Yoruba community have strong beliefs in the efficacy of herbs in pregnancy management and child bearing; and that attitude of health workers also impair health seeking. The study therefore recommends that community mobilization should be geared towards ensuring that appropriate health-seeking behaviour becomes part of local social norms. Community education must address traditional beliefs about pregnancy related complications that are often blamed on women behaviour, fate, evil influences and other factors beyond the reach of the health care system. Due to the fact that Yoruba society is patriarchal in nature, men also should be educated on the intricacies that revolve around maternal health because, they dominate family decision-making. Also there is a need to strengthen policies and capacity building, training of health care providers, for improved quality of care and sustained research on reproductive health among the Yoruba people of Nigeria.

**Keywords:** cultural beliefs, maternal health care, "Millennium Development Goals".

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## 1. INTRODUCTION AND BACKGROUND

Globally, maternal healthcare system is an important segment of any medical system in every society; this is as a result of the significance of mothers to the overall sustenance of human society. Despite the significance of maternal health care, however, there is an increasing gap between the developed countries and the developing countries in terms of levels of morbidity and mortality and mothers' survival at prenatal, delivery and postnatal periods (WHO, 1999). Universally, more than 50 million women suffer from poor reproductive health and serious pregnancy related illness and disability and every year more than 500,000 women die from complications of pregnancy and childbirth (WHO, 2002). Most of the deaths occur in Asia, but the risk of dying is highest in African countries (World Bank, 2004).

More than 99% of the world's maternal deaths are due to complication of pregnancy and childbirth occurring in the developing countries whereas less than one% of these deaths occur in developed countries, demonstrating that maternal death could be avoidable given available resources and services (WHO 2002). In 2012, 40 million births in developing regions were not attended to by skilled health personnel, and over 32 million of those births occurred in rural areas (MDGs Report, 2014). Statistics has shown that maternal mortality in 2013 put Sub-Saharan Africa at the highest region with 510 maternal deaths per 100,000 live births of women aged 15-49 compared to North Africa and Latin America with 69 and 77 respectively (MDGs Report, 2014). This is not unconnected to the problems associated with the socio-cultural beliefs and attitudes towards maternal health seeking (Dada, 2005).

Scientific literature in the area of public health has been dominated by the view that challenges of maternal health are primarily the result of unavailable, unutilized or unskilled health care with focus on the economic and biomedical factors working against improving maternal health (Thaddeus and Maine, 1994, Geller et al, 2006, Gil-Gonzalez et al, 2006 and Paine, 2009). However, there are evidences suggesting that in some cases when skilled, formal health care is accessible, some women choose not to utilize such care facilities. As interventions designed to increase access to skilled maternal health care have not yielded the desired results, research that focuses on maternal health seeking needs to consider other factors, such as socio-cultural beliefs and practices, as potential contributors to improve maternal health seeking.

Cultural beliefs has a direct and weighty influence on the behaviour of mothers and their care givers during neo-natal, natal and post-natal periods, but there are inadequate researches and understanding of the proximate effect of cultural beliefs and attitudes of women in relation to maternal health seeking (Thaddeus and Maine, 1994, Kyomuhendo, 2003, Thaddeus and Nangalia, 2004, Geller et al., 2006, Gil-Gonzalez et al. 2006, Paine, 2009 and Sibley et al., 2009). As noted earlier, previous research that focused solely on biomedical factors being responsible for maternal health challenges has largely neglected the reality that in most of the countries where maternal health challenges remain high, culture and its traditional practices have an important influence on women's decisions.

In spite of the great efforts that have been put forth to achieve the 8<sup>th</sup> "Millennium Development Goals" which is aimed at eradicating extreme poverty and hunger; achieve universal primary education; promote gender equality and empower women; reduce child mortality; improve maternal health; combat HIV/AIDS, malaria and other diseases; ensure environmental sustainability and; develop a global partnership for development, much work is yet to be done to assuring maternal health for women worldwide. As a result of the above, there is a need to investigate whether, how and to what extent socio-cultural beliefs and practices affect maternal health with a view to reducing the gap in knowledge in order to improve maternal health especially in the sub-Saharan Africa.

Specifically, the study area is the Ido/Osi Local Government Area (LGA) in Ekiti State, Nigeria, with the population census of 159,114 inhabitants (NPC, 2006). There are 13 communities within the local government jurisdiction. It is about 20 kilometers from Ado Ekiti, the State capital city. The people are predominantly peasant and some are civil servants. Their major diet comprises food items such as yam, cassava, maize and their derivatives. The people of Ido/Osi LGA are predominantly Christians.

## 2. METHODOLOGY

Social Research is conceived as a systematic, controlled, empirical and critical investigation of hypothetical propositions about presumed relations among natural phenomenon (Yomere and Agbonifor, 1999). As a process, this study was carried out based on series of sequential but interrelated and interwoven steps like a spiral. The procedural nature of social research as engaged in this study dictates the orderliness of the research investigations which in the long run guaranteed the reliability and validity of the results and conclusions of the study. In addition, for the study to be systematic in compliance with research in social sciences, all the stages and procedures of the study follows a specified plan and

method and was carried out with a degree of painstakingness and thoroughness. Issue on factors affecting maternal health seeking in many of the “developing” nations of sub-Saharan Africa is of sufficient significant and interest to the entire globe to warrant the expenditure of time, effort and material recourses on this study.

Due to the exploratory nature of the study, the researcher made use of mixed-method. Qualitative methods such as interviews were undertaken to complement the survey research (quantitative). The primary aim of selecting these two different methods rested on the importance of confirming, cross-validating, or corroborating findings within this single study. By using separate qualitative and quantitative methods, it serves as an avenue to compensate for the weakness inherent within one method with the strength of the other method (Cresswell 2003). Equal priority were given to the two methods by integrating the findings from both methods during data interpretation and analysis stage as revealed in chapter five. By so doing, it has strengthened the knowledge claims and conclusions of the study. Never the less, it also display a trace of lack of convergence (though negligible), for instance the results from the quantitative data did not corroborate with that of qualitative data regarding the claim on rampant teenage pregnancy as claimed by the later. By adopting the above inter-method triangulation, the study did not only ensure that the advantages of both methods were exploited but also fulfilled the basic purposes of research.

The design of the Questionnaire for the study was guided by a pilot study. This method facilitates a proper understanding of the target population and their culture. Pilot research for the study involved interviews with gate keeper, community leader, traditional birth attendant, orthodox health provider and religious leader within Ido/Osi LGA.

### 3. SAMPLE DESIGN

Sampling refers to the process of selecting a number of individuals to represent a larger group. Gray et al. (2007) posited that a sample is regarded as the selection of a relatively small group of individuals from whom we obtain data in order to be able to generalize about a larger group. Sampling demonstrates idea that science is a blueprint for research because there are indeed some rules for proper sampling that are essential. In social research, as in day to day life experience, we sample about a few cases and seek to make judgments about a much larger number of cases. In our daily life, we adapt our sampling procedure to the situation. We discover that for some purposes a sample of one is more than adequate as evidence for the generalization we are interested in making; for other purposes, a more sophisticated sampling procedure is required.

The sample for the study begins by obtaining a complete list of enumeration areas in Ido-Osi LGA, demarcated for the 2006 census. An Enumerated Area (EA) refers to a compact area carved out of a locality with well-defined and identifiable boundaries. According to the National Population Commission’s demarcations, there are 160 EAs in Ido-Osi LGA with an estimated 125 households per EA and an average number of 8 persons per household. This gives an estimate of 1000 persons per EA and 20000 (125 x 160) households in all. The LGA is divided into 11 political wards. There are 13 communities that made up of these 11 political wards.

In summary, 18 respondents were selected from each political wards except “Ido ward 1” where 20 respondents were drawn, being the local government head quarter and having the largest number of households in the LGA. In all, the total number of respondents is 200.

Since the target population is women of child bearing age who were pregnant or who had child(ren) of not more than 24 months old therefore, the woman that fall within this category in each selected household serve as respondent. However, where in a household that have more than one woman of child bearing age who was either currently pregnant or has had a baby within the last twenty four (24) months at the time of the study, a simple random technique (which allowed each of these women to pick a folded paper, with only one of them getting the piece that will qualify her as a respondent for the study) was adopted to select the one that will finally be interviewed. In a situation, whereby there was no woman that falls within the category in a random sample, then the next household with the desired sample within the EA was considered.

### 4. STUDY POPULATION AND SAMPLE SIZE.

A cross-section of women of child bearing age who were pregnant or who have child(ren) of not more than 24 months old were selected as respondents, using a multi-stage sampling technique. 200 questionnaires were administered.

As regards the qualitative approach for the study, eight semi-structured (in-depth) interviews were conducted; four among orthodox health workers and traditional birth attendants respectively, which assisted in gaining further insight on factors affecting maternal health seeking, which the survey did not readily elicit. These participants were selected purposively in respect to their status in the community.

## 5. DATA PRESENTATION AND ANALYSIS

Table 1 illustrates that 99.4 percent of the respondents have heard about family planning programmes before and 57.1 percent of this category heard it through media (mostly radio and television) while another 40.8 percent of them got informed at various health facilities, and a negligible percentage (2.1) heard it through other source such as village meetings. The table also reveals that 79.1 percent of the respondents had been using contraceptives while 29.9 percent claimed not to have used at all. A closer examination of the table shows a slight consistence or direct relationship between being informed about family planning and its adoption or usage.

**Table 1: Distribution of Responses Related to Family Planning in Percent**

| Variables                                                        | Responses                                             | Frequency | %    |
|------------------------------------------------------------------|-------------------------------------------------------|-----------|------|
| 1 Have you heard about family planning programme                 | (a) Yes                                               | 195       | 99.4 |
|                                                                  | (b) No                                                | -         | -    |
|                                                                  | (c) No Response                                       | 1         | 0.6  |
| 1b If yes, state source of information                           | (a) Media                                             | 112       | 57.1 |
|                                                                  | (c) Hospital                                          | 80        | 40.8 |
|                                                                  | (d) Others                                            | 4         | 2.1  |
| 2 Do you ever-used contraceptives                                | (a) Yes                                               | 155       | 79.1 |
|                                                                  | (b) No                                                | 41        | 20.9 |
| 2b If yes, which method are you currently using                  | (a) Billing /calendar                                 | 18        | 11.6 |
|                                                                  | (b) Condom                                            | 62        | 40.0 |
|                                                                  | (c) Withdrawal                                        | 14        | 9.0  |
|                                                                  | (d) Intra uterine devices                             | 1         | 0.6  |
|                                                                  | (e) Norplant implant                                  | 2         | 1.3  |
|                                                                  | (f) Pill                                              | 34        | 21.9 |
|                                                                  | (g) Injectables                                       | 3         | 1.9  |
|                                                                  | (h) Others                                            | 5         | 3.2  |
|                                                                  | (g) No response                                       | 16        | 10.3 |
| 3a. What are the traditional methods of family planning you know | (a) External use (beeds, ring, Asoro)                 | 85        | 43.4 |
|                                                                  | (b) orally administer (herbs, Aseje, Lime and Efirin) | 8         | 4.1  |
|                                                                  | (c) Natural (calendar/billing, withdrawal)            | 39        | 19.9 |
|                                                                  | (d) combination of oral & external use                | 29        | 14.8 |
|                                                                  | (e) combination of natural & external use             | 4         | 2.0  |
|                                                                  | (f) combination of oral & natural use                 | 1         | 0.5  |
|                                                                  | (g) All                                               | 1         | 0.5  |
|                                                                  | (h) No response                                       | 29        | 14.8 |
| 3b. which one have you used                                      | (a) External use (beeds, ring, Asoro)                 | 32        | 16.3 |
|                                                                  | (b) orally administer (herbs, Aseje, Lime and Efirin) | 11        | 5.6  |
|                                                                  | (c) Natural (calendar/billing, withdrawal)            | 40        | 20.4 |
|                                                                  | (d) combination of oral & external use                | 8         | 4.1  |
|                                                                  | (e) Never use                                         | 105       | 53.6 |

Source: Field Survey, 2018

Data gathered from in-depth interviews reveals that most of the facilities do not have family planning facilities readily available in the center as at the time of the field-work. Of the 195 respondents that have ever used contraceptives, 11.6 percent declared to have been practicing billing/calendar method and 40 percent indicated that they were currently using condom while 21.9 percent used pills. 1.3 percent and 9 percent of this cohort were using Norplant Implant and withdrawal method respectively while 1.9 percent and only one (0.6%) respondent indicated using injectable and intra uterine devices (IUD) respectively.

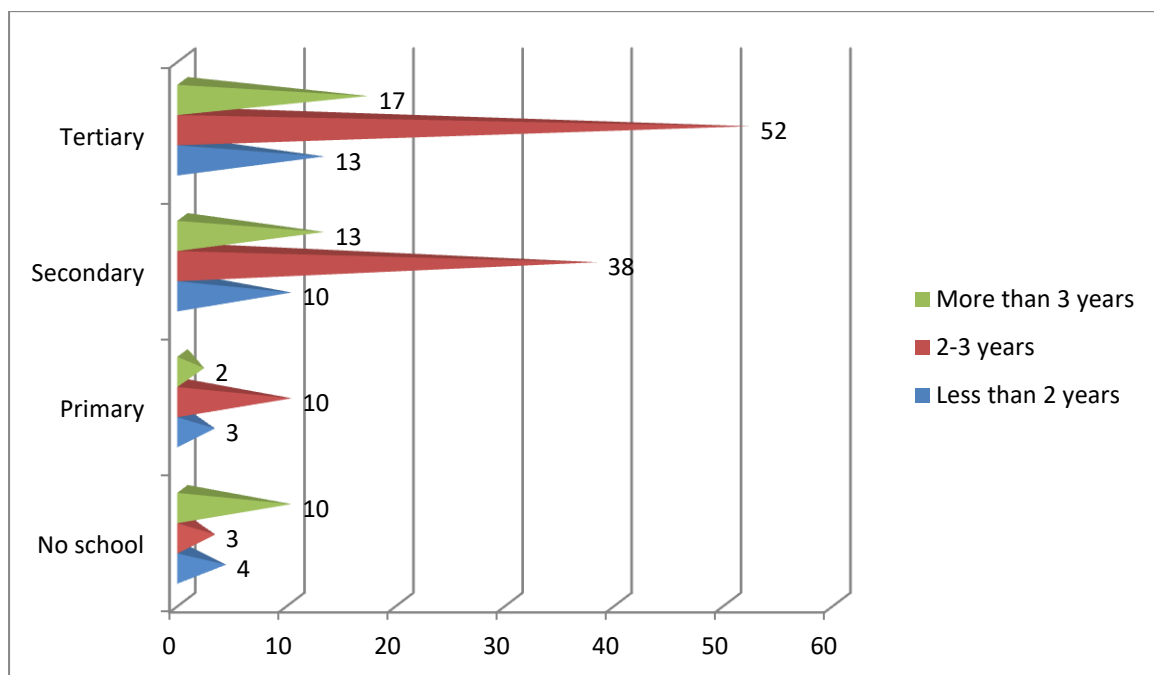
Pertaining to knowledge of traditional methods of family planning, 43.4 percent of the respondents were aware only of the use of such traditional methods as “asoro”, waist beads and rings: all these are categorized as methods that are for external

use only. 19.9 percent of the respondents indicated that they were aware of only the natural method. Classified under this method are: abstinence, billing/calendar and withdrawal.

Worthy of note is the fact that, it is a common cultural practice among the Yoruba people of Nigeria that a husband should abstain from sexual intercourse with his breastfeeding wife for a certain period. The third group under this cohort is 4.1 percent of the respondents that claimed they were aware of only those methods that are orally administered (like, aseje, lime, eferin, salt and water, other herbs, and gbere (incision on the body). In all, about 48 percent of the respondents were aware of both external and oral traditional methods of family planning while 2 percent of the respondents were aware of both external and natural methods. Only one respondent (0.5%) indicated awareness of both oral and natural methods and the same was applicable to the set of respondents that claimed awareness for all three categories.

Table 11 also displays the usage of traditional methods of family planning by the respondents. Respondent use rates of more than 20 percent are recorded for only periodic abstinence and withdrawal while 16.3 percent use solely beads, ring and asoro. 5.6 percent of the respondents used only herbs while 4.1 percent represent the number of respondents that combine both oral (herbs) and external use. The overall picture shows a significant relationship between awareness and use of traditional family planning methods. In-depth interviews suggest that most Yoruba women in Nigeria have little access to family planning and reproductive health services.

*“.....they are aware because we do enlighten them; we do refer those that request for family planning to health centre because it is not within our jurisdiction. some of them have got about six kids already and the current economy of the nation does not even support having too many children like fowl hence there is need to have the very few that you will be able to cater for. In lieu of this we do advise them to go for family planning at the hospital as we do not have the facility here.” (CAC Mission Home, Ayetoro)*



Source: Field Survey, 2018

**Figure 1: Distributions of Respondents by Educational Qualification and Child Spacing Period**

From the above chart 20.7% percent out of the entire eighty two responses related to child spacing among respondents with tertiary education shows a waiting period of more than three years between births while a significant proportion of 63.4 percent (52) indicates child spacing period of between two to three years while about 15.8 percent (13) of the cohort practice child spacing period of less than two years. Among respondents with secondary education, about 16.4 percent (10) of them waited between births for less than two years and about 62.3 percent (38) observed a child spacing period of between two to three years while about 21.3 percent (13) waited between births for more than three years.



From the cohort with primary education, 20 percent indicated that they observed child spacing period of less than two years while 66.7 percent and 13.3 percent of the group waited between births for two to three years and more than three years respectively. Regarding respondents with no formal education, 23.6 percent of them waited between births for less than two year while 17.6 percent of the respondents practiced child spacing of between two to three years and a significant proportion of 58.8 percent were involved in child spacing of more than three years.

**Table 2: Distributions of Respondents by Child Spacing Period and Reasons**

| Reasons                   | Less than 2 Years        |      | 2-3 Years |      | Child Spacing More than 3 Years |      | No Response |      | Total  |      |
|---------------------------|--------------------------|------|-----------|------|---------------------------------|------|-------------|------|--------|------|
|                           | Number                   | %    | Number    | %    | Number                          | %    | Number      | %    | Number | %    |
|                           | <b>Tradition/Culture</b> | 16   | 59.3      | 85   | 82.5                            | 10   | 23.8        | -    | -      | 111  |
| <b>Medical</b>            | 06                       | 22.2 | 17        | 16.5 | 27                              | 64.3 | -           | -    | 50     | 25.5 |
| <b>Finance</b>            | -                        | -    | 01        | 1.0  | 05                              | 11.9 | -           | -    | 06     | 3.1  |
| <b>Personal Intention</b> | 05                       | 18.5 | -         | -    | -                               | -    | -           | -    | 05     | 2.6  |
| <b>No Response</b>        | -                        | -    | -         | -    | -                               | -    | 24          | 100  | 24     | 12.2 |
| <b>Total</b>              | 27                       | 13.8 | 103       | 52.6 | 42                              | 21.4 | 24          | 12.2 | 196    | 100  |

Source: Field Survey, 2018

Looking at the various reasons given by the respondents for child spacing period, Table 12 suggests that the majority (56.6 percent) of the respondents attributed it to cultural beliefs system while about 25.5 percent gave medical reason, 3.1 percent indicate finance as a reason while as few as 2.6 percent attribute their reasons to personal intention. 12.2 percent (24) of the entire respondents did not respond to the question on child spacing simply because some of the respondents were having either their first pregnancy or child at the time of the survey.

## 6. SUMMARY

### Introduction

This study investigated the relationship between socio-cultural factors and maternal health seeking in a Yoruba community of Nigeria. The study was also predicated on the argument that maternal health seeking is principally a cultural event and should be studied within the sociocultural contexts in which it occurs. The review of the existing literature reveals that the rate of maternal morbidity and mortality in Nigeria and many other developing countries is very high. Also by extension maternal health (and health seeking) is largely influenced by socio-cultural beliefs and practices. Sub-Saharan Africa, however, has been identified as the area where cultural beliefs and practices exert the highest influence on maternal health seeking. The quest for holistic understanding of maternal health seeking in a Yoruba community of Nigeria resulted in the convergence of Medical Sociology and Demography.

By combining these sub-fields, data collection was undertaken through the method of triangulation. The interdependence of Demography and Medical Sociology guided the designing of the study objectives, which sought to provide insights on the associations among socio-economic status of women, educational qualification of women, women's beliefs and practices towards maternal health seeking, women's perception of health workers and services, patriarchal influence on women decision making power and the assessment of the existing social structure.

The study employed the convergence of Model of Behavioural Change in Public Health, Rational Choice Theory, Location Theory and Feminist Theory to analyze the links between the dependent and independent variables. The combine influence of these theoretical perspective pinpoints some hidden socio-cultural factors affecting maternal health seeking behaviour in particular and the health of women of child bearing age in general.

Triangulation of qualitative and quantitative methods was adopted in gathering data for the study. The essence of triangulation is to enhance our ability to understand phenomena under investigation more holistically and that the use of multiple methods would compensate for the individual shortcomings or weaknesses inherent in each of them. The combination of these two methods resulted in the findings of this study.

## 7. FINDINGS

The study found the following:

- i. That majority of Yoruba women rely ultimately on their husbands' finance to pay for medical bills.
- ii. That there is a falling standard of education among Yoruba women of Nigeria.
- iii. That early marriage is not pronounced among Yoruba people.
- iv. That Yoruba people attach strong stigma to divorce.
  - i. Most of the facilities do not have family planning services readily available in the centers.
  - ii. Yoruba culture reinforces periodic postpartum abstinence.
- iii. There is a significant relationship between awareness of traditional family planning methods and the use of these methods.
- iv. The cultural beliefs of Yoruba people encourage child spacing.
- v. Attitude of health workers towards maternal health care seekers have a significant relationship on maternal health seeking.
- vi. Some practices in the hospital such as male health worker examining the private part of a female health care seeker are against the cultural beliefs of Yoruba people.
- vii. There is a significant relationship between proximity of health facility and maternal health seeking.

## 8. RECOMMENDATIONS

The study has been able to identify the factors that affect maternal health seeking behaviour and highlights that these factors cannot be separated from the environment in which they occur. This implies that the recommendations related to improving maternal health seeking should necessarily recognize the relative and specific demand of Yoruba people of Nigeria, as characterized by many rural areas in sub-Saharan Africa. The recommendations can be classified into three broad categories, which include: education and sensitization; public and private sector intervention, and academic contributions.

The study recommends the following:

- i. Community education and mobilization is essential so that women and their family members learn about the need for special care during pregnancy and childbirth. Such education must include how to recognize obstetric complications and when and where to seek help. The goal of community mobilization should be to ensure that appropriate health-seeking behaviour becomes part of local social norms. Community education must address traditional beliefs about pregnancy-related complications that are often blamed on woman behaviour, fate, evil influences and other factors beyond the reach of the health care system. Due to the fact that Yoruba society is a patriarchal in nature, men also should be educated on the need for family planning, contraceptive use, child spacing and moderate family size because they dominate family decision-making. Also dialogue among communities, policy-makers, and health system staff is essential to identify ways of overcoming barriers to women seeking maternal care. There is need for educating the TBAs with the most current maternal health care techniques for effective management of varying maternal health situations in light of the fact that large majority of Yoruba women patronize them.
- ii. In light of the socio-economic status of women in Ido/Osi are characterized by low-income and low literacy level, it is suggested that women's status and power be increased through awareness programmes. Governments, donors and international agencies can take steps to increase women's decision-making power within the family and community, particularly by investing in the education of women and girls, raise awareness of the critical importance of women's health to children and families and the need for women to have the power to make decisions about their own health and reduce women's disproportionate poverty, lack of economic power and lack of quality education, all of which constrain their ability to seek and receive the necessary maternal health care throughout the cycle of pregnancy and birth.

- iii. Majority of women in Ido/Osi are poor, so based on this, targeting public sector subsidies to poor families and disadvantaged areas is essential. Poorer areas will need more financial and human resources to improved accessibility and improve quality of services. Introduction of community-financing schemes and making sure that public funds are used to finance transportation and care for the poor and needy.
- iv. There is need to strengthen policies and capacity building, training health care providers, for improved quality of care, availability of drugs, equipment and supplies and improve logistics. Ensure availability of emergency care services that also include Emergency Obstetric Care (EOC).
- v. It is also recommended that effective “poor-friendly” referral system should be developed. Communities and private sectors should be sensitized on their roles. There is need to strengthen partnerships between traditional birth attendants and skilled formal providers, build linkages with other reproductive health, nutrition, gender and adolescent health interventions.
- vi. There should be a sensitization of communities and development of alternative outreach strategies that will take the MCH services to the poor women in their homes through community based skilled birth attendants, mobile teams for prenatal and EPI, community-based distribution of contraceptives, maternity waiting homes and rural midwifery programmes. Since it is established that TBAs meet a vital community need in supporting women throughout pregnancy, childbirth and the postpartum period, it is advised that they work with the healthcare team to act as community educators to lend support for accurate maternal and neonatal health messages.
- vii. Lastly, it is recommended that sustained research on reproductive health should be encouraged particularly among the Yoruba people of Nigeria and among the rural communities of sub-Saharan African in order to proffer lasting solution to many health challenges which serves as a cog in the wheel of development of the developing nations.

## 9. CONCLUSION

This study has provided data that pinpoint the factors affecting maternal health seeking in a Yoruba community of Nigeria. By examining the separate and collective influences of the identified variables on maternal health seeking, the study contributes significantly to the methodological and theoretical aspect in the field of Demography and Medical sociology. In an attempt for a comprehensive analysis of the relationship that exist between the dependent and independent variable-models of behavioural change, rational choice theory, location theory and feminist theory were employed.

This theoretical triangulation employed in examining such a social phenomenon explains the serendipity of data collected for the study. The central concern has been that pre-industrial society must naturally take considerable interest in maternal health care To do this may exact a high level of re-socialization and re-thinking on the patriarchal nature of most sub-Saharan African societies. There are considerable constraints to the independence with which individuals can act, particularly as it concerns what may, in Parsonian terms, be described as the society’s ultimate “functional prerequisite”

The conclusion to be drawn from this study is that the search for a holistic understanding of maternal health care seeking behaviour viz-a-viz maternal health transcend the linearistic nature of medical science rather, it calls for an interdisciplinary triangulation. This will invariably reduce the lacuna in knowledge and understanding of various issues in public health as a whole which will invariably guarantee more valuable information for researchers and policy makers.

## REFERENCES

- [1] Dada, A. A. 2005. Access and Use of Maternal Health Facilities in Ido/Osi LGA, Ekiti State, Nigeria. Unpublished Thesis University of Ibadan.
- [2] Geller, S.E. et al. (2006). Postpartum Haemorrhage in Resource-Poor Settings. *International Journal of Gynecology and Obstetrics* 92, 202–211.
- [3] Gil-Gonza´lez, D. et al. (2006). Knowledge Gaps in Scientific Literature on Maternal Mortality: A Systematic Review. *Bulletin of the World Health Organization* 84(11),903–909.
- [4] Kyomuhendo, G. B., (2003). Low Use of Rural Maternity Services in Uganda: Impact of Women’s Status, Traditional Beliefs and Limited Resources. *Reproductive Health Matters* 11 (21), 16–26.



- [5] Maine, D. (2002). “Why Aid Maternal Mortality Decline in Materlab? Studies in Family Planning 27(4): 179-187.
- [6] Millennium Development Goals Report, (2014). United Nations.
- [7] National Population Commission and ICF Macro. 2009. *Nigeria 2008 Demographic and Health Survey*. Abuja, Nigeria: National Population Commission and ICF Macro, Calverton, Maryland, USA.
- [8] Piane, G.M., 2009. Evidence-Based Practices to Reduce Maternal Mortality: A Systematic Review. *Journal of Public Health* 31 (1), 26–31.
- [9] Sibley, L.M. et al., 2009. Cultural Theories of Postpartum Bleeding in Matlab, Bangladesh: Implications for Community Health Intervention. *Journal of Health Population and Nutrition* 27 (3), 379–390.
- [10] Thaddeus, S and Main, D. 1994. “Too Far to Walk: Maternal Mortality in Context”. *Journal of Social and Science Medicine* 38 (8), 1091-1110.
- [11] Thaddeus, S., Nangalia, R., 2004. Perceptions matter: barriers to treatment of postpartum hemorrhage. *Journal of Midwifery and Women’s Health* 49 (4), 293–297.
- [12] World Health Organization, 1999. “Making a Difference”. Geneva: WHO.
- [13] World Health Organization, 2002. “Reducing the Risk, Promoting Healthy Life”. Geneva: WHO.