Socioeconomic Determinants of Women's Choice of Place of Delivery in Cross River State, Nigeria

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Abstract

To increase women's utilisation of skilled attendants during pregnancy and childbirth, the government of Cross River State, Nigeria, in 2009, introduced a cost-free maternal health programme. The project was intended to help reduce the high maternal mortality rate in the state, which occurs mainly because of the utilisation of unskilled attendants by women during pregnancy and childbirth. However, the patronage of unskilled attendants by pregnant women in the state has persisted. This study thus examines the factors that influence women's choices when it comes to where they choose to get care during pregnancy and childbirth. Cross River State, Nigeria, was the study area, and the mixed method was the study design. Women of childbearing age in the state constituted the study population, while a total of 613 respondents were selected purposively to form the subjects for the study. Quantitative data for the study was obtained using a structured questionnaire, while the Focus Group Discussion and interviews were utilised to generate the qualitative data. Two hypotheses were formulated and tested using the Chi-Square and Multiple Regression Analysis as statistical tools. Findings based on the test of the Hypothesis I revealed that delivery demands significantly influence women's choice of place of delivery. The analysis of the second hypothesis using the multiple regression further revealed that religious belief and income level both had statistically significant *p-values* of 0.000, which is less than the 0.05 alpha levels of significance; meaning that both religious belief and income level significantly influence women's choice of place of delivery. Educational status, however, had a *p-value* (0.078)> 0.05 alpha levels of significance. This is not statistically significant, implying that educational status does not significantly influence women's choice of place of delivery. The study recommends that beyond making delivery cost-free, the government of Cross River State should adequately equip hospitals to prevent the demands placed on women at the time of birth, which scares a number of them, forcing some to opt for unskilled attendants. Also, the study recommends increased effort towards the empowerment of women to curb the

difficulties created by income as well as the intensification of awareness campaigns, among other measures.

Keywords: Women, Choice of Place of Delivery, Maternal Health, Healthcare, Socioeconomic Determinants.

Introduction

Maternal health is of utmost importance to the global community, owing to the fact that around the world, women die every day from pregnancy and childbirth-related health problems. In 2015 alone, approximately 303,000 women died around the globe due to pregnancy and childbirth complications (UNPFA, 2016). Although the United Nations Population Fund acknowledges that the world has witnessed a 44 per cent decline in the rate of maternal death since the 1990s, the agency still stresses that about 830 women continue to die every day from pregnancy and childbirth, a figure which narrows down to about one maternal death every two minutes. With statistics such as this, it is certain that maternal mortality contributes significantly to the global death burden.

To safeguard maternal health, as well as ensure that maternal mortality is kept at the barest minimum, the United Nations listed maternal health as the fifth of the eight Millennium Development Goals (MDGs), set by all its 191 member states in 2000. The UN further sets the target of reducing the number of women dying as a result of pregnancy and childbirth by three quarters by the year 2015. To achieve this, attention was directed by the United Nations to the usage of skilled birth attendants, among other options during pregnancy and childbirth.

In line with achieving the number five of the UN MDG goals, and in a bid to contribute to the target of significantly reducing by 2015 the global maternal mortality rate, which is particularly high in Nigeria, the Cross River State Government in 2009 implemented a cost-free maternal healthcare programme for pregnant women tagged "PROJECT HOPE." With this cost-free maternal healthcare programme in place, it was expected that women would adequately utilise healthcare facilities during pregnancy and childbirth and, by so doing, avoid preventable maternal deaths occurring during deliveries handled by unskilled birth attendants outside orthodox healthcare facilities. However, contrary to expectations and despite the laudable effort of the Cross River State Government, as expressed in "PROJECT HOPE," women in the state continue to patronise unskilled and unorthodox birth attendants during pregnancy and childbirth.

A particularly disturbing trend in Cross River State is the fact that a good number of women register with and attend antenatal clinics in orthodox healthcare facilities, but at the point of delivery, they opt for their preferred

alternative service providers. Etuk (2017) revealed that a staggering 47.8 per cent of women who booked for antenatal care in the teaching hospital located in the State (the University of Calabar Teaching Hospital) had their deliveries outside the hospital, with 43.5 per cent of them delivering in unorthodox facilities where there are no skilled birth attendants. In a separate study of 336 antenatal defaulters, Etuk (2017) found out 44.3 per cent of them had their childbirth in churches, 29.2 per cent in their homes, while 26.5 per cent delivered with traditional birth attendants (TBAs). This corroborates the report of Edu, Agan, Monjok, and Makowiecka (2017) that 59.1 per cent of women in Cross River State deliver at home or with TBAs.

Even with the free maternal health programme in place, in 2013 alone, the maternal mortality rate in Cross River State stood at 250 deaths per 100,000 live births (Edu et al., 2017). Such a maternal mortality rate is not surprising given that a recognisable proportion of women in the state still patronise unskilled birth attendants, even after some of them had already been pre-registered with antenatal clinics. With a scenario such as this, one is left to imagine why women in Cross River State would continue to patronise unskilled and unorthodox birth attendants, even with a free maternal healthcare programme in place. Or better put: why would some of them go as far as receiving antenatal care in orthodox healthcare facilities only to end up patronising unskilled service providers at the point of delivery? Thus, the impetus for this study is the need to unravel some of the social and economic factors that determine women's choices when it comes to choosing where to receive care during pregnancy and delivery. The objective of the study will, therefore, be to examine:

- The extent to which delivery demands and women's socioeconomic characteristics such as religious belief, educational status, and income level influence women's choice of place of delivery in Cross River State, Nigeria.

Literature Review and Theoretical Framework

Based on a report by Rosenfield, Maine and Freedman (2006), skilled care by trained attendants is of prime importance in achieving a reduction in maternal deaths. For developed countries, as Munsur, Atia and Kawahara (2010) noted, maternal deaths have been reduced to almost insignificant levels as a result of the use of skilled attendants at deliveries (98 per cent), antenatal attendance (97 per cent), and institutionalised deliveries (98 per cent). Thus, based on evidence, trained attendants and skilled care at deliveries produce positive outcomes for the fate and health status of women during pregnancy and delivery.

The maternal mortality rate in Sub-Saharan Africa ranks highest in the world currently constituting about 66 per cent or two-thirds of all maternal deaths worldwide (UNICEF, 2017). In the case of Nigeria, the African Population and Health Research Centre (APHRC) reports that the country alone is the second highest contributor to maternal mortality in the world and until recently, it registers an estimated 40,000 maternal deaths annually, which amount to 14 per cent of global maternal mortality rate. However, between 2010 and 2013, the maternal mortality rate in Nigeria had reduced from 610 to 530 deaths per 100,000 live births (Edu et al., 2017). Notwithstanding, the 530 deaths per 100,000 live births is still relatively high.

The maternal death rate has remained high in Sub-Saharan Africa mainly because, as Edu et al. (2017) observed, the region has low rates of skilled birth attendance; with that of Nigeria standing at 30% as at 2013. Within the same period, as Edu et al. (2017) reported, the South-South geopolitical zone where the study area (Cross River State) is located ranked lowest in compliance with recommended practice. This certainly means that the low rates of skilled birth attendance in Cross River State can be linked to the fact that many women patronise unskilled attendants during pregnancy and childbirth.

Robert K. Merton's Anomie Theory provides insight into the possible rationale for women's choices in terms of where to get care during pregnancy and childbirth. According to Merton (1968) cited in Haralambos and Holborn (2007), society members respond differently to societal values and goals as well as prescribed means of attaining them. Merton argues that some society members' response to social goals and values is that of conformity, in that they strive to achieve societal goals through socially prescribed ways. This is the case with women who choose to get care from skilled attendants in institutionalised healthcare facilities during pregnancy and childbirth. However, there are society members whose response to social values and goals, according to Merton, is that of innovation. Such individuals reject prescribed means of achieving societal goals and attempt to innovate by devising non-institutionalised means of achieving goals. Women who patronise non-institutionalised delivery facilities fall under this category because, based on Merton's argument, by patronising unskilled attendants, such women are in effect deviating to an alternative means in their response to seeking care during pregnancy and childbirth. However, this constitutes a form of deviance on their part.

Merton's Anomie theory further aids the understanding of why women deviate or innovate in issues relating to seeking care during childbirth. According to Merton, society members are placed differently on the social strata. That is to say, people belong to different social classes and as a result have unequal access to education, income, information, and other resources.

Consequently, they often have unequal opportunities to realise shared goals and as such respond differently in how they approach the achievement of societal goals. For those whose response is that of innovation, in that they adopt unconventional means to achieve goals as is the case with women who patronise unskilled birth attendants, the argument from Merton's perspective would be that they turn to these unconventional options because they have limited access to adequate income, proper education, adequate awareness, and other social resources. As a result, often, they are hardly able to make ends meet. Also, they are easily given to holding misconceptions and as such are more susceptible to rejecting conventional methods of achieving goals.

Based on Merton's submission, therefore, women's choice of place of delivery in Cross River State might depend, for instance, on how much income they have, their level of education, and even the type of information they are exposed to. Those with stable employments and businesses would have a more stable income and can afford hospital services. However, those who are outside this class might have less income, which would make it difficult for them to have the capacity to afford some basic health requirements (Archibong & Agan, 2010)—which might include charges in cash or other demands in kind required for childbirth in most health facilities. As such, they might innovate in seeking care during pregnancy and delivery by patronising 'affordable' but unskilled attendants such as TBAs or faith-based delivery centres. This also applies to women who have an inadequate or low level of education. Hence, a study by Ravi and Kulasekaran (2013) found that women who had completed higher education preferred health institutions for their deliveries, while a majority of home deliveries were among illiterate groups, who had less exposure to mass media. Lastly, Merton's argument explains the place of religion in how women seek care during pregnancy and childbirth. Nigeria is not only a highly religious society, ranking fourth alongside Cambodia, Cameroon, Jordan, Malaysia, Philippines, and Senegal in the list of the most religious countries in the world (World Atlas, 2018); also, religion has pervasive effects on various aspects of people's lives, attitude, and behaviours, affecting even how they approach health issues (Fadeyi & Oduwole, 2006). However, Nigerians vary in their religious beliefs, arising from their religious information and teachings. Thus, in the case of women, their health-seeking behaviour during pregnancy and childbirth will depend on the type of religious information to which they are exposed. Those with balanced religious teachings will likely conform by patronising conventional healthcare facilities. On the other hand, those who are religiously misinformed might innovate by seeking care outside institutionalised health institutions, such as TBAs and faith-based birth attendants, due to wrong religious teachings.

Methodology

The setting for this study is Cross River State, one of the coastal states of the Niger Delta region, located in the South-South geopolitical zone of the country. It has three senatorial districts and a total of 18 Local Government Areas with Calabar being its capital city. The state occupies a total of 20,156 square kilometres, with a projected population of 3,737,517 for 2016 and lies within $5^0$45'N $8^0$30'E coordinates (https://en.m.wikipedia.org).

This study, which is essentially a survey, adopts a mixed design as it has both qualitative and quantitative components. Qualitative data for the study were obtained through focus group discussions (FGD) and in-depth interview, using FGD and interview guides, respectively. On the other hand, quantitative data were obtained using a structured questionnaire. The population of the study consisted of women of childbearing age (15-49).

The study utilised a sample size of 613 subjects. This figure was determined using the estimate of the proportion of women aged 15-49 that receive antenatal care in Nigeria which according to World Bank (2018) stood at 62.60 per cent in 2015. However, 60 per cent was chosen as the worst possible. The sample size was therefore determined as follows: $n = \frac{Z^2 \pi(1-\pi)}{E^2}$

Where:

Z - degree of confidence. For this study, it is set at $Z_{0.005} = 2.57$

π - estimate for ante-natal care coverage for Nigeria = 60 per cent (i.e. 0.6)

E - estimate error = 0.05

The sample size therefore:

$n = \frac{(2.57)^2(0.6)(0.4)}{(0.05)^2} = 612.552$. This is approximately 613

The needed data, qualitative and quantitative alike, were obtained in 12 delivery facilities including hospitals, TBA homes, and faith-based delivery centres. Data analysis and test of the study hypotheses were done using the Chi-square and Multiple Regression statistical techniques.

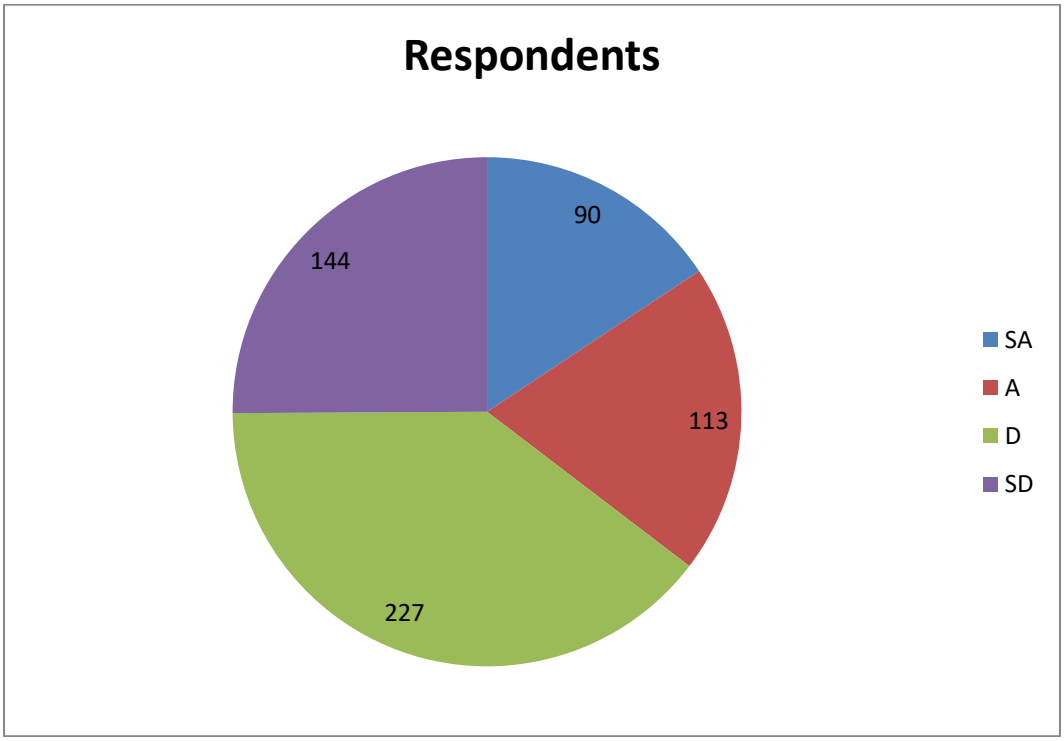
Results and Discussion of Findings

Delivery Demands and Choice of Place of Delivery

Figure 1 is a Pie Chart presentation of subjects' perception of delivery demands as a determinant of choice of place of delivery. The chart shows that the proportion of subjects who would not be influenced by delivery demands appear to be in the majority (altogether, 371 respondents – 64.6 per cent). However, those who consider delivery demands to be a deterrent to delivering in certain places (a total of 203 respondents – 35.4 per cent) still constitute a proportion that cannot be considered negligible as far as the matter of maternal health is concerned. As a matter of fact, the 35.4 per cent figure implies that one out of three women in Cross River State would consider delivery demands

to be a challenge, and within the scope of maternal health, such a statistic is still worrisome. The result of the test of the null Hypothesis I, as displayed in Table 1, provides further insight on this.

Figure 1. Pie Chart Distribution of Subjects' Perception of Delivery Demands as a Determinant of Choice of place of Delivery



Test of Hypothesis I

Ho: Delivery demands do not significantly influence women's Choice of place of delivery in Cross River State.

Table 2. Chi-Square Analysis on Delivery Charges and Women's Choice of Place of Delivery

Variables	Observed N	Expected N	Residual	Df	Cal. X^2	Sig.
SA	90	143.5	-53.5	3	75.017[a]	.05
A	113	143.5	-30.5			
D	227	143.5	83.5			
SD	144	143.5	.5			
Total	574					

The result in Table 2 reveals that the calculated χ^2 value of 75.017 is greater than the critical chi-square value of 7.82 at 0.05 level of significance. As such, the null hypothesis is rejected, implying that, even if fewer women consider delivery demands to be an influencing factor when it comes to where to have their deliveries, its influence on women's choice of place of delivery is still significant. Thus, the alternate hypothesis of this study is accepted, suggesting that delivery demands significantly influence women's choice of place of delivery in Cross River State, Nigeria.

Delivery demands are used in this study to describe items other than cash, which delivery attendants in both orthodox and unorthodox facilities require pregnant women to present at the time of delivery. Archibong and Agan (2010) reveal that attendants in orthodox health facilities, for instance, usually ask for items often described as 'consumables' such as toilet soap, disinfectants including Dettol and bleach, as well as olive oil, cotton wool, spirit, among others. These items, as noted by Archibong and Agan (2010), place an additional burden on women. Some participants in the FGD and oral interview stated clearly that they considered the cost of these 'consumables' put together as practically amounting to cash equivalents they might find burdensome to cope with. Obviously, women who hold this view fall within the 35.4 per cent of the subjects in this study who consider delivery demands to be a determining factor of where they would have their deliveries. A particular participant in the FGD stated as follows: "the government claims a delivery is free, yet they use other means to still get us to pay, free should mean free." This is, undoubtedly, the principal reason that even with the cost-free delivery service (PROJECT HOPE) in place, some women in Cross River State still choose alternatives such as TBAs, home deliveries or even faith-based delivery centres. In these places, the demands are often negotiable or payable in instalments as Abia, Charles, Ering and Mboto (2007) observed. Also, for a number of these women, the latter terms of payment are most convenient.

Test of Hypothesis II

Ho: Socio-economic characteristics of women in terms of religious belief, educational status, and income level have no significant influence on choice of place of delivery among women in Cross River State.

Hypothesis II is tested using the Multiple Regression Analysis and presented in Tables 2a, 2b and 2c, and it is tested at .05 levels of significance.

Decision rule: if the *p*-value is less than or equal to 0.05 Alpha (α) levels of significance for the test, reject null hypothesis (H_O) and retain the alternate hypothesis (H_1).

The summary of the results of the Multiple Regression Analysis for the test of hypothesis two, as presented in Tables 2a, 2b, and 2c reveals as follows:

1. Religious Belief

Based on the Multiple Regression analysis, the *p-value* of religious belief turned out to be 0.000, which is less than (<) the 0.05 alpha levels of significance. Therefore, the hypothesis that socioeconomic characteristic of women, in terms of religious belief, has no significant influence on women's choice of delivery in Cross River State is rejected. This implies that religious belief as a social factor significantly influences women's choice of where to deliver in Cross River State.

Mueller, Plevak, and Rummans (2001) reported that religion and spirituality had been found to be associated with better health, including greater longevity, coping skills, less depression, anxiety, and suicide among other health issues. A report such as this holds in the views of many Nigerians, which makes it that in health matters, including the ones relating to pregnancy and childbirth, religion is often not left out in their options of how to seek care. Moreover, many Nigerians believe in their spiritual leaders, who often advise and issue them with prophecies regarding different aspects of their lives, including issues bordering on pregnancy and childbirth. Also, several Nigerians believe in supernatural intervention in many of their endeavours, including the area of health. As a way of attracting such supernatural interventions during childbirth, many women succumb to religious misinformation presented by some of their religious leaders as 'prophecies' (or *perceived* divine instructions) and then end up delivering outside orthodox health facilities, sometimes in faith-based delivery centres. Hence, in the interviews and focus group discussion (FGDs) of this study, some subjects indicated that delivery in faith-based centres was a preferred option for:

i. Ensuring spiritual protection and warding off evil;
ii. Not falling victim to witches and witchcrafts;
iii. Having a prayer back-up to attract help from God during delivery;
iv. Obeying prophecy in which 'God' instructed against delivery by a caesarean section which happens in hospitals, and to prevent the loss of their lives.

It is not surprising, therefore, that Etuk's (2017) study of 336 antenatal defaulters found that churches (spiritual churches in particular) alone handled the delivery of as much as 44.3 per cent of these women. Religious belief is, therefore, a major influencing factor in women's choice of place of delivery in Cross River State, Nigeria.

Table 2a. Multiple Regression Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the estimate
1	.931[a]	.876	.866	.374433

3 Predictors: (Constant) Religious Belief, Educational Status, Income Level.

Table 2b. ANOVA[a]

Model	Sum of Squares	df.	Mean Square	F	Sig
Regression	520.746	3	173.582	1238.145	.000
Residual	79.911	570	.140		
Total	600.657	573			

a. Dependent Variable: Choice of Place of Delivery

b. Predictors: (Constant) Religious Belief, Educational Status, Income Level.

2. Educational Status

The multiple regression analysis further revealed a *p-value* of 0.078 for education as a predictor of choice of place of delivery. Since this *p-value* of 0.078 is greater than (>) the 0.05 alpha levels of significance, it is, therefore, not statistically significant. As such, the null hypothesis as it applies to education is not rejected, implying that educational status does not significantly influence women's choice of place of delivery in Cross River State, Nigeria. This suggests that in the study area, where a woman would deliver is not a function of how highly or poorly educated she is. This means that highly educated women can deliver in hospitals, with TBAs or with faith-based delivery centres, just like their uneducated counterparts. Studies including those of Akinyo (2009), Ravi and Kulasekaran (2013), as well as Pallikadavath, Foss, and Stones (2004) suggest that women with some level of education are likely to receive care in hospitals because of their exposure to knowledge about health issues. One, therefore, wonders why educational status might not influence a woman's choice of place of delivery in Cross River State as found in this study.

In Cross River State, like several other parts of Nigeria and indeed in Africa, there is widespread belief in witchcraft and sorcery. In places where this belief is obtainable, witches and sorcerers are believed by both the educated and uneducated in Cross River State to have powers for destroying lives, as well as for causing harm or bringing misfortunes to people at will

(Akak, 1982). Subjects in the FGDs and interviews confirmed that they nursed fears for witchcraft attack, especially during pregnancy, while some indicated that they believed many maternal deaths were caused by witchcraft attacks and other evil forces known in the primary local language as *Ifot*.

Table 2c. Multiple Regression Coefficient Parameters of Model for Predicting Choice of Place of Delivery from the Socioeconomic Characteristics of Women (Religious Belief, Educational Status, Income Level) in Cross River State.

Model	Un-standardized Coefficients		Standardized Coefficients	t	*P-value*
	B	Std. Error	Beta		
Constant	.431	.040		10.690	.000
Religious Belief	.450	.034	.516	13.127	.000
Educational Status	.098	.055	.100	1.768	.078
Income Level	.331	.059	.337	5.651	.000

a. Dependent Variable: Choice of Place of Delivery

According to Offiong (1991), the fear of witchcraft attack makes people in this area to go any length to take precaution against possible attacks by witches. One of such precautions is to identify with churches, where they are assured that through prayers and other spiritual activities popularly known as 'assignment', witches, and other evil forces can be conquered. For many pregnant women, therefore, educated or not, once there is that fear or suspicion of witchcraft attack (the educated ones would only manifest their education by registering for and attending antenatal clinic) at the point of delivery, they opt for mainly spiritual churches or other such places where they have assurance of availability of supernatural powers. These, they believe, would guarantee them protection against evil attack during delivery. Moreover, as pointed out by some participants in the FGD, pronouncements by a doctor that delivery

would by caesarean section (known in the primary local language as *uman ikwua* –meaning knife delivery) is one way many women and their relatives suspect that witches or other evil forces are manipulating the pregnancy with the intention to harm or even kill the woman and baby. They believe this to be the reason why normal delivery is obstructed. As such, for some of such women, once they are informed by attendants in orthodox health facilities to prepare for caesarean section, irrespective of their level of education, they seek care in other alternatives where delivery will not be by surgery, sometimes to their peril.

3. Income Level

As is the case with religious belief, the *p-value* for income level is also 0.000, which is statistically significant being that it is less than (<) the 0.05 alpha levels of significance. The null hypothesis as it applies to income level is therefore rejected, meaning that income level as a socioeconomic factor significantly influences women's choice of place of delivery.

Karl Marx in his capitalist ideologies argued that in society, the infrastructure, which is the economy, shapes the superstructure, which represents other aspects of society. At the level of the individual, this means that their income level will shape other aspects of their lives, including where and how they seek medical care. In the case of women, since they vary in their income levels, such variations will reflect in how they seek care in the event of health challenges as well as during pregnancy and delivery. Nigeria has a high poverty rate, which stood at 33.1% as of 2014 (https://en.m.wikipedia.org). The situation got even direr from 2015, due to the recession that hit the country following the drop in the global price of crude oil. Being that women are more vulnerable to poverty, definitely, there would be a ripple effect in how they seek medical care during pregnancy. Archibong and Agan (2010) stressed that those with stable income would be able to afford hospital services while those outside this group might not be in a position to afford even the most basic of health requirement in healthcare facilities. In line with this view, Anthony (2010) noted that payment for healthcare, among the poor population, is one of the deterrents to women's use of appropriate medical attention.

In the case of Cross River State, although there is a cost-free maternal care programme, which means that income level should not be a problem, the demands in kind or 'consumables' required of women who come for delivery still present a challenge to many women, a sizable proportion of whom live on less than one dollar a day. A woman in one of the FGD sessions stated as follows, "if I had all the cash to buy all the things that those hospital nurses ask for, why would I not deliver in a very good place? I can even pay a pastor to be praying for me. Who doesn't like good things? I just don't have all the

money." Another participant said, "if I spend the little I have completely on delivery alone, what would we survive on afterward? I just need to spend wisely, so I don't steal to survive after my delivery." Little wonder, Etuk (2017) based on her study of 336 women, who attended antenatal clinics but ended up delivering in unorthodox facilities, found that the highest proportion (24. per cent) indicated that hospital charges (whether in cash or kind) were the cause.

To add to this, many women in the state live in very remote rural areas and may not even be able to afford the cost of transportation to the urban centres where the cost-free maternal services are obtainable. Consequently, some of them might opt for delivery at home by themselves or with the help of relatives, in which case no demand will be placed on them. Others may settle for the services of TBAs or Faith-Based Attendants who, in most instances, give room for negotiations in their demands, or allow for payments in instalments.

Summarily, though, it turned out that educational status had a *p-value* (0.078) > 0.05 alpha levels of significance, which is statistically insignificant. Yet, with the multiple regression result indicating F (3,570) = 1238.145 and R^2 = .867, as well as the *p-values* of the two other socioeconomic variables namely: religious belief and income level being 0.000 which is < 0.05 alpha levels of significance, it can well be concluded that socioeconomic characteristics of women still significantly determine their choice of place of delivery in Cross River State, Nigeria.

Conclusion and Recommendations

The utilisation of skilled attendants is essential for safeguarding women's lives during pregnancy and delivery. It is, therefore, pertinent that women be assisted to both come to terms with this, as well as make the right choices when it comes to place of the delivery. Orthodox healthcare faculties remain the best option since they guarantee the services of skilled attendants. To ensure that women irrespective of their social, economic, or cultural backgrounds make orthodox healthcare facilities their preferred place of delivery and also based on the findings of this study, the following are therefore recommended:

- Religious leaders should be encouraged to make skilled professionals part of their team during the process of providing spiritual services to pregnant women. These skilled professionals would give health talks on pregnancy and childbirth-related issues to women on the days they gather to meet with their religious leaders. These professionals would also use such opportunities to encourage them to seek care from

appropriate healthcare facilities. Some churches in Cross River State are already practising this.

- Many women believe in their religious leaders. The government should therefore work with them to get them to encourage their pregnant members to seek care from appropriate health facilities. If this instruction comes from a religious leader, there would be widespread adherence.
- The government should ensure that the cost-free maternal health programme on ground is cost-free indeed. Efforts should be made to provide delivery materials so that no demand tending to unnecessary expenditure would be placed on women at the time of delivery.
- Women empowerment efforts should be intensified by government. Economic empowerment for women would certainly have a trickling down effect on their health-seeking behaviour, even during pregnancy and childbirth considering that they would be able to afford demands in cash or kind for the care they seek.
- There should be an intensification of public campaigns to enlighten the public to get them to unlearn the myths and misconceptions they hold about issues surrounding pregnancy and delivery, especially as they concern caesarean sections.

The government should make the pay of skilled attendants posted to rural areas attractive enough to make them stay in those places. This is particularly important because rural dwellers are more susceptible to patronising unskilled attendants in that often, there are hardly professional attendants in rural health posts. Most of them prefer providing their services in urban areas. However, if their pay is made irresistible, a number of them would see this as a motivation to stay in those areas and render their services.

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