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Spatial Location and Utilization of Maternal Healthcare Services by Women in Niger East Senatorial Zone

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Abstract

Maternal healthcare remains a major challenge to the global public health system, especially in developing countries. Access to appropriate health care including skilled birth attendance at delivery and timely referrals to emergency obstetric care services can greatly reduce maternal deaths and disabilities, yet women in Niger East Senatorial continue to face limited access to skilled delivery services. The study adopted a cross sectional survey design using multi-stage sampling methods to achieve the required sample size of one thousand four hundred and forty-five (1,445) respondents. Questionnaires were administered to women of reproductive age (15-49 years), who are married. The respondents were selected from the sampled local government in Niger State. All the interviews were administered face-to-face ensuring 100% completion of the copies of the questionnaires. Focus Group Discussions (FGD) was also used for data collection. Data were analysed using descriptive and inferential statistics. The findings of the study revealed that: socio-economic index, who takes decision on health matter and religion were determinants of access to maternal health service. Women in households with high socioeconomic index are more likely to access maternal health services than those in households with low socioeconomic index ($p < .001$). Furthermore, women in households where men monopolized decision making are less likely to access maternal health services than women where joint decision is taken ($p < .001$). The higher the level of education of a woman the greater her access to maternal health services in health facility ($p < .001$). Finally, the study showed that there is high prevalence of maternal mortality rate in the study area, poverty is identified as one of the major barriers to accessing maternal health services and high illiteracy level among women is responsible for inability to access maternal health services.

Key Words: Spatial location, Utilisation, Access, healthcare and women

Introduction

One of the acclaimed objectives for the creating local government is to bring development closer to the people. A crucial aspect of development that the creation of local government was supposed to provide is health care services. In Nigeria, spatial considerations have usually been given inadequate concern in designing health care system for rural areas. This is why, despite the huge amount of resource pumped into rural areas on health care delivery, and there still exists a wide disparity in the distribution and allocation of health facilities between rural and urban centres.

Maternal healthcare remains a major challenge to the global public health system, especially in developing countries. In most countries in sub-Saharan Africa, however, women continue to have very limited access to skilled delivery services. The high prevalence of maternal illnesses, near misses, and other potentially devastating and acute obstetric complications suffered by women in the region have generally been linked to their poor utilization of health care facility. The state of maternal health is an important indicator of health care delivery system and level of society development (FMOH and NPHCDA, 2009). Improvement in maternal health is, therefore, a central focus in global health programmes. This explains the 5th Millennium Development Goal, which is directly related to maternal health.

Despite these efforts, maternal mortality remains worrisome in Nigeria, which has one of the poorest maternal mortality rates in the world (Chudi, 2010). Nigeria constitutes just 1% of the world population, but accounts for 10% of the 529,000 world maternal mortality rates (WHO, 2004). Annually, an estimated 52,900 Nigerian women die of pregnancy related complications. A woman's chances of dying from pregnancy and child birth in Nigeria is 1 in 13, while it is 1 in 5000 in developed nations and only about 40% of deliveries are attended to by skilled birth attendants in Nigeria (Audu and Ekele, 2002; FMOH, 2007).

More than 70% of maternal deaths in Nigeria are due to five major complications: haemorrhage, infection, unsafe abortion, hypertension and obstructed labour (Lissner and Weissman, 2006). Although many of these deaths are preventable, the coverage and quality of health care services continue to fail women and children despite the large investments made by Government and its partners (Galadanci, Idris, Sadauki & Yakasai, 2010).

Literature Review

Women's status generally underlies and shapes their access to health services. In countries as diverse as Nigeria, Ethiopia, Tunisia, India and Korea studies show that women do not decide on their own to seek care (Theddeus & Maine, 1994). Erinosh (1998) observes the behaviour pattern of women during ill-health, and asserts that Nigerian women in some ethnic groups do not seek immediate help from health care agents when they are about to deliver babies unless they obtain the formal permission of their spouses. To buttress this point, Stock (2001) in a study of health care behaviour in rural setting observed that in Kano State, Nigeria, a woman must obtain the permission of her husband before leaving the home/compound. This practice is not only in Kano State but also throughout the Northern Nigeria, particularly the rural areas. The Hausa culture does not allow women to seek medical care without the prior permission of their husbands through the practice of *Purdha*. These practices make facilities out of bound to these categories of people (Dansabo, 2004). Most women in the North only go to the hospital when they develop complications (Adamu & Salihu, 2002).

Where women's mobility is severely restricted because of such cultural prescriptions, efforts to seek timely care may be thwarted (Thaddeus & Maine, 1994). According to Adamu (2010), in Zaria no matter how obvious the need for hospital management becomes for the girl who develops obstructed

labour, permission to leave home for hospital can usually be given only by the husband: If he happens to be away from home, those present are often unwilling to accept such responsibility. This shows that, for women with obstetric complication's access limited to the nearest primary care Centre is not of much help.

Furthermore, among the strict Muslim communities of North-Eastern Nigeria, Women are not allowed to ride bicycles and donkeys. Although these means may be physically present in the community, they are effectively unavailable to women. Stock (2001) showed that bicycles, motorbikes, horses and donkeys were used by 28 percent of men in their trips to health facilities, but by only 3 percent of women. This indicates that travelling to health facilities is easier for men than for women. Furthermore, Stock points out that when illness is seen as minor and amenable to local treatment, most Muslim men in Northern Nigeria are reluctant to allow women to travel long distances for care.

Writing on "Household relations and women's health in Hausa Muslim society of Northern Nigeria", Adamu (2010) observed that power relationship within the household affects women's health decision and access to health facilities. She argued that decisions about women's health and their children are not decisions women take independently, but within a web of intra-household relations. The position of a person within household relations and how the relation is socially defined and practiced, influenced person's access to and utilization of health services and decisions within the Hausa household arrangement; part of the husband's right to his wife is obedience, which means that women's access to medical care is dependent on husband's consent. To support this point, Adamu cited an instance of an NGO's visit to rural areas in 1999/2000, which revealed that many women cited social pressure as why they did not go for antenatal care. Some even said that their antenatal visits would decrease the eligibility of their daughters in securing husbands because men will have the fear that their daughters will emulate them and therefore consider them costly. It is evident from all these studies that the low value placed on women adversely affects their utilization of health services. However, this link has been generally overlooked.

Theoretical Framework

Understanding of human social actions is based on some existing theories. The theory of Urban Bias is adopted for explanations on issues under study. Michael Lipton's theory of urban bias is an explanation of distorted and uneven development in the third world. In the rural health sector, for example, few and inferior facilities and specialists are allocated to the villages (Lipton, 1980). The allocation of inferior health facilities and specialists to the rural areas is of negative and detrimental effect to the health condition of the rural dwellers because the facilities in these areas cannot deal with most of the maternal health problems of the rural people. This situation makes the rural people to desire to seek care from the health facilities located in the urban areas, which are not readily accessible and affordable to them. Most rural areas in Nigeria are without good and well-maintained roads and where they exist; the means of transportation are unreliable, inadequate, and unsafe or carry exorbitant prices which are beyond the capability of an average rural person. In this light, the rural people are being deprived of their rights. Thus, efforts aimed at achieving health for all must as a matter of necessity democratize access to opportunities for a healthy life.

Ideally, scarce health resources in poor countries should be distributed by need and not by ability to pay. Ironically, the state in these countries is just an embodiment of powerful interests, especially the interest of the city. Its officials are concerned with urban health; their own, that of their employees and their customers at the expense of the overwhelming majority-the poor. Lipton believes that the only way in which genuine mass development can occur is through a dramatic change in policy favouring a

shift of resources to the rural poor. Lipton's theory of urban bias could be used to explain the uneven distribution of health facilities between rural and urban areas

Research Hypotheses

- i. The closer a woman lives to health facility, the more she can utilize healthcare services.
- ii. Women in households with high socio-economic index are more likely to utilize health facility than women in households with low socio-economic index.
- iii. Women in households where men monopolise decision making are less likely to utilize maternal health services in health facility than women in households where joint decisions are taken on health matters.
- iv. Muslim women are less likely to utilize health facility than women in other religious groups.

Methodology

The study adopted a cross-sectional survey design. The study was conducted in Niger East Senatorial Zone, covering nine (9) local government councils. With an estimated 36.6 percent antenatal care (ANC) usage among women of child bearing age (121,984) in the senatorial zone (NPC and ICF Macro, 2009), and 95 percent and 2.5 percent confidence level and error margin respectively, a sample of 1,426 women was computed for this study. An additional 1.7 percent was added for contingency. There were three instruments, namely questionnaire In-Depth interview (IDI) and Focus Group Discussion (FGD) guide, used for the collection of data in this study. One thousand, four hundred and forty-five (1,445) questionnaires were administered on women of reproductive age currently married. Ninety-six study participants participated in the twelve (12) FGD sessions.

Multi-stage sampling technique was employed for the study, which entailed the use of cluster, systematic, simple random and purposive sampling to select zone, communities, households and individuals at different stages were employed. The qualitative data collected were transcribed. In going through the transcriptions, attention was placed on phrases with contextual or special connotations and they were noted. After review and corrections, all FGDs transcripts were typed with standard word processing package. Themes were developed in form of codes. Responses and comments were put under the appropriate thematic codes and headings. The quantitative data collected were subjected to appropriate statistical analysis. Specifically, charts, frequency counts and simple percentages were used. For the purpose of making inferences, Chi-square statistics was employed to test the hypotheses generated for the study.

Data Analysis and Discussion of Findings

Table 1: Distribution of Respondents by Socio-Demographic Characteristics (n = 1445)

Socio-Demographic Characteristics	Frequency	Percentage
Age		
15 – 19 years	83	5.7
20 – 24 years	311	21.5
25 – 29 years	319	22.1
30 – 34 years	315	21.8
35 – 39 years	252	17.4
40 – 44 years	103	7.1
45 - 49 years	62	4.3
Annual Income of Respondents		
No Income		
Less than N6,000	254	17.6
N6,001 – N20,000	182	12.6
N20,001 – N25000	389	26.9
N25,001 – N50,000	122	8.4
N50,001 – N65000	182	12.6
N65,001 and Above	100	6.9
	216	14.9
Respondent's level of education (Husbands)		
No formal Education	284	19.7
Primary	166	11.5
Secondary	435	30.1
Tertiary	560	38.8
Religion		
Muslim	1005	69.6
Christian	421	29.1
Traditional Religion	14	1.0
Others	5	0.3

Source: Field survey, 2017

Table 1 shows respondents distribution by age, occupation, income, education and religion. The age distribution of the respondents reveals that majority of the respondents were within the age bracket 25 – 29 years with 22.8%, followed by 30-34 years with 21.8% while 21.5% of the respondents fell within the age bracket 20 – 24 years. Age brackets 40 – 44 years, 15 -19 years and 45 – 49 years constituted 7.1%, 5.7% and 4.3%, respectively. The age groups 15 – 49 years were selected to represent Women of Reproductive Age (WRA) currently married which is the focus of the study.

Results from Table 1 show that the income level per annum of respondents varies. Out of the total respondents, 17.6% earned no income per annum, 12.6% of the respondents earned less than N6, 000, 26.9% earned N6,001 - N20, 000, 8.4% earned N20, 001 – N25, 000 while 12.6% earned between N25, 001 - N50, 000, 6.9% earned N50, 001 – N65, 000 and those who earned N65, 001 and above constituted 14.9 percent. In a nut shell, the table on income reveals that majority (85.1%) of the respondents are living below the poverty line.

As far as level of education is concerned, the respondents fell under four categories. On education attainment, 30.2% had no formal education, 21.2% attained primary school, and 25.8% had secondary education while 22.8% attained high level of education (OND, NCE, HND, BSc, MSc and PhD). The percentage distribution of respondents with no formal education (30.2%) and primary school qualification (21.2%), is an indication of low literacy level in the study area. Furthermore, the percentage distribution of respondent’s husbands’ educational qualification reveals that 19.7% had no formal education, 11.5% had primary school education, while 30.1% and 38.8% of respondents had secondary and tertiary education respectively. The literacy level is high among men (husbands) when compared to women.

On religious affiliation of respondents, the table shows that 69.6% were Muslims, followed by the Christian faith with 29.1% while 1% was traditionalist. Only 0.3% indicated no religious affiliation.

The means of transportation owned by households was investigated to determine the type used by women to access maternal health services. This is presented in Figure 1 below.

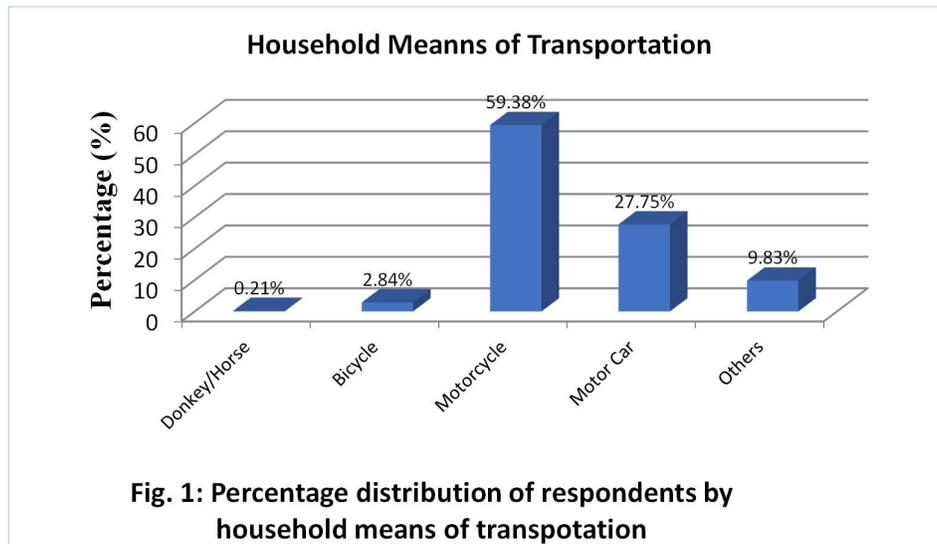


Figure 1 above shows that 59.38% of respondents had motorcycles as household means of transportation, 27.75% said they have motor cars, and 2.84% had bicycles. Only 0.21% has donkeys/horses while 9.83% had none. The findings were supported by the FGD sessions conducted which showed that motorcycle is the major means of transportation for most households in the study area. In all the FGD sessions, most of the study participants had motorcycle as their household’s means of transportation. The reasons are that motorcycle is a convenient means of transportation in their communities because of the nature of roads. In one of the FGD sessions in rural area, a participant had this to say:

The main means of transportation for most households in this village is motorcycle. As you can see, the road to this village is not accessible by motor car most especially during rainy season because of the bad nature of the road.

This is typical of the expressions by other rural participants on this subject

Table 2: Distribution of Respondents by Reproductive Health Experiences (N =1,445)

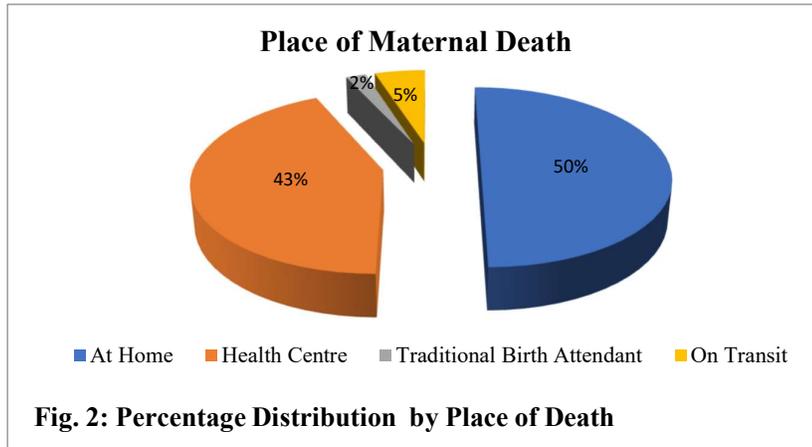
Reproductive Health Experiences	Frequency	Percentage
Experienced maternal mortality in respondent's household		
Yes	561	38.8
No	884	61.2
Distance of government maternal health service centre		
Near	1,376	95.2
Far	69	4.8
Do you attend ANC when pregnant?		
Yes	1,307	60.4
No	138	39.6
Where did you deliver your last baby?		
At home	497	34.4
PHC	895	61.9
Other places	53	3.7

Source: *Field Survey, 2017*

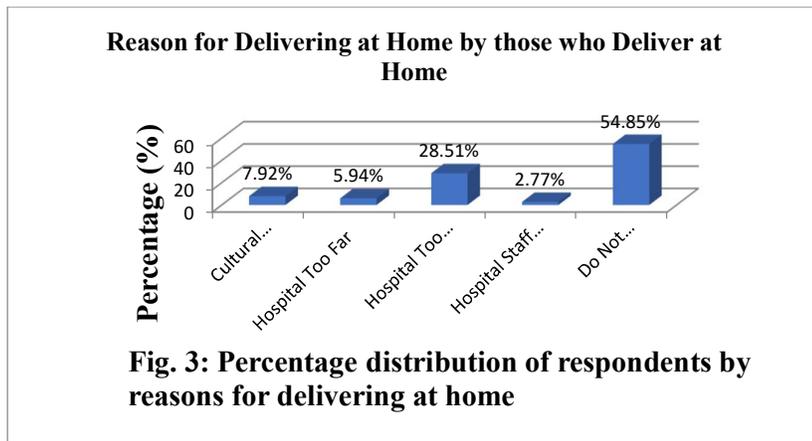
On the experience of maternal mortality in respondent's household, Table 2 reveals that 38.8% of the respondents agreed to have lost at least a woman to maternal mortality in their household as against 61.2% who did not lose anybody. By implication this shows a relatively high maternal mortality rate in the study area. This result was supported by the FGD conducted where most of the participants admitted knowing at least a woman that died as a result of pregnancy or childbirth in their immediate community.

On distance of government maternal health Centre from residents, the result from Table 4 shows that 95.2% of the respondents live near a maternal health Centre while 4.8% live far away from government facility. On antenatal care attendance when pregnant, the table reveals that 60.4% of the respondents attended antenatal care when pregnant while 39.6% of the respondents did not attend antenatal care in PHC facilities.

Similarly, on place of care during last pregnancy, the table reveals that 7% of the respondents received care at home during their last pregnancy while 66.6% received care in PHC facilities and 26.4% received care in other places; such as spiritual homes, TBAs, private clinics, general hospitals, etc. On where the respondents' delivered their last baby, the results in Table 4 indicate that 34.4% of the respondents delivered their last babies at home while 61.9% in PHC facilities and 3.7% delivered in other places. The results indicate that significant number of women (34.4%) preferred to deliver at home with the assistance of relatives and family members.



The Figure 2 above shows the percentage distribution of place of death. As indicated in the figure, 50% of the respondents said a member of their household died at home during pregnancy or child birth, 43% at a health facility, 5% on transit and 2% at traditional birth attendants place. The implication is that most maternal deaths were recorded outside health facility in the study area. This result is supported by the responses of participants during the FGD sessions that many of the maternal deaths occurred at home.



In Figure 3 above, respondents were asked the reason why they delivered at home. The chart depicts that 7.92% of the respondents said it is culturally unacceptable for a woman to deliver in health facility, 5.94% said hospital is too far, 28.51% said hospitals are too expensive, 2.77% said hospital staff are not friendly while the majority (54.85%) do not consider going to hospital necessary.

In the FGD sessions, participants were asked why they prefer to deliver their babies at home. In all the FGD sessions, study participants maintained that poverty, cultural practice and attitude of husbands were the major reasons identified for the preference of home delivery by women in the study area. Most study participant's preferred to deliver at home with the assistance of their family members due to high cost of hospital delivery and husband preferred where they would little or nothing as delivery expenses. This group of participants saw hospital delivery as an unavoidable alternative; that is, unless it was

absolutely necessary, women in the study area would not want to deliver elsewhere but home. Below are comments of study participants in most of the sessions.

A rural participant had this to say:

You know most women do not consider delivery in health facility necessary because of the cost involved in delivery in a health facility. The cost is too much and there is no money to pay, therefore, a woman would prefer to deliver at home with the assistance of family members as long as there are no complications. (Female participant, 40 years, Galadima Kogo village)

Further comment by another rural participant:

I don't know why people go to deliver in the health facility. For me, I don't allow my wives to deliver in health facility because I was born at home, my father was born at home and even my grandfather was also born at home safely. So why should I allow my child to be born in a health facility? (Male participant, 48 years, Jadna village)

An urban study participant had this to say:

The reason I deliver at home is because that is where my husband wants me to deliver. He always complains of high cost of hospital delivery. (Female participant, 34 years, Lambata town)

Assessment of Facilities in Healthcare Centres

To assess the facilities available in health facility, respondents were asked questions during the IDI sessions held with heads of health facilities on the available personnel and equipment and how relevant these are to maternal health, and suggestions on ways to improve maternal health service in their clinics. In all IDI sessions, most of the rural study participants lamented on shortage of qualified personnel to manage the existing health facilities while on the other hand most urban participants said they had enough personnel. According to rural participants, this has hampered the effective and efficient maternal health service delivery in the area. In one of the sessions, a rural study participant had this to say:

Here in this clinic, we are facing a serious problem of shortage of personnel to manage the facility. We are only two managing this facility (one senior Community Health Extension Worker (CHEW) and one junior CHEW). The number is grossly inadequate considering the large number of patients that come here for antenatal or delivery. (Male participant, 52years, Gwam village)

Another rural study participant commented further by saying:

I am the only staff posted to manage this clinic for the past ten years with no assistant. I had written so many letters requesting our 'oga' to post additional staff but all efforts were in vain. As you have seen, I am the only one registering patients, conducting examination, prescribing drugs and administering injection. (Female participant, 38years, Baida Village)

On the other hand, the situation is different in urban areas. One of the urban study participants had this to say:

On the issue of staffing, we don't have any problem. There are 15 members of staff posted to this facility including one visiting doctor. By all standards the number of staff

that we have here is adequate to handle obstetric cases within our mandate. (Male participant, 49years, Minna town)

Another urban participant emphasizes that:

We have adequate number of staff to handle obstetric cases within the scope of our operation. Presently, we have 17 members of staff in addition to one medical doctor. With this number, I can say we don't have problem of medical personnel in this clinic (female participant, 52years, Dikko town).

Similarly, on available medical facilities, the IDI study participants in rural areas maintained that there were acute shortages of medical equipment in health facilities to cater for the increasing obstetric cases. Where the equipment is available some were not even functional. In urban areas the situation is different; most of the health facilities in urban areas were equipped with modern medical equipment capable of handling obstetric cases. One of the rural study participants had this to say:

We have 2 beds and one non-functional weighing scale in this clinic. Beside this equipment, we don't even have simple equipment like scissors, kidney dish, sterilizing pot, BP apparatus etc. Some of the few equipment used in managing patients are personally owned by individual staff. In short, the available equipment is grossly inadequate in handling obstetric cases (male participant, 37years, Lambata).

Another rural participant made the following statement:

As you can see, to start with, the clinic building is near collapse. The available medical equipment is inadequate to handle obstetric cases. Here in this clinic we don't even have weighing scale, BP apparatus, water supply, standby generator, etc. (Female participant, 51years, Rafin Kuka).

The urban study participants had contrary view on the subject. In one of the IDI sessions held, a participant had this to say:

This clinic is well equipped with modern medical facilities. The equipment is also relevant in handling obstetric cases within the scope of our mandate. We have a scanning machine (Ultra sound), BP apparatus, weighing scale (functional), mucus extractor, sterilizing pot, kidney dish, scissors etc. to mention just a few. In addition, we have standby generator and constant water supply (Male participant, 55years, Limawa).

This is typical of the expression by other urban participants on this subject.

Test of Hypotheses

Table 4: Distribution of respondents by selected socio-demographic, socio-economic and perceptual variables by utilization of health facility

Selected Variables	Do you utilize healthcare facility when pregnant?		Total	χ^2 P-value
	I access care	I do not access care		
Socio-economic index				
Low	352 (61.9)	217 (38.1)	569(100)	$\chi^2 = 35.640$ df = 2 P = 0.000
Medium	399 (76.4)	123 (23.6)	522(100)	
High	212 (59.9)	142 (40.1)	354(100)	
Total	963 (66.6)	482 (33.4)	1445(100)	
Distance to healthcare facility				
Near	1248 (90.70)	128 (9.30)	1376(100)	$\chi^2 = 2.0492$ df = 1 P = 0.152
Far	59 (85.50)	10(14.50)	69 (100)	
Total	1,307 (90.45)	138 (9.55)	1445(100)	
Who takes decisions on obstetric emergency				
Husband	693 (86.20)	111 (13.80)	804 (100)	$\chi^2 = 39.2476$ df = 4 P = 0.000
Wife	56 (96.55)	2 (3.44)	58 (100)	
Joint (Husband & wife)	362 (95.77)	16 (4.23)	378 (100)	
Relative	43 (91.49)	4 (8.51)	47 (100)	
Anybody	153 (96.84)	5 (3.51)	158(100)	
Total				
Religion				
Muslim	652 (64.9)	353 (35.1)	1005(100)	$\chi^2 = 4.641$ df = 1 p = 0.031
Other religions	311 (70.7)	129 (29.3)	440(100)	
Total	963 (66.6)	482(33.4)	1445(100)	

Source: *Field Survey, 2017*

To test hypothesis one, a crosstab between respondents' socio-economic index and access to health care services was done (Table 4). The result from Table 4 reveals that 61.9% of respondents with low socio-economic index accessed maternal health services in healthcare facility as against 38.1% who did not. For respondents with medium socio-economic index, 76.4% accessed maternal health services as against 23.6% who did not, while 59.9% of high socio-economic index respondents accessed maternal health services as against 40.1% who did not. Here, the statistics show a significant difference ($X^2 = 35.640$, $df = 2$, $p = 0.000$) on socio-economic index of a woman and access to maternal health services. The test statistics show that there is a significant relationship between socio-economic index of the respondents and access to healthcare facility. Therefore, the null hypothesis is rejected.

To test hypothesis two, a crosstab between respondents' nearness to health care facility and access to primary health care services was done. Result from Table 6 shows that 90.7% of the respondents who live near healthcare facility access care in clinics as against 9.3% who did not. For the respondents who live far from facility 85.5% accessed care in healthcare facility clinics as against 14.5% who did not. There is no significant relationship ($X^2 = 2.0492$, $df = 1$, $P = 0.152$) on nearness to Healthcare facility and access to maternal health services. The result reveals that there is no significant relationship between nearness to Health Care facility and access to maternal health services. Therefore, the null hypothesis is accepted.

To test hypothesis three, a crosstab between 'who takes decisions on obstetrics emergency and access to health care services was done as shown in Table 4. The Table shows that 86.2% of respondents where husbands take decision on obstetric emergency accessed care in health facility as against 13.8% who did not. Similarly, 96.55% of respondents where wives take decisions accessed care in health facility as against 3.44% who did not. Where joint decisions are taken, 95.77% said they access care in health facility as against 4.33% who did not. Where decisions are taken by relatives, 91.49% of respondents' access cares in healthcare facility as against 8.51% who did not. There is a significant relationship ($X^2=39.2476$, $df=4$, $P=0.000$) on who takes decision on obstetrics emergency and access to maternal health service in facility. The test statistics show that there is a significant relationship between who takes decision and access to maternal health service in facility. Therefore, the null hypothesis (H_0) is rejected by the result. This may be attributed to the economic empowerment of men over women. Men (husbands) are the bread winners of the household and responsible for paying all medical bills of their wives whenever they seek medical care, and therefore, determine where and when to seek care during pregnancy or child birth.

To test hypothesis four, a crosstab between respondent's religion and access to health care services was done. As it is revealed in Table 6 that 64.9% of respondents who are Muslims accessed maternal health service during their last pregnancy as against 35.1% who did not. Similarly, 70.7% respondents of other religious faith accessed maternal health services in facility as against 29.3% who did not. There is a slightly significant relationship ($X^2 = 4.641$, $df = 1$, $P = 0.031$) on religious affiliation of a woman and utilization of healthcare facility when pregnant. The test statistics reveal that there is slightly significant relationship between religious affiliation of a woman and access to facility when pregnant. The null hypothesis is rejected. This may be attributed to purdah (sequestration of women) practiced by Muslim and prohibition of physical examination by male health workers during antenatal visit or delivery.

Discussion of Findings

The study showed that maternal mortality is still high in the study area. Majority of the respondents indicated losing at least a woman in their households during pregnancy or childbirth. This finding corroborates the submission of National Demographic and Health Survey (NDHS) conducted in 2008 and 2013 which shows a high maternal mortality rate of 545 and 576 respectively in Nigeria. Nigeria is adjudged to have one the worst maternal mortality rate in the world (WHO, 2010).

The current study revealed that most of the maternal deaths were recorded at home, outside health facility. This corroborates the submission of Ganatra et al (2008), in their study of "Too far, too little: community-based control study of maternal mortality in rural Maharashtra, India". Their study revealed that nearly half the maternal deaths were recorded outside health facility. The submission of Adamu and Salihu (2002) explained why most of the maternal deaths in the study area were recorded at home. They pointed out that most women in Northern Nigerian have high preference for home delivery, without the assistance of skilled birth attendant. Among this group, hospital delivery was seen as unavoidable alternative due to high cost of hospital delivery.

Similarly, it was discovered in the study that such variable as socio-economic index, who takes decision on health matters and religion are statistically significant to access to maternal health care service at healthcare facility in the study area. It is not surprising that socio-economic index of the respondents has a significant relationship with access to maternal healthcare service. This finding complements earlier studies (Erinosho;1991, Jegede; 1991; Worrall et al; 2002, Isiugo-Abanihe;2003, Uzochuka & Onwujekwe 2004) that socio-economic index such as income, occupation and level of education of husband and wife are strongly related to up-take of services, and choice of 'safe' service in developing country settings, Niger East senatorial zone not an exception.

Similarly, who takes decision on health matter constituted another important variable in accessing maternal healthcare in the study area. The finding shows a significant relationship between who takes decision on health matter and access to maternal health care service. In the study area, men play a significant role in health seeking behaviour of their household; they are major makers of decision in the family and by extension on health issues of every member of the family. This finding corroborates the submission of Adamu (2010) that power relationship within the household affects women's health decision and utilization of health facilities. She argues that decision about women's health and their children are not decision women take independently, which means that women's access to maternal health care during pregnancy or childbirth depends on husband's consent.

Religion of the respondents has a significant influence on utilization of maternal healthcare in facilities in the study area. This finding indicated that religion, though a super structure in African cultural environment, revealed a slightly significant relationship. This finding corroborates the submission of Stock (2001) in a study of health seeking behaviour in rural setting. Stock (2001) observes that in Kano State Nigeria, Muslim women obtain the permission of their husbands before leaving the home/compound for treatment. This practice is not only in Kano but also throughout Northern Nigeria. Islam does not allow women to seek medical care without the prior permission of their husband, even during obstetrics emergence in the study area. These practices make health facilities out of bound to these categories of women (Dansabo, 2004).

Conclusions and recommendations

The following conclusions were drawn from the study:

There is high prevalence of maternal mortality rate in Niger State which is due lack of access to health facility by pregnant women. In the process of this study it has been discovered that the available health facilities are not adequate and evenly distributed in the study area. However, there are some wards in the senatorial zone without Healthcare facilities to cater for the maternal health needs of women of reproductive age. Women trek long distances to access maternal healthcare services in other wards. Most of the healthcare facilities in the study area are concentrated in urban centres, furnished with modern medical equipment and enough qualified health personnel to delivering qualitative maternal healthcare services to women of reproductive age. The few clinics allocated to rural areas are characterised with deplorable buildings, inadequate medical equipment and qualified health personnel.

The finding of the study reveals that socio-economic index; who takes decision on health matters; and religion of the respondents are significant in access and utilization of maternal healthcare service. The study shows that women in households with high socio-economic index are more enlightened on reproductive healthcare and they are financially empowered to access maternal healthcare service during pregnancy or childbirth. Women in households where joint decisions are taken on health matters were found to have more access to maternal healthcare services, during pregnancy and childbirth. Muslim women in the study area have less access to maternal healthcare in PHC during pregnancy and childbirth when compared to women of other religious groups. This is not unrelated to purdah practice by Muslim women.

To achieve any significant improvement in access and utilization healthcare facility and reduction in maternal mortality rate in Niger State, series of policies must be put in place to cater for some constraints challenging women's health in the study area. Based on the findings of the study, the following recommendations are made:

Niger State like any other African societies is patriarchal in nature, hence, the need to effectively engage men in antenatal and postnatal care seeking. This becomes imperative owing to the social position of

men in Nigerian and African societies at large where men are at the apex of family and societal hierarchy. Men function as gate keepers to women's sexual and reproductive health because of many powerful roles they play in societies as husbands, fathers, uncles and religious leaders (Isiugo-Abanihe, 2008). In line with the above, there is need to integrate women fully into family decision making process so as to improve access to maternal healthcare in PHC facility.

Education is a strong tool that empowers women to improve their access to maternal health service in health facility during pregnancy and childbirth. Women's educational status in the study area is relatively low. There is the growing need for improvement of women's educational status, particularly in rural areas through adult literacy programmes. The girl child should also be encouraged and prioritised in Niger State. This will enhance their economic status and knowledge on the importance of maternal healthcare during pregnancy and childbirth, consequently encouraging greater access to maternal healthcare service in PHC facility.

Government and its partners should embark on massive and aggressive campaign to create awareness on the need for maternal healthcare service during pregnancy and childbirth. There should be regular house-to-house campaign by health workers, sponsor radio and television programmes to sensitising women on the benefits of attending regular ANC and delivery in health facility. They should also enlighten the public on the consequences of home care during pregnancy and childbirth.

The study recommends that an effective poverty alleviation strategy should be put in place by government and their partners at all levels. The programme should aim at reducing poverty among women of reproductive age in the study area through skills acquisition and provision of soft loans. This will empower women economically and consequently enhancing their access to maternal health services in health facility.

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