



# Why Women Are Averse to Facility Delivery in Northwest Nigeria: A Qualitative Inquiry

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## Abstract

**Background:** In many sub-Saharan African countries the rate of antenatal care (ANC) has been increased but skilled birth attendance rate is still low. The objective of this study was to evaluate the reasons why women prefer home delivery when facility based delivery is available at minimal cost.

**Methods:** This study was conducted in Northwest Nigeria using a qualitative method (phenomenology) among five categories of women in April – May 2013. This study investigated different categories of women (those that never attend ANC nor deliver in the facility, those that attend ANC but delivered at home and those that delivered once in the facility but fail to return in subsequent deliveries, the in-laws and facilities staff).

**Results:** Through focus group discussions and In-depth interviews several reasons why women are averse to hospital deliveries were identified. Women reported ignorance, abuse, illiteracy, and poverty, and low esteem, poor attitude of health workers, few working hours and some integrated health services like preventing mother to child transmission of HIV testing as deterrents, while cheap and accessible services were reasons for preference to traditional birth attendants.

**Conclusions:** The findings highlighted important entrenched barriers to facility deliveries among women, which is basically socio-cultural and economic. Therefore emphasis must be given to health education program to ensure comprehensive and target specific messages that will address individual needs of the groups.

**Keywords:** Barriers, Hospital delivery, Qualitative inquiry, Northwest Nigeria

## Introduction

Despite the fact that women's health issues is coming to the forefront of health priorities in many countries, yet, it was observed that women in developing world remain susceptible to poor health because of lack of services and lack of education and information about health issues(1). In developing countries, complications of pregnancy and childbirth are the leading causes of death among women of reproductive age. Women risk death and disability each time they become pregnant; and

face these risks much more often since they bear many more children than women in the developed world. WHO report that women's risk of dying from pregnancy related complications stood at 1 in 48 for all developing countries as compared to 1 in 1,800 for developed countries meaning the risk of dying from pregnancy related complications are highest in Africa (2).

Maternal and child mortality remains of public health concern. Delivery in health facility by skilled

birth attendant is recommended for all pregnant women as a strategy to reduce maternal and neonatal mortality (3, 4). Delivery in health facility allow for proper management of labor, early detection of problem in both the mother and the fetus in the event of complications which are usually unpredictable it allows for prompt and effective response. This is impossible if women choose to labor at home. In this paper we report findings from Zamfara state in northwest Nigeria, where an on-going health system strengthening project with technical and financial support from Department for International Development (DFID) /Norwegian government in collaboration with the state government aimed at addressing challenges related to maternal and child health in all its ramification, this provide a unique opportunity to understand why women are averse to facility delivery even when facility based delivery is available at minimal cost.

Materials and Methods

The study was conducted in sub-urban and rural settings in (Zamfara state) Northwest Nigeria between May 2012 and Mar 2013. Its population as at the 2006 National Population and Housing Census was 3,259,846 (1,630,344 males and 1,629,502 females) (5) It covers a landscape area of 38, 48 square km. The public healthcare system is made up of primary, secondary and tertiary health facilities. There are more than 600 primary health centers, 18 general hospitals with 1 federal medical Centre, in addition, 23 health facilities are privately owned. The Local Government Areas (LGAs) are

responsible for the construction and running of village dispensaries, Basic Health Clinics and Primary Health Centers. The State Ministry of Health and Health Services Management Board are responsible for the Secondary Healthcare System.

Study Design and Sampling

The study used a qualitative method (phenomenology). Key informant interview (KII) and focus group discussion participants were selected purposively and saturation of information was used to decide on adequacy of the samples. Ethical approval for this study was obtained from State Operational Research Committee (ORAC) and informed verbal consent was obtained from all participants. A total of 30 focus group discussions were conducted in secluded indoor places. The discussions involved five separate groups of women (Those who attended antenatal care (ANC), but delivered at home, those who delivered once in facility but fail to return on subsequent deliveries and Those who neither had ANC nor deliver in facility, Mother-in-laws and men (Husbands) who’s wives opted for home/facility delivery for the most recent births. The participants group and characteristics are presented in Table 1 & 2 respectively. A total of 180 people participated in the five focus group discussions. In addition, in-depth interviews were held with six health care providers (Nurses/Chews) and Six Traditional Birth Attendants (TBA).

Table 1: FGD categories in the communities

Women (Delivered facility onces only, ANC and facility delivery, Neither ANC Nor delivery)	3 X 6 (6 persons) Per session	1hour according to your study methodology
Mother In-laws	1 X 6 (6 persons) Per session	1 hour
Father In-laws	1 X 6 (6 persons) Per session	1 hour
TBAs	2 X 6	45mins
Facility in-charges	2 X 6	45mins
Total	30	24

**Table 2:** Characteristics of participants in focus group discussion and in depth-interview

Categories of participating women	Age Mean (Range)	Parity Mean (Range)
Women who never attend the facility for ANC or Delivery	21 (19-32)	4.5 (1-6)
Women who attended ANC but delivered at home	20 ( 29-34)	5.6 (2-6.5)
Women who delivered once in the facility but fail to return for subsequent delivery	21 (19-31)	5.6 ( 2- 7)
Mothers/ Father In-laws	30 ( 28-45)	6 ( 4-9)
b,		
Key community leaders	Categories	Gender
TBA	6	Female
Nurses and CHEWS	6	Female 4, Male 2

Five different interview guide were used for the different sub-groups, trying to explore entrenched socio-cultural/religious barriers to facility delivery within and between categories of women, TBA and health workers (Table 3). The questions included issues affecting who decide when and why a woman should be taken to facility for delivery, what are the motivations for patronizing TBA, and what are the experiences of those that used the facility for delivery. In addition we explored the health workers perspectives on why women are averse to facility delivery.

The study teams consisted of the principal researcher, five female secondary school teachers with past experience in FGD one male undergraduate student of sociology of Usmanu Danfodio University, Sokoto. The research teams participated in a two-days training; the session included: study overview, ethical conduct of research, role play and pre-testing the study instruments.

**Data analyses**

Basic demographic data such as age parity and location of participants were collected from each study participant before the start of each focus group. All focus groups were held in Hausa, the local language familiar to all research participants. The focus groups lasted about an hour each; Interviewers took extensive notes, in addition to tape recording and transcribing the interviews. The demographic data were processed using SPSS version 16 (Chicago, IL, USA), and information obtained

were transcribed verbatim. This textual data was compared and combined with information notes taken during the interview sessions. In addition, the content of the textual data was double checked with summaries and conclusions made at the end of the interview sessions in order to ensure that those notes were similar to what they answered during the interviews. Basic description of data was done through open coding where textual data was decomposed into parts, marked and coded with the aid of Nvivo software. Then, the parts were compared based on the similarities and differences that combined to form a new category and subcategories.

This was followed by linking the various categories, this is often referred to as axial coding, and the information of each category and it is subcategories was refined and determined in relation to its conditions, context, strategies and consequences.

**Results**

The concept and idea of antenatal care (ANC) enjoyed universal acceptability among the participants in all the communities studied, with low utilization of facilities for delivery. Women who delivered outside health facilities relate their circumstances to the following factors, getting permission from husband/family, distance to a health facility or lack of transportation, cost of service fee for treatment, trust in service quality, belief that it may not be necessary or customary (Fig. 1).

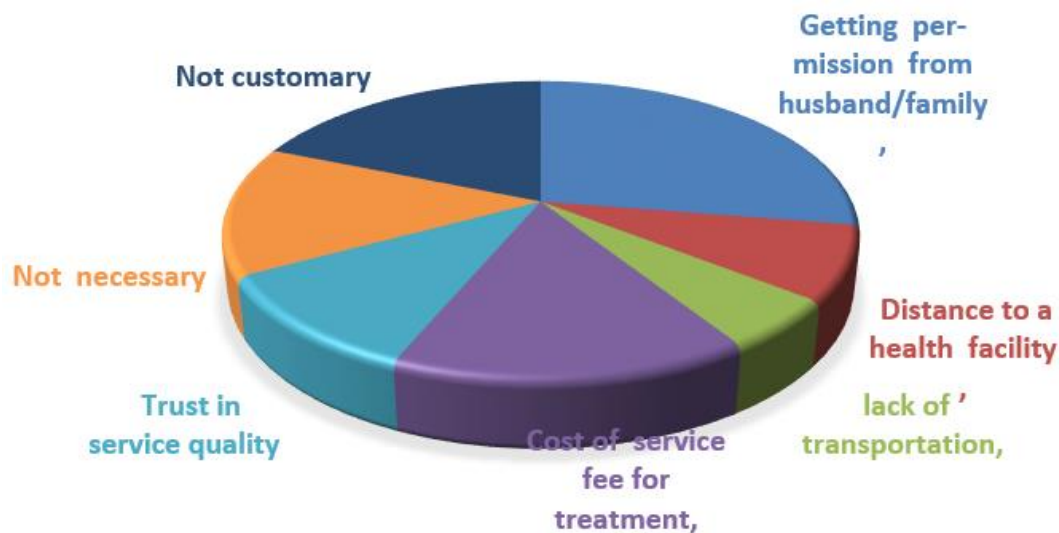


Fig. 1: Reasons for not delivering in facilities

In addition, cultural sensitivity, social support, availability and affordability of services, previous negative experiences with health facilities delivery, cultural perception of the role of TBAs, attitude of health workers to clients, clients’ assessment of quality of care, ignorance/ low awareness of facility services, economic constraints, and relative autonomy of women/empowerment were among other findings. Analyses of the data revealed two patterns in terms of the responses, the general and the specific. The general related to responses common to all the groups and the second related to themes gleaned from the specific responses of the different groups of participants as outlined above. The general related to issues that were found to commonly emerge from the narratives of all the participants in all categories, male and female relating to perceptions and practices on traditional and modern management of pregnancies and births within the local culture. The specific, on the other hand, related to analyses of narratives of participants in FGDs with specific groups of women on their different experiences, supported by data from the KII interviews. These are presented below.

**General response**

Most of the respondents were stoic about the possibility of other interventions which, at any

rate, were in the realm of divine providence pertaining to their occurrence and resolution. A key indicator of such a perception was the very frequent use of the (Hausa (local language) word *matsala* to mean complications/problems, etc.). Typical answers included... *Allah (God) has now brought succor in ANC. Our eyes had been opened and now we are enlightened. Labor is now short, quick and uncomplicated...*

And... *If you go to the hospital for delivery, people will think problems have emerged and you need assistance. Others were out rightly spiritual... We don't have problems now. Allah is helping us*

It is a known fact that most facilities are located in the urban areas and less, in the rural areas. According to a young mother, hospital delivery was.....*very important; that is why in the town when it is time you just pick your kit and go there to deliver but in the village we don't do that unless there is a problem.*

In short, across all categories, male and female, the participants did not see facility delivery as a necessity, or even a priority, as obvious in such opinions expressed in FGDs by ANC-regular women during the FGD sessions:... *Yes, attending for ANC is important but you only go there to deliver if you become weak or cannot deliver on your own without assistance*

...*One goes there only if a problem develops or when the labour takes much time*

Typical indications about this possibility include the following statements attended from two women who regularly accessed ANC services: *.....I went for ANC but no one told me to return for delivery*

*.....they only said that if you have any problem you go to the hospital but nobody will tell you that when it is time for delivery we should go to the hospital*

In contrast facility delivery clearly did not enjoy popularity. Several misgivings or disincentives were expressed by almost all the participants, males and females, irrespective of age, location, specific previous experience with facilities, etc. The misgivings related to discomfort or dislike with specific procedures or bureaucracy at facilities, including:

- a) Restricted or limited availability or accessibility to social support network, (family members, relations, friends, and other significant others);
- b) Cumbersome procedures, such as requirements to pay for certain services (such as tests). A female participant stated that *"sometimes they collect money"*, but it was not clear if such payment(s) were official or as gratifications offered/demanded. However, a young female regular ANC attendee added that *"if drugs are available, they give us and if not they ask us to go and buy."*
- c) fixation/obsession with hospital cards (*"kati"*, understood to include registration cards and files), found or viewed as "modern" irritants;
- d) rigid working hours observed by facility staff, especially in the rural areas such that the staff were available only at specified times (business hours) and days (no service on weekends);
- e) Rejection of or delays in attending to women showing up for delivery (often due to complications) but who had not been attending ANC. Such people were often berated and spoken to in harsh tones. A contributor narrated the experience of an acquaintance who took his (acquaintance's) wife, in a critical condition to a health facility. The wife needed immediate atten-

tion (*"rai a hannun Allah"* or who looked like she could die at any moment) only for the health worker to berate the husband as "a villager who only now is bringing a corpse" to the facility, even as the patient could not indeed be helped at the location: as if the "insult" was not bad enough, they were *.....Referred us to the Hospital at Gusau. Ultimately, the wife died for lack of attention. Do you think we would ever take our wives to the hospital?*

- f) Negative attitudes of facility workers, a rampant complaint. Words used to describe such experiences or perceptions and attitudes translated into arrogance, impatience, lack of empathy, partiality (tending to pay greater attention to elite women); poor public relations, etc. rendered in Hausa words and phrases conveying such negative attributions, such as *cin zarafi*, *to-zartarwa* and *wulakanchi* (all loosely translated to mean humiliation, meanness, etc.). An elderly husband related his wife's experience of reaching a facility apparently with a complication (probably an obstructed labour) only to be called.... *A lazy villager. Ironically, my wife delivered safely on her own even before the midwife got round to attend to her. My wife then asked the midwife who the villager was in that situation. Since then my wife had vowed never to return to the hospital. She had even instructed me never to be taken to the facility for delivery...if it ever became obvious that a delivery would end her life, she would rather die than accept that the medical treatment given with humiliation.*

Another recounted a discouraging experience thus... *We rushed my friend's wife to the hospital only to be told that the doctor was at home. Three times they went to call him without luck. The condition of my friend's wife was visibly deteriorating and the nurses appeared helpless. When the doctor eventually emerged after a very long delay...he insisted he was travelling to Gusau and would not see any patient...my friend lost it, went wild, grabbed the doctor by the collar and threatened to kill him (doctor) should the wife in labour die! He wouldn't calm down despite all efforts. It was only then that the doctor*



*attended to the woman and she eventually delivered. That story travelled far...these kinds of stories are unpleasant and do not inspire or encourage positive attitudes to hospitals and the doctors*

A woman who had indeed even given up on ANC visits claimed to have so decided because a facility staff “*used to shout on people...such that now I don’t go there*”.

### **Specific Findings Unique to Groups**

#### ✓ ***Perceptions of the Home and Facility Environments Among Women who Neither Accessed ANC nor Health Facilities for Delivery***

For women who neither went for ANC nor go to facilities to deliver, there was deep-seated preference for the home, and apprehension about, the facilities, virtually all, the major attractions of home delivery were, foremost, low costs and the privacy that the home environment offered. In particular, the home environment resonated with a desire not to be publicly “exposed” to non-relations during the birth process, in line with cultural practices in this predominantly Muslim Hausa and Fulani majority environment, where reticence and stoicism were expected of persons undergoing physical and psychological pains/challenges. Sensitivity of the home environment to entrenched cultural practices (and, in particular, clear separation between males and females) was thus a critical deciding factor. Further, the home environment allowed the woman in labor to be attended to by TBAs, as were the availability of extensive network of social support including husbands, mothers, relations, co-wives, etc., who readily rendered assistance, relieve women in labor of responsibility for household chores, etc. Such social support also allowed pregnant women to do things that were not allowed or permitted in hospitals (e.g. access to foods and drinks). In short, the home environment was such an entrenched and very supportive comfort zone incomparable to the open (“public”) nature of facilities. For such women, modern health facilities offered no guarantees (for safe deliveries) anyway, as shown in the following narratives: *after all, these were what we grew up to know and had been used for generations...!*

*And: ...even health facilities cannot prevent divine ordination – in case of the outcome of complications.*

It needs be stated here that generational differences were found among women in this category: older women expressed greater confidence in traditional remedies, while younger women expressed doubts about the efficacy of traditional remedies calling them “*hade-hade*” (or concoctions of unknown efficacy, given on trial-and-error basis). Thus, for the younger women, except for other factors, facility deliveries would be preferable to home delivery. Still, and not surprisingly, both the older and younger generation of the women were aware of the shortcomings of the home environment, including the lack of facilities and expertise to handle complications that may arise (obstructed labor, excessive bleeding, retained placentas, etc.). While the older women hesitated to admit the inadequacy of the home environment to deal with such eventualities (complications), the younger ones were more open to admitting the doubtful/unreliable efficacies and effectiveness of herbal concoctions, and other home remedies (i.e. the *hade-hade* alluded to above).

#### ✓ ***Women who delivered once but fail to return in subsequent deliveries***

This category of women were clear about the fact of modern health facilities having advantages relating, especially, to monitoring the pregnancy process and offering effective management of birth complications, as well as the availability of modern reliable and effective drugs. Additionally, as revealed by a participant at a rural location during an FGD session, an additional attraction going for facility delivery was the incentives given to patrons such as baby kits and mosquito nets. The gifts had become symbols of conformity to modern care that women now compete to acquire and show off, as indeed confirmed by a facility worker at a KII session.

Another woman given up on ANC visit explained that she was put off because of a facility staff: *...she used to shout on people but now I don’t know because I don’t go there again.*

### ✓ *FGD with women who attend ANC but delivered at home*

This category of women expressed a lot of the sentiments as well as re-echoed perceptions of facilities as expressed by participants of the other categories treated above. However, their most frequently mentioned disincentives for going to facilities to deliver were:

- (a) Costs associated with transportation fare, especially for those who could only attend facility outside their villages/localities. A male household head and participant at an FGD session in a rural location, was emphatic that the problem revolved around *ta-lauchii*, (translated to condition material poverty)... *Make no mistake about the bush on this facility delivery thing: our problem is poverty; our daily struggles relate to feeding our families. You are thinking of how to feed the family, buy a ram to slaughter to celebrate births, you hardly boast of N5.00 and you struggle with transportation to reach the hospital with a woman in labor only to be confronted with a list of things to purchase. God save you if you the wife now needs surgery which can costs thousands of Naira... the simple truth is government has to help us*

Reflecting such resignation to fate/stoic philosophy a TBA expressed during a KII that: *.....A pregnant should indeed be taken care of and people do try within the limits of Allah's provision for them, but you know we are villagers; some people try but some just can't afford to.*

Similarly a woman participant of this category complained that...*they also collect money for blood tests and you must pay for that or they will not attend to you*

- (b) Shyness and reticence, and deep dislike/distaste for being touched by males other than their husbands; *"...there are others disallowed by their husbands, from going to the clinic"* because such husbands could not contemplate their wives being attended to by strange males.
- (c) Distaste for blood transfusion and being forced to accept vaccination; Fear of surgical interventions (including any procedure that involved cutting and stitching parts of the body, episiotomy, etc.). There was a

wide belief that all too often facility workers were quick in deciding to go for surgical interventions, even when the need for same was not obvious to husbands/relations accompanying pregnant women to the hospital. Several participants recalled situations where pregnant women delivered babies on their own as preparations were being made to admit them into labor rooms or theatres for caesarian operations (CS) at facilities.

Another recounted a discouraging experience thus... *We rushed my friend's wife to the hospital only to be told that the doctor was at home. Three times they went to call him without luck. The condition of my friend's wife was visibly deteriorating and the nurses appeared helpless. When the doctor eventually emerged after a very long delay...he insisted he was travelling and would not see any patient...my friend lost it, went wild, grabbed the doctor by the collar and threatened to kill him (doctor) should the wife in labor die! He wouldn't calm down despite all efforts. It was only then that the doctor attended to the woman and she eventually delivered. That story travelled far...these kinds of stories are unpleasant and do not inspire or encourage positive attitudes to hospitals and the doctors*

A woman who had indeed even given up on ANC visits claimed to have so decided because a facility staff *"used to shout on people...such that now I don't go there"*.

### *Traditional Birth Attendants*

The Traditional birth attendants (TBA) that participated in this study were mostly elderly women, and often conduct delivery alone. Most TBAs inherit the role from their mothers, they are normally called only after delivery or when a complication has set in, and may not be around at critical times when danger signs need to be identified. TBAs cut the cord and bury the placenta, bath the baby for seven days and assist women to take a hot bath for forty days after delivery.

A TBA expressed during a KII that: *..... A pregnant should indeed be taken care of and people do try within the limits of God's provision for them, but you know we are villagers; some people try but some just can't afford to* Similarly a woman participant of this category complained that... *they also collect money for blood tests*

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Shyness and reticence, and deep dislike/distaste for being touched by males other than their husbands; “...there are others disallowed by their husbands, from going to the clinic” because such husbands could not contemplate their wives being attended to by strange males.

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**Table 3:** Main themes and sub-themes from FGDs and KII Data on barriers to delivery in health facilities

Main Theme	Sub-Theme
Previous negative experiences	Embarrassment
	Alienation
	Extortion
	Lack of Social support
Perceived role of traditional birth attendants	Availability and Utilization
	Affordability of services,
	Continuity of care
Ignorance	Low awareness, Illiteracy
Perceived quality of care	Issues to do with Privacy
	Counselling
	Confidentiality
	Health workers attitude
Women’s Autonomy	Less women empowered
	Low esteem
	Cultural sensitivity,

Discussion

This study shows that there is good acceptance of antenatal care and it will result in safe delivery. But there is more preference for home delivery than facility delivery. The major and common reasons across board for preference for home delivery include poverty, affordability, facility delivery is alien, and unattractive to them and inadequate / lack of empathy from facility staff when compare with empathy and support from relation at home.

rooms or theatres for caesarian operations (CS) at facilities.

Mother/Father In-laws

The home preference is largely related to cost, with hospital deliveries known to be very expensive. One man mentioned the sum of Naira 2,000 (equivalent to twelve dollars) for a routine hospital delivery. By contrast, untrained TBAs are cheap and available. TBAs are usually paid in kind, with anything within your reach, even farm produce. A Narrative by one male regard to TBAs was: ‘We were born through their services, and we are around today.’

Similar phenomena are highlighted by Kruk et al finding in rural Tanzania study (9).But in contrast to Orisaremi’s finding among Tarok women in North-central Nigeria, where bravery and audacity are the main factors that discourage most women from facility delivery (10). Apart from user fee being unaffordable to many, the payment procedure is cumbersome and no credit facility, instalment payment or exchange of goods for service as practiced by traditional birth attendants, which provide succour to many families. In Shah’s study in Karachi, India, the two most common reasons for home deliveries are family tradition and lack of affordability / poor socio-economic condition of the family (11).

Lack of privacy and exposure to non-relatives and men and dislike / distaste for being touched by male other than their husband which is borne out of cultural and / or religious belief are another major factors that drive women away from facility delivery in this study. Since there is no guarantee that they will meet a female staff at time of labour. Some attitudes of the hospital staff and hospital practices such as shouting on patients, arrogance, impatience, humiliation, lack of empathy and abuse, tapping patients in labour, all these discourage women from facility delivery. Many women cannot bear it and that is one of the reasons why they use facility as last resort when they have no other option.

This study also reveal perception about facility delivery which is seen to be as necessary if complica-



tions emerged, a last resort, an aide in the management of difficult births or those that come with complications. Most of the respondents are stoic about the possibility of other interventions which, at any rate, are in the realm of divine providence pertaining to their occurrence and resolution.

Among the less common reasons for aversion to facility delivery in this study is fear of surgical intervention. This is the most common reason among Guatemala women for not going to facility for delivery even in the case of life threatening complications (12). The caesarean section is often thought to be unnecessary and may have effect on future fertility. There is a generational difference in perception and attitude towards facility delivery between younger and older generation of women. Younger women prefer facility delivery to home delivery. Most of the women are aware of the possible drawbacks of home delivery such as lack of facilities (equipment), expertise to recognize early complication signs and management of complication.

Based on these findings it is recommended that facility services should be subsidized if not free, girls / women should be educated and empowered, health care providers should have seminars on attitudinal change so as to cultivate positive attitudes, Traditional birth attendants should be officially engaged in encouraging women to embrace facility delivery and provision of incentives such as mosquito nets and baby kits to encourage facility delivery.

## Conclusion

The common reasons for aversion to facility delivery include poverty, cost of service, non-permission from husband, alien and negative attitude of staff. Other reasons include its unnecessary, lack of privacy and exposure to non-relatives and men and dislike / distaste for being touched by male other than their husband and lack of empathy.

## Ethical considerations

Ethical issues (Including plagiarism, informed consent, misconduct, data fabrication and/or falsification, double publication and/or submission, redundancy, etc.) have been completely observed by the authors.

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