

**HEALTH SEEKING BEHAVIOUR AMONG MARRIED
WOMEN IN NORTHERN NIGERIA: A FRAMEWORK
TO PROMOTE AUTONOMY**

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Thesis submitted in fulfilment of the requirements for the Degree in Doctor of
Nursing in the Faculty of Health Sciences at the Durban University of
Technology

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DECLARATION

This is to certify that the work is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources). The work has not previously been submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.

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DEDICATION

I dedicate this dissertation to the lord God almighty, Jesus, and holy spirit, for being the source of wisdom, guidance and help. And to my son Timothy for being a great inspiration engine of encouragement in my life.

Psalm 125 v 1:

They that trust in the Lord shall be as mount Zion which cannot be removed, but endures forever.

Mathew 19 v 26, Mark 10 v 27:

Nothing is impossible with God; with God all things are possible.

Psalm 126 v 2 - 3:

Then was our mouth filled with laughter, and our tongue with singing: then said they among the heathen, the Lord hath done great things for them. The Lord hath done great things for us; whereof we are glad.

ACKNOWLEDGEMENTS

My deepest gratitude/appreciation goes to my lord and saviour Jesus Christ in whom I live, move and have my being, who by his grace and will has inspired me to start and complete this thesis. For the strength, endurance, wisdom and determination and for taking me to a height that I could never have imagined.

I would also like to express my sincere gratitude to the following:

A special thank you to my main supervisor, Professor T. S. P. Ngxongo, whose intellectual and academic guidance enabled me to organise and make sense of this study. Your experience and expertise has made this thesis possible. You are not only my supervisor, but also my mentor. I am particularly appreciative of your useful and invaluable suggestions and constructive critique which have greatly improved the quality of this thesis. Words cannot adequately express how much I appreciate all your efforts and sacrifices.

Sincere thanks also to my co-supervisor Dr V. Naidoo, for her unreserved guidance and suggestions from the proposal stage right through to the end stage. I thank you for teaching me how to work hard, and also helping me to develop confidence in my abilities.

Mr Paul John Oyigene and my beloved son Timothy, thanks for spurring me on to achieve my dreams and for being a pillar of comfort in times of discouragement. Timothy you are my little angel and I recognise the sacrifices you made during the period I was away from home, may God bless you abundantly.

Thanks to the chairperson of Lemu community for allowing me the opportunity to use the community hall to collect data from the married men and women, without which the research would not have been possible.

Thanks to the married men and women in Lemu community, Gbako Local Government Area Niger state, Nigeria, for participating in the research programme.

Thanks to the research assistant, Mr Theophilus Audu for assisting me with translation. Mr and Mrs Olonade, Mr Donald Kukwa, Dr Sam Iyore and all others who contributed to the success of this research physically, intellectually and spiritually.

ABSTRACT

Introduction and background

Morbidity and mortality rates (MMR) continue to be a major health care problem in developing countries such as Botswana, Cameroon, Chad, Congo, Guyana, Lesotho, Namibia, Somalia, Swaziland, Zimbabwe, Nigeria, South Africa and many others. The majority of deaths are often as a result of disparities that prevail in health care delivery, especially in rural areas **such as** inaccessibility, unavailability of health care facilities, inadequate material, lack of human resources, poor road infrastructure to facilitate the utilisation of ante natal care, and difficult access to health care providers by pregnant women. The cultural and social beliefs of the community cannot be overlooked due to their influence on the decision to utilise health care services. Autonomy to seek healthcare among married women (MW) is a major challenge in most developing countries, including Nigeria. Autonomy is the ability to make your own decisions without being controlled by anyone else, or the right of an organisation, country or region to be independent and govern itself. Cultural and religious beliefs affect the MW from Nigeria, many of whom face the possibility of dying due to the lack of autonomy to seek healthcare early. Globally, men often control decisions about the health of their wives and children, including the family's use of healthcare services.

Aim of the study: The study aimed to develop a framework to promote healthcare decision-making autonomy **amongst** MW in northern Nigeria.

Objectives of the study: The objectives of the study were to explore the process of healthcare decision-making and autonomy practices among married men (MM) and women in northern Nigeria, then develop a framework to facilitate healthcare decision-making and autonomy practices among MW in that region.

Method: A qualitative descriptive research design was employed whereby data were gathered from both the MM and MW from the Lemu community in Gbako Local Government Area of Niger State Nigeria through semi-structured interviews and focus group discussions.

Findings: The current study was guided by Andersen's Health Belief Model and findings from the study confirmed poor health seeking behaviours due to lack of autonomy for health seeking decisions for MW from the Lemu rural community in northern Nigeria. Recommendations from the study focused mainly on strategies to ensure awareness of MM and other community members regarding the importance of autonomy for MWs to be able to make decisions to visit healthcare centres. This study also found that strengthening collaboration and partnerships between healthcare workers and the community was a means to create a platform where critical information regarding healthcare related issues could be discussed. A tailored practice framework to facilitate healthcare decision-making and autonomy practices among MW in northern Nigeria was developed.

Conclusion: The findings from the study confirm that although autonomy for MW for making health-seeking decisions is one of the critical factors that influence health seeking behaviour, several socio-demographic and socio-economic factors are also responsible for health-seeking behaviour.

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GLOSSARY OF TERMS

Autonomy: The ability to make your own decisions without being controlled by anyone else, or the right of an organisation, country or region to be independent and govern itself (Cambridge Advanced Learners Dictionary and Thesaurus Dictionary 2018).

Access to health care: Health care access is defined as being able to access a service, a provider, or an institution, by consumers of health care so as to be able to use appropriate services with regards to their health needs (Levesque, Harris and Russell 2013).

Framework: A particular set of rules, ideas, or beliefs which you use in order to deal with problems or to decide what to do (Merriam-Webster.com Dictionary. n.d.)

Health seeking behaviour is any action or inaction of individuals who perceive themselves to have a health problem, or to be ill, for the purpose of finding an appropriate remedy (Latunji and Akinyemi 2018).

Health facility: Any location where health care is provided. These range from small clinics and doctors' offices to urgent care centres and large hospitals with elaborate emergency rooms and trauma centres. Health facilities may be owned and operated by the government, non-governmental organisations, profit business and in some cases by individuals (Ahmadi-Javid, Seyedi and Syam 2017).

Maternal mortality: This is death that occurs to women during pregnancy or 42 days after pregnancy termination. Notwithstanding the duration of pregnancy, the death must be caused or aggravated by the pregnancy and not by accidental or incidental cause (World Health Organization [WHO] 2013).

Maternal morbidity: Defined as chronic and persistent ill-health occurring as a consequence of complications of pregnancy and childbirth (Graham *et al.* 1995).

LIST OF ACRONYMS

Acronym	Full term
ANA	American Nurse Association
FRN	Federal Republic of Nigeria
HPM	Health Promotion Model
HIV	Human immunodeficiency virus
ICPD	International Conference on Population and Development
LRCMWAFF	Lemu Rural Community Married Women Autonomy Facilitation Framework
MM	Married Men
MW	Married Women
MPMWAFF	Mary Paul Married Women Autonomy Facilitation Framework
MMR	Morbidity and mortality rate
NSHDP	National Strategic Health Development Plan
NDHS	Nigeria Demographic Health Survey
NHP	National Health Policy
NHA	National Health Act
NPCN	National population commission Nigeria
NC	North-Central
NE	North-East
NW	North-West
SE	South-East
SS	South-South
SW	South-West
WHO	World Health Organization

OUTLINE OF CHAPTERS

CHAPTER 1: OVERVIEW OF THE STUDY

Presents the introduction and background, aim, objectives, research questions, problem statement and significance of the study.

CHAPTER 2: LITERATURE REVIEW

Presents a literature review covering healthcare-seeking behaviour among MW globally, internationally, nationally and locally with the aim of gaining a broader perspective regarding health-seeking autonomy among MW in other settings as well as Nigeria, and strategies used to address challenges in this regard.

CHAPTER 3: THEORETICAL FRAMEWORK

The theoretical framework that guided the study is presented, including details on how it was applied to the study.

CHAPTER 4: RESEARCH METHODOLOGY AND DESIGN

Presents step-by-step description of the research methodology and design that was used for the study including strategies to ensure research rigour and ethical considerations.

CHAPTER 5: PRESENTATION OF FINDINGS

Presents the findings of the study, highlighting themes and the sub-themes that emerged from the interviews and findings on triangulation of selected data components.

CHAPTER 6: DISCUSSION OF FINDINGS

Discusses the findings in relation to peer and non-peer reviewed literature.

CHAPTER 7: DEVELOPMENT OF A FRAMEWORK TO PROMOTE AUTONOMY FOR HEALTH SEEKING BEHAVIOUR AMONG MARRIED WOMEN IN NORTHERN NIGERIA

Details on development and verification of a framework to facilitate healthcare decision-making and autonomy practices among MW in northern Nigeria **are provided**.

CHAPTER 8: A FRAMEWORK TO PROMOTE AUTONOMY FOR HEALTH SEEKING BEHAVIOUR AMONG MARRIED WOMEN IN NORTHERN NIGERIA

This chapter presents the framework developed to facilitate healthcare decision-making and autonomy practices among MW in northern Nigeria

CHAPTER 9: SUMMARY OF FINDINGS, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

A summary of findings on data analysis and interpretation including conclusions, limitations and recommendations **is provided** .

CHAPTER 1: OVERVIEW OF STUDY

1.1 INTRODUCTION

Morbidity and mortality rates (MMR) continue to be a major healthcare problem in developing countries such as Botswana, Cameroon, Chad, Congo, Guyana, Lesotho, Namibia, Somalia, Swaziland, Zimbabwe, Nigeria, South Africa and many others (Lawson and Keirse 2013).

Over 300 000 women die annually worldwide from preventable causes related to pregnancy and childbirth (United Nations International Children's Fund 2014; World Health Organization [WHO] 2015a). The WHO (2019) reported that approximately 830 women die every day from preventable causes of death in developing countries. The majority of these deaths are often as a result of disparities that prevail in health care delivery, especially in rural areas. These disparities include inaccessibility, unavailability of health care facilities, inadequate material, lack of human resources, poor road infrastructure to facilitate the utilisation of ante natal care, and difficult access to health care providers by pregnant women (Arthur 2012). Solnes Miltenburg *et al.*, (2016) attest that socio-economic status such as education, occupation, and income of women and their families are the most important indicators for the utilisation of maternity care services. However, the cultural and social beliefs of the community cannot be overlooked due to their influence on the decision to utilise health care services. Cultural diversity means that each community group has their inherent belief **systems**, traditions, and lifestyles, which are responsible for people having different preferences in terms of healthcare-seeking behaviour (Karout *et al.*, 2013). This sometimes leads to poor or **no utilisation** of health care services by the female gender.

1.2 BACKGROUND

In south and southeast Asian countries like Nepal, India, Pakistan, and Bangladesh, about 225 million women lack the autonomy to seek health care and make decisions about their health (United Nations Fund for Population Activities [UNFPA] 2016). Women's health and autonomy are global concerns associated with reproductive health behaviour, and has emerged as a focal point of investigation and intervention worldwide. To improve healthcare and access

to services for women, international conferences such as the Safe Motherhood conference in 1987 and the International Conference on Population and Development (ICPD) in 1994 proposed several interventions regarding women's autonomy and healthcare (McLemore *et al.* 2018). In the Cairo 1994 and Beijing 1995 United Nation's conferences, the role of women was a priority area in terms of sustainable development, reproductive health, and health challenges of women generally (McLemore *et al.* 2018). At the ICPD (2014) meeting, an agreement was reached to improve women's status. Much of the increased attention given to married women (MW), and women in general, is to focus on the reduction of maternal mortality.

In developed countries where women have access to all aspects of basic health care and good antenatal care, childbirth is a positive and satisfying experience (Rivera-Franco and Leon-Rodriguez, 2018). In contrast, in developing countries, the opposite is the case. Adhikari (2016) found in Bangladesh that the ability of women to seek healthcare is low, and in Nepal that the lack of healthcare decision-making autonomy was a contributing factor in reduced maternal health services utilisation. These findings are similar to those of Mistry, Galal and Lu (2009) in India. Similarly, a study conducted in South Asian countries ,such as Nepal, Bangladesh, and India have reported that women's healthcare decisions were made without their participation (Senarath and Gunawardena 2009). A study in northern Tajikistan by Nabieva and Souares (2019) explored factors influencing the decision to seek health care among labour migrants' wives and found that 100 000 deaths occurring in a year could have been prevented if appropriate access to rural health care services was available. Not having the freedom to access healthcare poses a threat to women's welfare, particularly in the aspect of healthcare decision-making. Chasowa, Kandodo, Jack and Kambalu (2015) attest that in most rural areas, males, and sometimes mothers-in-law, are responsible for a woman's health care decisions.

A study in Ethiopia reported that even though women from sub-Saharan African countries are often perceived to have less control over resources and participation in reproductive health decisions (Makinwa and Jensen 1995; Alemayehu and Meskele 2017), healthcare decision-making autonomy should not be over-generalised due to the extent of control men have over their wives. The Control over wives differ from place to place. For example, evidence from Ethiopian demographic and health surveys showed that nearly a quarter of MW had no health care decision-making autonomy (Alemayehu and Meskele 2017).

In the northern part of Nigeria, men mostly take the healthcare decision for MW without women's involvement (Osamor and Grady 2016). Men feel that by making decisions for women they are protecting their wives; the women, on the other hand, see this protection as a way of curtailing their healthcare decision-making autonomy (Princewill *et al.* 2017a). Freedom is essential for MW for decision-making in a range of healthcare situations. Utilisation of healthcare services by choosing among treatment options and autonomy that supports healthcare decision-making is associated with better health outcomes (Osamor and Grady 2017).

Women's status in developing countries is in many cases related to their educational, economic and political position in society, which frequently limits their decision-making power because of the patriarchal system in place. In a lot of regions in developing countries like Nigeria, the lower social status of women is a significant social determinant of healthcare-seeking potentials of women; socio-economic factors such as poverty, education, income, and occupation are also some of the most consistent predictors of healthcare-seeking autonomy (Hausmann-Muela and Muela 2003). Nigeria is a multi-lingual, multi-cultural and multi-religious country where patriarchy is being practised. A recent study in Nigeria by Princewill *et al.* (2017b) indicated that the social and cultural discrimination experience of girls and women in developing countries is a result of the belief that men are superior to women, thereby denying women their autonomy, which in turn affects their healthcare choices.

There are also cultural and religious taboos, norms and control over resources that prohibit MW from exercising autonomy in terms of healthcare services, impacting negatively on their healthcare choices, access, and affordability (Araromi (2018). Cultural and religious norms, such as early marriages and high parity among MW and girls in the northern parts of Nigeria, contribute to the poor use of healthcare facilities provided in that region of the country (Umar and Bawa 2015). Practices that place women in the care of their husbands or male relatives are more common in the northern region than Nigeria's southern region (Umar and Bawa 2015).

1.3 PROBLEM STATEMENT

Autonomy to seek healthcare among MW is a major challenge in most developing countries including Nigeria. Cultural and religious beliefs affect the women from Nigeria, who are more likely to die due to reproductive-related complications and other disease conditions, such as,

HIV/AIDS, hypertension, and more others, due to the lack of autonomy to seek healthcare early (National Population Commission (NPC) and ICF Macro. 2009). In most African countries, women are culturally considered inferior to men, and, therefore, the family, clan, and political system reflect traditional patriarchal attitudes and practices. In the northern region of Nigeria, the right of women to utilise healthcare services remains the husband's responsibility or other elders in the family, such as grandparents or parents-in-law. This patriarchal way of thinking has been passed down through many generations (Jegade 2009; Okemini and Adekola 2012; Sai and Nassim 1989). Women with educational attainment belonging to professional employment such as lawyers, health workers, and teachers are likely to have the autonomy to seek healthcare compared to those who are illiterate, unemployed and those who have no access to seek healthcare (National Population Commission (NPC) and ICF Macro. 2009), MW's healthcare outcomes are generally poor in sub-Saharan Africa and south Asia due to lack of autonomy for MW to make decisions for their healthcare needs.

Women's autonomy is important for better healthcare decision-making. According to Osamor and Grady (2017), autonomy is considered to be essential for decision-making in a range of healthcare situations, from healthcare-seeking and utilisation to choosing among treatment options. Autonomy that supports healthcare decision-making is associated with better health outcomes. According to Ononokpono and Odimegwu (2014), information relating to MW healthcare and the factors influencing such behaviour is crucial considering the poor maternal health situation in Nigeria. Women should have the freedom to access general healthcare services and exercise reproductive rights, especially to have access to basic focused antenatal care services, without the encumbrances of patriarchy, financial or geographical inhibitions impacting their overall health (Olonade *et al.* 2019).

Although the Nigerian government through the Ministry of Health has invested its resources purposely to reduce the barriers of autonomy faced by MW in Nigeria, MW healthcare in Nigeria has remained poor (National Population Commission (NPC) and ICF Macro. 2009). Several studies have been conducted on women's autonomy to seek health care, most of which have used access to and control over resources, participation in household decisions, mobility, freedom from domestic violence, and self-esteem to measure women's autonomy (Alemayehu and Meskele 2017; Tiruneh, Chuang and Chuang 2017; Wado 2018). However, challenges still exist in conceptualizing and measuring women's autonomy and **the many inequities** (Osamor

and Grady 2017). Delays in rectifying health care are largely due to lack of direction, and policy-makers' failure to guide the translation of policy rhetoric into health actions. This affects the global autonomy and decision-making of every individual. The philosophy of health-seeking behaviour and autonomy is **also** an important component of global health transformation processes during this uncertain time of **the COVID- 19 infection**.

1.4 1.4 AIM OF THE STUDY

The study aimed to develop a framework to promote healthcare decision-making autonomy among MW in northern Nigeria.

1.5 STUDY OBJECTIVES

The objectives of the study were to:

- Explore the process of healthcare decision-making and autonomy practices among MW in northern Nigeria.
- Determine and describe the untoward outcomes experienced by MW due to the inability to make their own healthcare decisions.
- Explore the awareness of MM regarding the untoward outcomes experienced by MW due to the inability to make their own healthcare decisions.
- Determine the perspectives of MM regarding healthcare decision-making and autonomy practices among MW in northern Nigeria.
- Determine the perspectives of MW regarding healthcare decision-making and autonomy practices among MW in northern Nigeria.
- Explore possible strategies to promote healthcare decision-making autonomy among MW in Nigeria.
- Develop a framework to facilitate healthcare decision-making and autonomy practices among MW in northern Nigeria.

1.6 RESEARCH QUESTIONS

1.6.1 Broad question

The study aimed to answer one broad question which was:

- What would be an ideal framework to facilitate healthcare decision-making and autonomy among MW in northern Nigeria?

1.6.2 Sub-questions

The study aimed to answer the following sub-questions to achieve the aim of the study:

- What were the practices regarding healthcare decision-making and autonomy practices among MW in northern Nigeria at the time of the study?
- Which were the challenges experienced by MW in northern Nigeria due to inability to make their own healthcare decisions?
- Were the MM aware of the untoward outcomes experienced by MW in northern Nigeria due to inability to make their own healthcare decisions?
- What were the perspectives of MM regarding healthcare decision-making and autonomy practices among MW in northern Nigeria?
- What were the perspectives of MW in northern Nigeria regarding healthcare decision-making and autonomy practices among MW in northern Nigeria?
- Which strategies according to the MW and MM can promote healthcare decision-making autonomy among MW in northern Nigeria?

1.7 RESEARCH DESIGN

A qualitative descriptive research design was employed whereby data were gathered from both the MW and the MM through semi-structured interviews and focus group discussions (FGDs).

1.8 RATIONALE AND SIGNIFICANCE OF THE STUDY

The proposed study intended to explore and describe the process of decision-making among MW in northern Nigeria and to explore the perspectives of MW and the MM regarding healthcare-seeking autonomy in northern Nigeria in order to identify possible strategies to promote healthcare decision-making autonomy amongst MW in northern Nigeria and ultimately develop a framework to promote healthcare decision-making autonomy for MW in this country as one of the strategies to improve maternal outcomes.

Some countries where full autonomy is allowed have experienced a low death rate of women at the point of childbearing/delivery (Snow 2011). Therefore, interventions to promote MW's autonomy in decision-making regarding antenatal, delivery, and postnatal services, may influence the rate of death of woman who give birth at home without antenatal care (ANC) services during the period of pregnancy. The adoption of the intervention may also improve the healthcare of children in the northern part of Nigeria .**The findings of this study can also act as levers to guide legislation that will assist women with autonomous decision-making with ANC, delivery and postnatal services.** Such legislation may promote a new awareness of child delivery and care services among mothers across Nigeria.

Although several studies have been conducted to explore women's autonomy regarding antenatal, delivery, and postnatal services, no studies have been undertaken to develop a framework to promote healthcare decisions among MW in the northern part of Nigeria. Thus the aim of the researcher was to develop a framework to promote healthcare decision-making among MW in northern Nigeria.

The findings and recommendations from this study can be used by policy makers at national and local levels to influence new and amendments to existing policies and practice guidelines. The framework will also assist health care services in ensuring that practices adopted are safe and within socially accepted norms.

1.9 CHAPTER SUMMARY

The chapter provides an overview of the study. The objectives of the study together with the problem statement and rationale are outlined. The next chapter reviews the outline and discusses relevant literature concerning healthcare-seeking behaviour among MW globally, in African countries, and in northern Nigeria particularly.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

This chapter surveys the evidence in the literature related to the **current study in order** to have a broader picture on the topic of inquiry and gain a broader perspective regarding research work already done in this regard. This chapter therefore presents findings in the literature related to the global, African and Nigerian perspectives of healthcare-seeking behaviour among MW and the challenges thereof. Other relevant information in line with the healthcare-seeking behaviour of MW and autonomy of women is also presented. This includes the presentation of an overview of Nigeria as a country highlighting the geographical demarcation, healthcare services provision, and challenges such as mortality rates and existing strategies instituted to address healthcare challenges.

Many studies on the healthcare-seeking behaviour of MW have produced various findings on the issues of MW and healthcare seeking behaviour. The literature reveals that MW's healthcare outcomes or healthcare-seeking behaviour are generally poor in sub-Saharan Africa and south Asia. The two sub-regions have a high maternal mortality rate as a result of the poor healthcare-seeking behaviour of MW. A strong body of evidence suggests the presence of a positive association between autonomy and healthcare-seeking behaviour, with specific reference to ANC. Nayak and Varambally (2017) describe women's autonomy as the ability to make decisions on one's own, and to control one's body without consultation with, or asking permission from, another person.

2.2 STRATEGIES USED TO SEARCH THE LITERATURE

Various electronic databases such as Cumulative Index to Nursing and Allied Health Literature (CINAHL), medical literature online (Medline), PubMed, and the EBSCO search engine focusing on nursing journals, were used to search for literature (Figure 2.1). Full-text peer and non-peer-reviewed journal articles published within the past five years were considered to ensure that the information gathered was topical, relevant and current. Supplementary materials were obtained through rigorous, sound internet sites searches, local and interlibrary online and

on-shelf books, and government publications. Selected theses, dissertations, conference proceedings, newspaper articles, blogs and reports were used sparingly (only when scientific articles were not available).

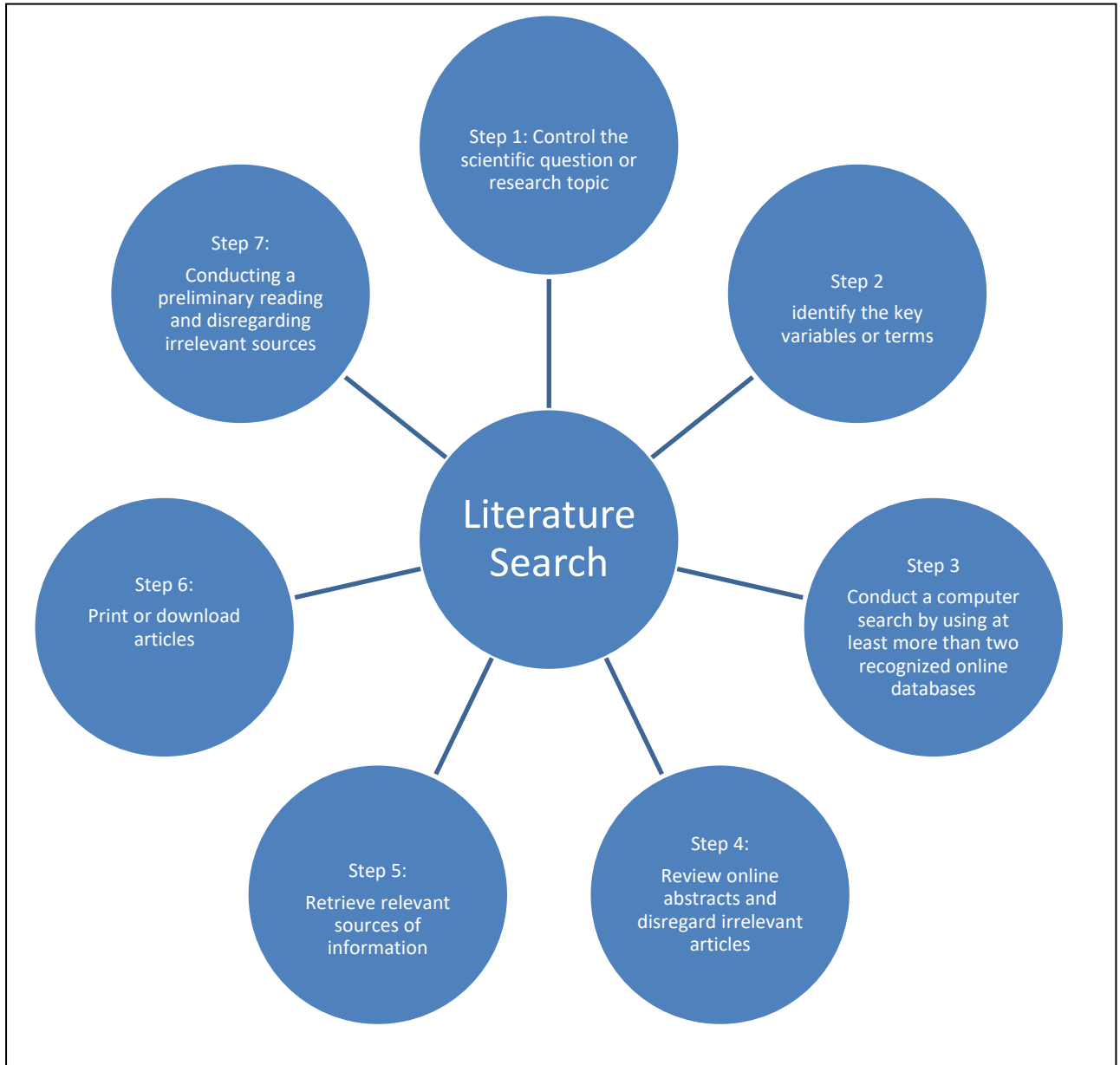


Figure 2.1: Steps for conducting a literature review

Source: LoBiondo-Wood *et al.* (2014: 97)

To facilitate the identification of the key variables or terms while conducting a literature search, a mind map was drawn. The creation of the mind map assisted in the formulation of keywords and the identification of key search terms. The focus was on MW and the key variables were

health seeking behaviour, access to health care services, and autonomy. These three variables were used as the key search terms focusing on the global, African and local context. Countries like, South Africa, Ghana and some other African countries were used for the African context and Nigeria for local context but focusing mainly on the rural areas in Nigeria. A list of relevant sub-terms was included under each key term as reflected in Figure 2.2. The search terms were initially used individually and then combined using Boolean operators AND, OR and NOT, which are the three most widely used to expand or delimit the search (Polit and Beck 2021).

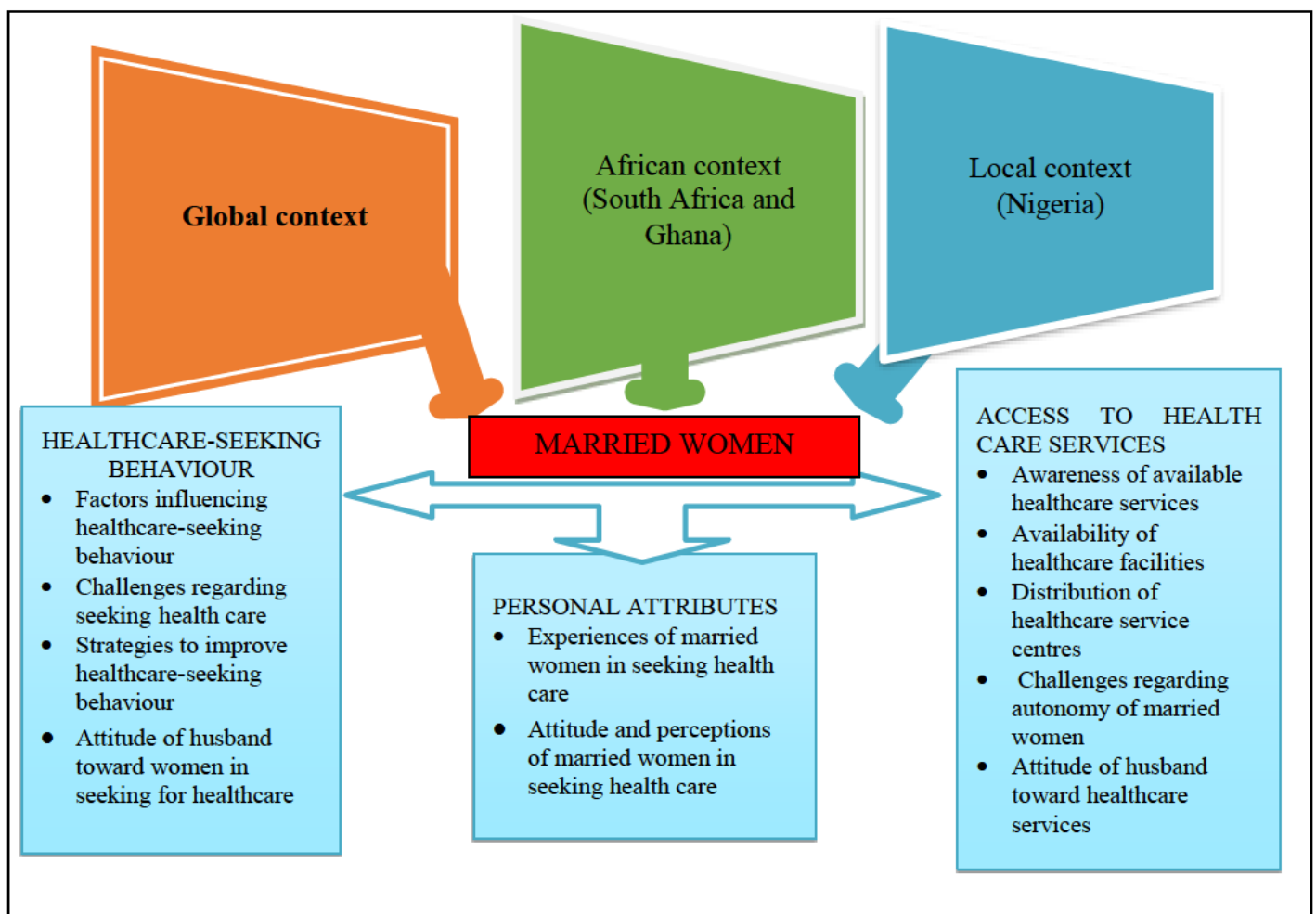


Figure 2.2: Mind map and search terms used for the literature search
Sources: Paul (2018), Beel and Langer (2011)

2.3 GLOBAL OVERVIEW RELATED TO AUTONOMY TO SEEK HEALTHCARE SERVICES

Globally, men often control decisions about the health of their wives and children, including the family’s use of healthcare services (Baker *et al.* 2011). A large number of women continue

to face inequalities in the area of the decision to seek healthcare. Globally, there are about 225 million women who lack the autonomy to seek healthcare or make a decision for their health (UNFPA 2016). Women in developing countries have been observed to have less freedom to act, have less personal autonomy, and have limited access to information, compared to their husbands (Zakuan and Hassan 2019). This implies less access to healthcare, specifically maternal healthcare, resulting in increased maternal mortality. Data shows that more than 20% of Haitian women are not empowered to make their own healthcare decisions, while in Mali, 79% of the laws and regulations guaranteed full and equal access to reproductive health and rights. Several studies show that in most parts of south Asia and parts of west Africa, women commonly have less power and autonomy than men in making decisions about their healthcare (Osamor and Grady 2017; Thapa Sharma, and Khatiwada 2014; Senarath and Gunawardena 2009).

A study by Bhandari, Kutty, and Ravindran (2016) in the Kapilvastu district of Nepal studied women's autonomies as being: decision-making autonomy, financial autonomy and freedom of movement autonomy. The findings from this study showed that overall the women's autonomy status was poorer than expected in the Kapilvastu district. Bhandari, Kutty, and Ravindran (2016) discovered that women's autonomy was significantly linked with higher age differences in marriage, advantaged caste/ethnicity, a higher level of education of women and their husbands, and better husband occupation and economic condition of the family.

Appraising the level of education among women, findings were revealed by studies from two Asian countries, Bangladesh and Nepal, where a higher level of education, residence in urban areas, increased age and a greater number of living children, exhibited positive and significant relationship with greater autonomy (Haque *et al.* 2012; Acharya *et al.* 2010). According to Senarath and Gunawardena (2009), who examined women's autonomy regarding their healthcare decisions in three Asian countries accounting for age, education, employment status and living children, the decision-making power of women concerning their healthcare was relatively very low in Nepal compared to Bangladesh and India. Senarath and Gunawardena (2009) and Umar (2017) recommended a free education policy for both males and females to encourage an increase in enrolments in schools, and a clear policy framework on employment for men and women, with an increase in educational attainment for women being a goal of the policy.

Several factors such as gender equality, women's empowerment and socio-economic status have been identified as being responsible for influencing women's autonomy status. Das *et al.* (2010) observed that poverty, customs and cultural norms, lack of time to get to the healthcare facility, and lack of institutional access, were found to be the key factors that influence healthcare-seeking behaviour. Also, indicators on healthcare services present in a community have been identified as a significant predictor of healthcare-seeking behaviour.

In terms of women's empowerment, Bangladesh ranks 100 out of 128 countries in terms of gender equality as reported by the global gender gap index of 2007 (Hausmann, Tyson and Zahidi 2007). Mainuddin *et al.* (2015) studied women's empowerment and its relationship with healthcare-seeking behaviour among MW in Cox's Bazar district, a rural area in Bangladesh, and showed that only 12% of MW decide on their own to seek healthcare services. This shows that women's empowerment has a profound influence on the use of healthcare services for MW, especially in relation to reproductive health outcomes and other disease conditions.

Healthcare-seeking behaviour is not only dependent on the individual's choice but also on the socio-cultural setting of the communities. Thus, cultural beliefs and practices, cost, gender, and distance were found to be related to healthcare-seeking behaviour (Shaikh *et al.* 2008; Griffiths and Stephenson 2001). Several diversities in healthcare-seeking behaviour were observed across all wealth quintiles, with women in higher socio-economic status utilising ANC services and skilled birth care services at a higher rate. This implies that the level of financial resources available to an individual can positively influence healthcare-seeking behaviour. Koenig *et al.* (2007) observed that concerns over medical costs and noticeable socio-economic disparities are major obstacles to healthcare-seeking behaviour in urban and rural Bangladesh.

Ojanuga and Gilbert (1992) conducted a methodical review of the access of MW to healthcare in developing countries, and found that socio-cultural factors can harm the access of MW to healthcare. Most women from Islamic countries, for example, have no place outside of their home and have few alternatives to economic independence. Also, the segregation and the restriction of Muslim women from public places by the cultural institution of purdah has a great effect on healthcare availability (Ojanuga and Gilbert 1992). Shaikh and Hatcher (2004), noticed that men control most of the resources and the decision of when and where women should seek healthcare rests solely with the men in countries like Pakistan and women are not

allowed to visit a healthcare facility or healthcare provider alone. According to Shaikh *et al.* (2008); Griffiths and Stephenson (2001). and Shaikh and Hatcher (2004), this lack of freedom to seek healthcare without the approval of the husband or head of the family may lead to a lack of attention to one's health and the inability of women to have access to healthcare even during emergencies.

2.3.1 Consequences of lack of female health seeking autonomy

The antenatal, delivery, and postnatal services recommendations notwithstanding, data from various countries indicate that maternal/women's autonomy to seek healthcare services is still lacking thus leading to most women not having access to maternal healthcare services (Titaley *et al.* 2010). About 830 women die every day from complications related to preventable health conditions, especially reproductive health conditions, as a result of non-clinic attendance and delay in seeking and reaching healthcare centres or providers early, due to lack of autonomy (WHO 2015a). Most of these deaths **occurred** in low-income countries like Nigeria and Kenya.

Intervention to overcome: The healthcare law in Mali guarantees access to maternal healthcare for women so this country is one of several countries with legal measures put in place to protect women's autonomy and women's experience (United Nations Population Fund 2020). India, accounting for 17% of the world's population making it the second-most populous country in the world, also has several interventions that have been designed and implemented under the banner of safe motherhood programmes. These governmental and non-governmental corporate organisations encourage gender equality and empower women through the creation of policies that emphasise women's education and access to healthcare services (Nayak and Varambally 2017; Self and Grabowski 2012).

2.4 AFRICAN COUNTRIES' PERSPECTIVES REGARDING HEALTH SEEKING BEHAVIOURS FOR WOMEN

In Africa, positions of power in the community and family are exclusively held by men who have absolute power to serve as custodians, making it impossible for an African woman to practice autonomy (Faneye 2011; Jegede 2009; Tangwa 1996; Wiredu 1980). Osamor and Grady (2018) conducted a study in Kenya and concluded that a vital factor in women's capability in sub-Saharan Africa for accessing and using skilled healthcare services depended

on discussion with family members first and afterwards making decisions. Furthermore, a couple's joint decision-making supported women's health outcomes especially when both couples take decision together rather than decisions made by only one partner (Story and Burgard 2012).

Fotso *et al.* (2009) found that women's autonomy encouraged the use of healthcare services among the middle income and least poor groups in the slums of Nairobi. Another study carried out in the Teso district of Kenya, observed that barriers to women seeking health care included unavailability and inaccessibility of healthcare facilities, poverty, high charges and poor healthcare services being provided at local and state levels of healthcare facilities (Ikamari 2004; Ononokpono and Odimegwu 2014). Among women in Ethiopia, autonomy was thought to be linked to maternal healthcare-seeking behaviour, with MW with greater autonomy having a higher likelihood of seeking health care than MW with lower autonomy. Additionally, socio-economic status, birthplace and order and area of residence have been observed to be related to the health seeking behaviour of MW (Ethiopian Society of Population Studies 2005). Furthermore, traditions and beliefs influence the use of maternal healthcare services among married woman.

Literature search has further yielded that education has been an important and influential determinant of healthcare-seeking behaviour and a perpetrator of inequalities in health (Tipping and Segall 1995). Education is related to knowledge, which enables or constrains an individual's capacity to act on health messages and access available services. Healthcare-seeking behaviour can influence an individual to future healthcare inequities as ill-health during childhood can affect academic attainment and accomplishment (WHO 2010). In African countries, the dominant findings in the literature are that education is an important factor of healthcare-seeking behaviour with lower levels of education connected with a reduced probability of seeking health care (Anselmi *et al.* 2015: 1-13; Njuki *et al.* 2014; Zyaambo *et al.* 2012). In contrast to this view, a study by Frie, Eikemo and Von Dem Knesebeck (2010), examined the healthcare-seeking behaviour of populations in 24 developed European countries and found a different effect with lower levels of education revealing increased healthcare-related activity.

A study conducted in Zambia aligns education to increased knowledge about ill-health, emphasizes how to to recognise symptoms, and increased awareness about where to go when sick Mubita-Ngoma (2016). Furthermore, Mubita-Ngoma, (2016) describes the factors that influence the health status of women as being the educational level, unemployment, poverty, nutrition status, violence against women, gender inequality, health seeking behaviour, representation in leadership positions, marital obligations and early marriages, socio-cultural factors, reproductive health and maternal morbidity and mortality. Education is an indicator of socio-economic status and educational attainment generally results in better employment and income which allows the individual a wider range of choices when it comes to healthcare (Zyaambo *et al.* 2012). Higher levels of education translate to improved maternal health outcomes (Edwards 2016; Albert and Davia 2011; Chou *et al.* 2010: 33-61), improved adolescent health (Viner *et al.* 2012), and reduced morbidity and mortality (Baker *et al.* 2011). The Marmot Review of health inequality reported that obtaining a tertiary education is connected with increased health and long life (Marmot 2010). Consequently, education can be suggested to be a significant factor in improving the life trajectories of population groups at the same time as reducing health inequalities that arise from disparities in healthcare-seeking behaviour. **Notably**, as the level of education increases, so does the likelihood of positive health outcomes (Zimmerman, Woolf and Haley 2015).

A study conducted in Burkina Faso found that increased educational attainment improved the likelihood of residents visiting a formal healthcare service provider (Beogo *et al.* 2014). A possible explanation for this was provided by Caldwell *et al.* (2014) who found that misconceptions and myths deterred people from seeking treatment from the formal healthcare sector as uneducated groups tend to perceive orthodox medicine as too strong for the treatment of their health conditions.

In Burkina Faso, husbands have to cover their wives' health expenses. Nikiema, Haddad and Potvin (2012) found that permission to go for care may be refused, or even not requested, when household resources are scarce and the woman herself is lacking personal money to contribute. The authors also showed that getting money for treatment and getting permission may be problematic with poor inter-spousal or intra-household relations, when the women's bargaining skills are poor. Pregnant women have to overcome several barriers to access medical care, particularly social, geographical and financial problems. Healthcare facilities are often far from

people's homes, particularly in rural areas, and transport is not dependable and is expensive (Burkina Faso Amnesty international 2010).

In South Africa, about 87% of MW participate, either alone or jointly with their partners, in the decisions about their healthcare and major household purchases, while 41% make decisions alone about their healthcare (South Africa. Demographic and Health Survey [SADHS] 2016). The South African Government, since the end of apartheid, has had the opportunity to create a new legal agenda for women and permit contributory reproductive health-related laws and rules that aim to give women whole control or autonomy over their reproductive choice (Lomelin 2013). Despite the progressive South African laws that allow women the freedom and autonomy to make reproductive choices, a research study by Orner (2011) found that an African woman's subordinate role in a patriarchal society affects reproductive decisions and choices. Furthermore, black South African women feel that men hold the superior role and often regard themselves as the "head" of women, thus having control over the woman's reproductive role; this influences a woman's decision to seek healthcare. In addition to the influences of a partner, women face pressure from family and community regarding reproductive decisions (Varga 2002).

Ghana is a **West** African country, covering a total land area of 238 305 square kilometres. Health service provision in Ghana is ordered at three levels, namely, primary, secondary, and tertiary, with their corresponding levels of management as national/central headquarters, regional, and district. Preventive and curative healthcare service delivery in in Ghana is generally decentralised, and the healthcare system is organised under four main groups of delivery systems: public, private-for-profit, private-not-for-profit, and traditional systems (Abor, Abekah-Nkrumah and Sakyi 2008). Like many countries in sub-Saharan Africa, Ghana has had a persistently high maternal mortality rate (Witter *et al.* 2007). According to the WHO's most recent estimates, Ghana's maternal mortality ratio stands at 380 per 100 000 live births (WHO 2014). Maternal mortality accounts for 14% of deaths among females aged 12–49 years and is the second-largest cause of female mortality after infectious diseases among women of childbearing age (Abor, Abekah-Nkrumah and Sakyi 2011). Although Ghana has since 2003 applied a maternal healthcare policy that provides free maternity care services in all public health facilities, disparities in skilled care services accessibility and utilisation still exist (Ganle 2014; Ganle 2007; Witter *et al.* 2007). Limited access to preventive and curative

healthcare services, inadequate health infrastructure and personnel, and inability to pay (Gage 2007; Bour and Bream 2004) have been recognised as difficult barriers to receipt of maternal healthcare. Research indicates that the supply-side factors alone do not fully explain the variability in women's ability to seek care as considerable gaps in coverage and other socio-cultural barriers remain even after adjustment for the availability of services (Adamu and Salihu 2002; Mumtaz and Salway 2007). Ghanaian studies propose that social factors like religious beliefs, cultural norms concerning pregnancy management and the need to seek permission from husbands and compound heads before care is accessed play important roles in determining whether women deliver at home or in a healthcare facility (Ganle 2007; Ganle, Parker, Fitpatrick and Otupiri 2014; Moyer *et al.* 2013; Gupta *et al.* 2015). Research by Bazzano *et al.* (2008), Mills and Bertrand (2005), Moyer *et al.* (2013) and Gupta *et al.* (2015) suggest that rather than women making decisions to access or use maternal health services by themselves, these decisions are frequently made on their behalf by their spouses or a senior member of their families, such as their mothers-in-law, fathers-in-law, grandmothers, or compound heads. While these studies have provided important insights into how social factors can influence women's ability to access skilled care, few of them have extended their scope beyond rural northern Ghana where families are patrilineal, and the eldest male or compound head typically has the final say in all decisions (Moyer *et al.* 2013).

2.5 NIGERIA'S PERSPECTIVES REGARDING HEALTHCARE-SEEKING BEHAVIOUR FOR WOMEN

In an attempt to understand the situation in northern Nigeria regarding healthcare-seeking behaviour, it is necessary to get an overview of the country to gain a clear understanding of the contributory factors that necessitate and influence healthcare-seeking behaviour such as the provision of services, cultural practices, norms and beliefs and strategies that the country has instituted to address some challenges.

Nigeria, officially known as The Federal Republic of Nigeria (FRN), is a country that is located on the west coast of Africa. The country features 36 states and a Federal Capital Territory (FCT), and is the most populous country in west Africa, and is ranked the seventh-largest country in the world (United Nations Department of Economic and Social Affairs, Population Division 2015). The population of Nigeria is presently 200 962 417 people according to recent

statistics by the WHO (2019), out of which 91 668 667 are classified as urban and 94 791 366 as rural, with women accounting for about half (49.31%) of the whole population. It was also estimated that by 2020 Nigeria was to be the third most populous country in the world (United Nations Department of Economic and Social Affairs, Population Division 2015; of the 2018). The population projection for 2050 is 350 million residents (WHO 2019). Nigeria is a country with great diversity, comprising over 350 ethnic groups and several religions. Over 500 different ethnic clusters exist with different languages (Nigeria Federal Ministry of Health 2008; WHO 2019). The predominant religions in Nigeria are Christianity and Islam, with a few traditionalist religions.

2.5.1 Zonal division of Nigeria

Nigeria is divided into six geopolitical zones: North-Central (NC), North-East (NE), North-West (NW), South-East (SE), South-South (SS) and South-West (SW) (Figure 2.2 and Table 1.1). The six geopolitical zones of Nigeria were created during the regime of the late president, General Sani Abacha. The economic, political and educational resources are often shared across the zones of Nigeria. The six zones were not carved out based on geographic location, but rather states with similar ethnic groups, and/or common political history were classified in the same zone (Eze *et al.* 2014). There was a need for the government to merge similar groups for effective allocation of resources because of different ethnic groups and languages. During the review of the Nigerian constitution in 2014, a memorandum suggested that all six geopolitical zones be recognised and strengthened to function effectively as a new structure in the Nigerian operating system (Yahaya 2019). On the other hand, Chief Nengi James, who was a political activist, advocated that all segments of the country should become one entity and that the geopolitical zones be recognised in the constitution. These groups advocated for the decentralisation of powers so that the geopolitical zones could become autonomous and manage the resources within their zones in a Federal Nigeria (Yahaya 2019). This system of geopolitical zones and states under them was adopted by the President Ibrahim Babangida regime. The states in Nigeria are grouped into zones, which make up Nigeria; the zones are divided according to the economic, political and ethnic preferences of Nigeria: Yoruba in the South-West; Hausa in the North-East and North-West; Nupe, Tiv, Bassa, and Gwari, in the North-Central; Efik and Edo in the South-South; and Igbo in the South-East. The states in Nigeria are made up of various ethnic populations which needed to be properly controlled.

The northern geopolitical zones engage in economic activities like cattle rearing, crop-farming, commerce, seed-oil, tomatoes, onion, potatoes, fishing, flax, groundnuts, as well as coal, tin, and semi-precious stones. The southern geopolitical zones are engaged in activities such as the production of mineral-oil and gas, farming, rubber, nut shells, periwinkle shells, fishing, granite, palm wine, herbal medicine, textile and industrialisation. The region is also rich in crude oil, natural gas, silver, nitrate, ceramics, iron ore, tin, rocks, and produces rice, biter-kola, cashew, breadfruit, yam and cassava.

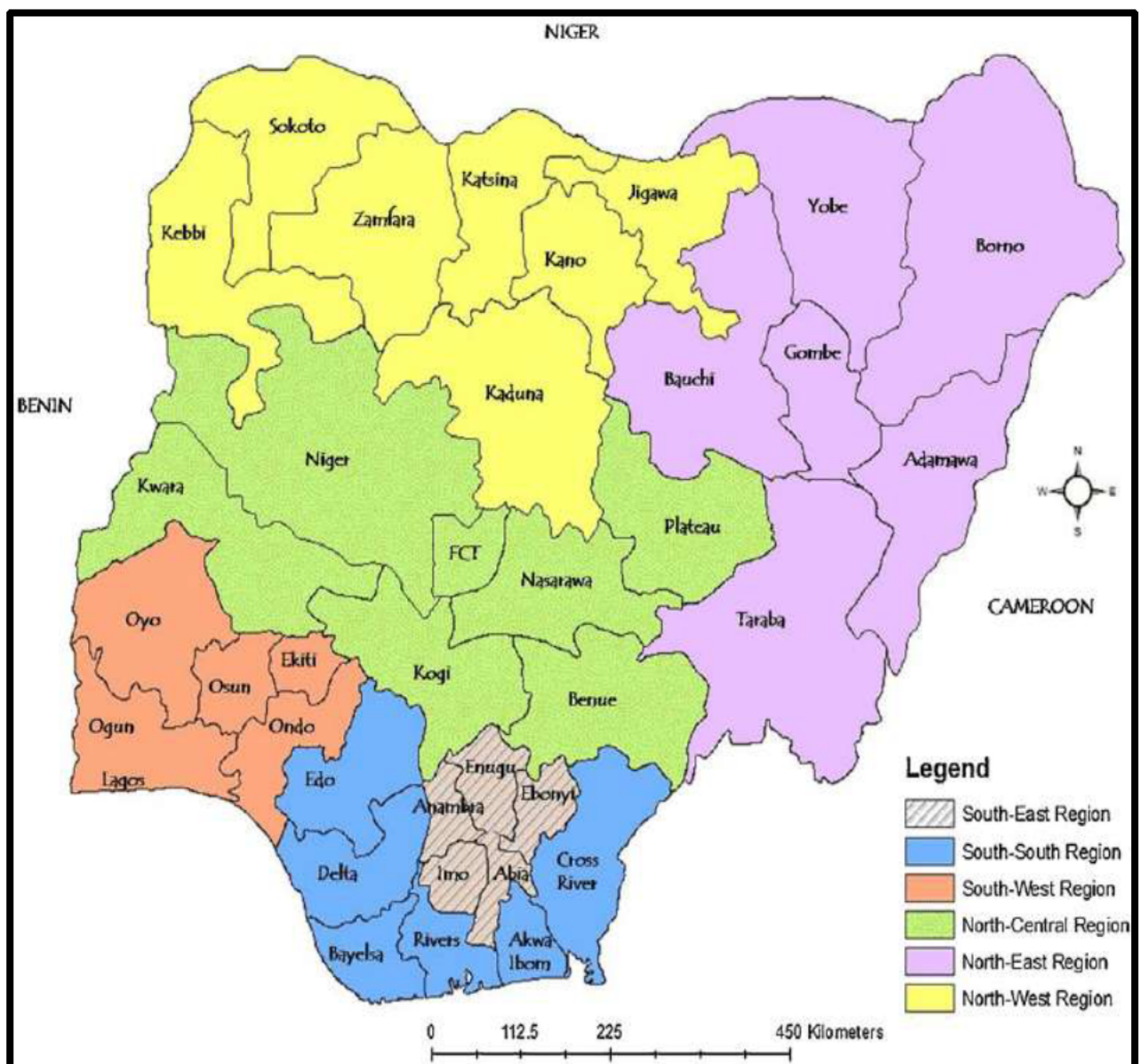


Figure 2.3: Map of Nigeria’s states and zones

Source: Nigeria, National Population Commission Nigeria and International Calverton Funding (2014)

Table 2.1: The six geopolitical zones of Nigeria

ZONES	STATES
NORTH-CENTRAL (NC)	Federal Capital Territory (FCT), Kwara, Kogi, Niger, Benue, Nassarawa, Plateau.
NORTH-EAST (NE)	Adamawa, Borno, Gombe, Taraba, Yobe, Bauchi.
NORTH-WEST (NW)	Jigawa, Kaduna, Kano, Katsina, Kebbi, Sokoto, Zamfara.
SOUTH-EAST (SE)	Abia, Anambra, Ebonyi, Enugu, Imo.
SOUTH-SOUTH (SS)	Akwa-Ibom, Bayelsa, DeIta, Edo, Cross River, Rivers.
SOUTH-WEST (SW)	Ekiti, Lagos, Ogun, Ondo, Osun, Oyo.

Source: (Nigeria Federal Ministry Health, 2008).

2.5.2 Healthcare provision in Nigeria

Healthcare in Nigeria is financed by tax revenue, out-of-pocket payments, donor funding, and health insurance schemes. Nigeria's health expenditure is relatively low even when compared with other African countries. Nigeria's first comprehensive health policy, the National Health Policy and Strategy, was implemented in 1998. Subsequently, the primary healthcare policy was instituted in 2011, and the National Health Act (NHA) finally came into being towards the end of 2014. The Nigerian national healthcare system provides three tiers of care: primary level, secondary level, and tertiary level. The primary level of healthcare is provided by the 774 Local Government Areas (LGA) in Nigeria, the secondary level of care is provided by the governments of the 36 states through the Ministry of Health and the FCT administration, while the responsibility of tertiary care lies with the Federal Government of Nigeria (FGN) through the Federal Ministry of Health (FMH), which also develops policy-guidelines, strategies, plans and programmes (International Association of National Public Health Institutes 2013; Mckenzie, Sokpo and Ager 2014).

However, the lack of a clear definition of responsibilities operated by the three tiers of care by the government of Nigeria has made it difficult for Nigeria to fulfil its commitment to providing universal healthcare. The inadequacies of the public healthcare system in Nigeria has led many, including MW, to seek healthcare in the private system, as well as from traditional and spiritual healers (Nigeria, Federal Ministry of Health 2002). The quality of Nigeria's healthcare institutions is generally poor. Nigeria faces financing challenges in its attempt to provide widespread adequate healthcare coverage. Consequently, the National Health Insurance Scheme (NHIS) was introduced in 2005, whereby those who are employed in the formal sector

and the Federal Government are covered under private company-owned health insurance, with community-based health insurance implemented in a few pilot areas. Out-of-pocket payments continue to be the main source of financing, a situation that has led to disparities in healthcare provision and take-up, pushing the poorest even further into poverty (Uzochukwu *et al.* 2015).

The Nigerian government implemented various policies to address the issue of health financing, including the National Health Policy (NHP), Health Financing Policy (HFP), National Health Bill (NHB) and National Strategic Health Development Plan (NSHDP) 2010-2015 and the life expectancy in Nigeria rose from 41 years old in 1970 to 53 years in 2013 (United Nations International Children's Fund 2014; Uzochukwu *et al.* 2015). Despite this, there continues to be inadequate government funding for healthcare provision. In Nigeria, the health sector comprises the public system under the Federal Ministry of Health, the States Ministry of Health, and parastatal organisations, and the private sector which comprises private for-profit, non-governmental organisations (NGO), and faith-based organisations (FBO) facilities. Healthcare services are provided through many health facilities: teaching hospitals, federal medical centres (FMC), specialist hospitals, general hospitals, rural health centres, and maternal and child-health community centres and dispensaries (International Association of National Public Health Institutes 2013). The teaching hospitals are the referral hospitals, providing sophisticated diagnosis, treatment, and rehabilitative services. The 36 states in Nigeria have at least one teaching hospital each, a specialist hospital and FMC in a few states. The teaching hospitals in Nigeria provide complex healthcare services, which require more complex technology and highly skilled health workers; their resources are highly concentrated and expensive to run. They play the role of training health workers, doctors, basic and postgraduate health professionals, and also provide complex curative and preventive care, receive and manage clients through a good referral system from general hospitals, specialist hospitals, and FMCs. Additionally, they contribute to providing solutions to local and national healthcare problems through research as well as policy-making (International Association of National Public Health Institutes [IANPHI] 2013; McKenzie, Sokpo and Ager 2014).

The FMCs, General Hospitals or State Hospitals, known as the secondary level of care, is the next level of referral comprising surgeons, general medical physicians, paediatricians, general and specialised nurses, midwives and public health personnel. They provide services in several units like intensive care unit (ICU), dermatology, ophthalmology, otology, nose and throat,

accident and emergency, obstetrics and gynaecology, psychiatry, dental services and many more. The rural healthcare centres are the primary level of care staffed by midwives, primary healthcare nurses, and clinical officers, as well as occasionally by a medical officer. They provide a wide range of basic curative and preventive health services for adults and children and perform minor surgical interventions like incision and drainage, reproductive health services, and conduct deliveries. They refer severe and complicated cases to the appropriate levels of healthcare for proper management (IANPHI 2013; Mckenzie, Sokpo and Ager 2014). Dispensaries are the lowest level of care to the public but are always the first point of contact, especially in rural areas. They are staffed by community health extension workers (CHEWs), and primary healthcare nurses, with few professional nurses. They provide ANC services and curative care for out-patients. Private clinics are operated by medical personnel and registered health workers, and mostly provide curative services.

2.5.3 Morbidity and mortality in Nigeria

In developing countries like Nigeria, the MMR continues to be a major health challenge. Nigeria is one of the major contributors to the global statistics on MMR. Globally, according to an estimate by the Maternal Mortality Estimation Inter-Agency Group (MMEIG), 300 000 MW deaths occurred in 2015 (WHO 2015a). Presently, Nigeria has an MMR of 814 per 100 000 live births (WHO 2015b). Iyabo, Sina, and Ayodele (2014) attest that people, especially women and children, die every day due to the poor quality of living. They confirmed that the low level of utilisation of healthcare facilities for antenatal, delivery, and postnatal services in most rural communities has continued to prevail, thereby exposing mothers and children to the highest risk of death due to lack of autonomy, especially among MW. According to Dibaba (2018), very few studies have shown the relation between socio-cultural factors such as unequal gender roles and women's autonomy within the household, with the use of reproductive health services. Women's autonomy and reproductive health researchers have used several indicators, including access to and control over resources, participation in household decisions, mobility and freedom from domestic violence and self-esteem, to measure women's autonomy. A study conducted by Osamor and Grady (2016) on women's autonomy in healthcare decision-making in developing countries revealed that women's autonomy is important for reproductive and maternal healthcare services.

2.5.4 Challenges of Nigerian women in accessing healthcare services

A study that explored healthcare services of married pregnant women carried out by Moore *et al.* (2011) noted that healthcare-seeking behaviour was related to distance from home, absence of means of transportation, lack of money, the hostility of health workers at the health facility, and poor service delivery. It should be noted that Nigeria has a very partial possibility of permitted attention for community defence (Ilo 2014) and over 90% of Nigeria's population is without health insurance coverage (Onwujekwe *et al.* 2011). The Nigerian health system has been developing over the years through healthcare reforms aimed at addressing public health challenges (Scott-Emuakpor 2010). These include the National Health Insurance Scheme (NHIS), National Immunisation Coverage Scheme (NICS), Midwives Service Scheme (MSS), and the Nigerian Pay for Performance scheme (P4P) (Welcome 2011; Wagstaff *et al.* 2006; Haddon 2013; Uneke *et al.* 2013). Thus, the inability to effectively address the country's numerous public health challenges has contributed to the detrimental and high-level of poverty and the weakness of the health system.

Aregbeshola (2019) states that political instability, corruption, limited institutional capacity, and an unstable economy, are the major factors that are responsible for the poor development of health services in Nigeria. Households and individuals in Nigeria tolerate the problem of a dysfunctional and inequitable health system since they actively delay or do not seek healthcare services, and prefer to pay out-of-pocket for healthcare services that are not affordable (Aregbeshola 2019). Although many attempts were made to implement legislation on health insurance since 1960, NHIS was established in 1999 and was launched in 2005. The goals of the NHIS are: ensure access to quality healthcare services, provide financial risk protection, reduce rising costs of healthcare services and ensure efficiency in healthcare through programmes such as the following:

- 1) Formal Sector Social Health Insurance Programme (FSSHIP)
- 2) Mobile Health
- 3) Voluntary Contributors Social Health Insurance Programme (VCSHIP)
- 4) Tertiary Institution Social Health Insurance Programme (TISHIP)
- 5) Community-Based Social Health Insurance Programme (CBSHIP)
- 6) Public Primary Pupils Social Health Insurance Programme (PPPSHIP)

- 7) The provision of healthcare services for children under 5 years, prison inmates, disabled persons, retirees and the elderly (National Health Insurance 1999).

Across the country, pregnant women/MW and children under five years are generally charged fees when accessing healthcare services, despite the federal government's declaration of free healthcare for pregnant women/MW and children under five years in 2005 (Ijadunola 2013).

Umar (2017) made use of the Nigeria Demographic Health Survey (DHS) dataset to study the role of women's education in the determination of their autonomy in the use of medical services during illness, ANC services and delivery periods. The author observed that education has a great influence on the number of ANC visits and place of delivery after age, parity, income, religious and distance factors. The study recommended more education for girls in the country. In Nigeria, according to Umar and Bawa (2015), great gaps exist in educational attainment among the different states of the country, with the zones in the south showing greater levels of education than people in the north. About 70% of women and half of the men have no education in the north compared with 15% of women and 8% of men in the south. The SW has the highest proportion of women (16%) and men (21%) who have completed more than the secondary level of education (Nigeria, Federal Ministry of Health 2008). As can be expected, more women in the southern region are profitably employed and are more likely to be in professional, technical, or managerial occupations. This, in turn, places them in greater wealth quintiles with freedom to seek healthcare compared with their northern colleagues.

Daniyan-Bagudu *et al.* (2016) used logistic regression to examine the household decision-making process of MW in public service and its impact in Nigeria. In their study, it was discovered that there is a substantial positive relationship between the decision-making of women and family healthcare. The authors recommended a programme to promote awareness among husbands about the role of women and the importance of shared decision-making; that is, permitting autonomy for wives or MW. Miller and Roseman (2011) and Orisaremi and Alubo (2012) unanimously agree that there is increased interest in women's rights globally, particularly reproductive rights.

there is increased interest in women's rights globally, particularly reproductive rights (Miller and Roseman 2011)

A recent study in Nigeria by Princewill *et al.* (2017b) indicated that the socio-cultural discrimination against girls and women in developing countries is a result of the belief that men are superior to women thereby denying women their autonomy, which in turn affects their healthcare choices. Reproductive rights are closely related to respect for autonomy since a woman can only exercise her autonomy if she is free to decide for herself. In a recent study in Nigeria, Latunji and Akinyemi (2018) found that as many as 71% of rural dwellers were found to have inappropriate healthcare-seeking behaviour, while only 53% of urban dwellers were reported to have inappropriate healthcare-seeking behaviour (Onwujekwe *et al.* 2011). Furthermore, Nigeria's MW living in areas where the ratio of the population to primary healthcare centres was higher, were less likely to have a skilled health attendant present during illness and childbirth than areas where the ratio of the population was lower (Ononokpono and Odimegwu 2014).

There are differences in who has the decision-making power regarding a woman's healthcare as one moves from one region to another in Nigeria. Only 1.5% of women in the North-West (NW) region can decide on their own, compared to 16.6% in the South-West (SW), while women whose husbands choose alone in SW are 27.2% compared to 83.8% in the NW (Yusuf 2014).

Women in some religions such as the Yorubas (60%), and Christians (30%) have a higher level of decision making autonomy and thus a higher proportion of MW that seek health care than those in the other religions such as Muslims where an estimated 98.7% of MW lack decision making autonomy and thus lesser proportion of women who seek health care. TLack of decision making autonomy for MW is also observed in rural areas 72.8%, compared to 27.2% urban areas which could explain the high MMR reported in rural areas (Umar and Bawa 2015).

Women living in urban areas and in the highest wealth quintiles have a higher level of autonomy and seek health care by visiting health facilities more frequently compared to those living in rural areas with less forms of autonomy and belonging to the poorest wealth quintile.

A 2008 report on reproductive health services in Yobe State shows that the MMR is 1 549 per 100 000 live births (Abdulrahman and Olaosebikan 2017)

Each of the major ethnic groups, particularly the Hausa, Igbo, Fulani and Kanuri have less than 90% adherents of either Christianity or Islam and each have different ethnically driven norms on pregnancy and childbirth.

Cultural and religious norms, such as early marriages and high parity among Nigerian MW and girls in the northern zones contribute to the poorer use of healthcare facilities provided in that region (Umar and Bawa 2015). The authors further reveal that practices which place women in the care of their husbands or male relatives are more common in the northern zones than southern zones. This outcome leads to a loss of independence for women and poor decision-making, which affects their autonomy in seeking health care. It has also been shown that the NE zone has the highest MW maternal mortality rate of 1 549 per 100 000 live births, compared with 165 per 100 000 live births in the SW, which is a ten-fold dissimilarity (Nigeria, Federal Ministry of Health 2005; Umar and Bawa 2015).

A study by Umar and Bawa (2015) in Yobe State, one of the northern parts of Nigeria, found that in the NE zone there are poor healthcare resources. In that study, 89.7% of the respondents were MW, 82% were illiterate, 50% were unemployed and 78.3% belonged to the poorest/poor wealth quintile. In Northern Nigeria, only 6.2% of MW could decide on their own about healthcare for antenatal, delivery, and postnatal services. In comparison, 61.1% of healthcare decisions were by the husband alone, and 32% made a joint decision for healthcare.

Osamor and Grady (2018) state that cultural and traditional, and, in some cases, legal constructs and practices contribute to the low decision-making authority of women. Women's autonomy is constrained by gender stratification and patriarchal authority, and they often have considerably lower social status and autonomy than men (Osamor and Grady 2016; Mason 1987; Balk 1994; Dyson and Moore 1983).

2.5.5 Strategies to improve healthcare services delivery in Nigeria

According to Medic West Africa Informa Markets (2019) the Nigerian healthcare system has made progress in some areas in the last few decades although there are still some niggling issues concerning healthcare in Nigeria that need to be addressed. The WHO (2019) stated that a well-functioning healthcare system needs to have a robust financing mechanism, with well trained and adequately paid workforce. Furthermore, the system needs reliable information on which to base decisions and policies, and well-maintained health facilities and logistics to deliver quality medicines and technology. Aregbeshola (2019) advise that it is necessary to improve the healthcare of mothers in Nigeria, and proposed five practical ways to improve Nigeria healthcare system: integrate adequate medical intelligence and surveillance systems, carry out regular health campaigns and awareness, ensure harmony in the health sector, inform people about the NHIS and support from the government.

2.6 CHAPTER SUMMARY

Chapter 2 presented the literature review **that supports the topic of inquiry and carried out literature searches on the healthcare-seeking behaviour of MW, globally, nationally and locally.** Other relevant information in line with the healthcare-seeking behaviours and autonomy for women was also presented. This chapter **also** presented an overview of Nigeria as a country highlighting the zonal demarcation of the country, healthcare services provision and challenges such as mortality rates, and the strategies instituted to address healthcare challenges. The next chapter will focus on the identification and description of the theoretical framework that will be used to guide the study.

CHAPTER 3: THEORETICAL FRAMEWORK GUIDING THE STUDY

3.1 INTRODUCTION

Chapter 3 describes the theoretical framework adopted for the present study. The researcher begins by describing several theories and models that were reviewed to identify the most suitable one to guide the study and clarifies why those that were not chosen were left out. The selected model is described in detail starting from its origin, its concepts and how it was used to guide the study.

Polit and Beck (2021) define a theory as an abstract generalisation that explains how phenomena are interrelated. According to these authors, a theory classically consists of two or more concepts and a set of propositions that form a logically interrelated system, providing a mechanism for deducing a hypothesis. The **researcher in this study** describes a framework as a conceptual underpinning of a study **that is used** as a structure to hold or support a theory of **the** research study. The authors further explain that a theoretical framework consists of concepts with their definition and existing theory used for a particular study and demonstrates the understanding of theories and concepts relevant to the topic of research that will relate it to a broader field of knowledge in the study. Purushothama (2014) describes a theoretical framework as the construction of concepts that are in the literature, a convenient plan for the study, which provides the organisation of a study, guides the researcher in the classification of results, and therefore monitors the entire research process. In line with these descriptions, the researcher identified and **selected a specific** theoretical framework to guide the study.

3.2 SELECTION OF AN APPROPRIATE THEORETICAL FRAMEWORK TO GUIDE THE CURRENT STUDY

The researcher searched and reviewed several theories, models and frameworks to identify the most relevant and appropriate to guide the study based on the research problem, aim and objectives of the study. Four models were deemed appropriate, namely: (1) The socio-ecological model (SEM) of health promotion, (2) Pender's health promotion model (PHPM),

(3) AI4People framework and (4) Health belief model (HBM). The four models were reviewed in detail and only one model appeared to be most fitting to guide the study, the HBM. A summary of review findings for the three models that were not selected and the reasons why they fell short of providing a framework for the planned study is presented below. The selected model is described including details of how it was used to guide the study.

3.2.1 The socio-ecological model of health promotion

Bronfenbrenner, in 1970, introduced the socio-ecological model (SEM) as a conceptual model for understanding human development and later formalised it as a theory in the 1980s (Kilanowski 2017). The SEM is a theory-based framework for understanding the multi-layered and interactive effects of individual and environmental factors that govern behaviour, and for recognising behavioural and organisational influence, opinions and mediators for health promotion within organisations or individuals; the communication between and interdependence of factors within and across all levels of a health problem (Kilanowski 2017). The framework highlights people's interactions with their physical and socio-cultural environments, and is a useful tool for understanding the range of factors that influence health and wellbeing. It is a model that can assist in providing a complete perspective on the factors that affect specific health behaviour, including the social determinants of health (Kilanowski 2017). This model could have been used as the framework for this study because the study had to do with health behaviour of MW (which is one of the socio-cultural factors that influence healthcare), but it was not because it is more concerned with the environmental behaviour that governs/influences opinion.

3.2.2 Pender's health promotion model

Pender *et al.* (2015), developed the Health Promotion Model (HPM) that is used universally for research, education, and practice. The HPM focuses on helping people to achieve higher levels of wellbeing. It encourages health professionals to provide complimentary resources to help patients achieve behaviour-specific changes. The goal of the HPM is not just about assisting patients in preventing illness through their behaviour, but to look at ways in which a person can pursue better health or ideal health. The HPM is a model that is used to explain and predict the health promotion constituents of lifestyle (Pender *et al.* 2015). The HPM model helps patients through professionals to achieve better healthcare, Nevertheless, is not directly

required for assessing health behaviour. Thus although the model focuses on helping people to achieve higher levels of wellbeing, it was deemed to be not well suited for a study on MW healthcare decision-making autonomy.

3.2.3 AI4 People framework

The AI4 People framework is a unified framework of principles for artificial intelligence in society. These are ethical principles that should undergird the development and adoption of artificial intelligence. They offer concrete recommendations to assess, develop, incentivise, and support good artificial intelligence, which in some cases may be undertaken directly by national or supranational policy-makers, while in others may be led by other stakeholders (Floridi *et al.* 2018). In addressing the opportunities and risks, the authors looked at the questions such as, who people can become (autonomous self-realisation); what people can do (human agency); what people can achieve (individual and societal capabilities); and how people can interact with each other and the world (societal cohesion) (Floridi *et al.* 2018).

Using the AI4People framework would explore the creation of centres, agencies, curricula, and other infrastructure, to make the case for an ambitious, inclusive, equitable programme of policy-making and technological innovation, which may contribute to securing the benefits and mitigating the risks of artificial intelligence for all people, and for the world we share. The AI4 People framework involves a multi-stakeholder forum involving individuals who are interested in shaping the societal impact of artificial intelligence application across international bodies such as the European Commission and the European Parliament. Also, the AI4 People framework offers four chief opportunities for societies that artificial intelligence offers, namely: who we can become, what we can do, what we can achieve and how we can interact with each other and the world. These four fundamental points elaborate on human potentials and their significance in life, but would not directly contribute to the success of this current study.

3.3 THE THEORETICAL FRAMEWORK THAT GUIDED THE STUDY

The researcher settled on the HBM by Ronald M. Andersen. The HBM has gone through various phases with the author continuously reviewing the model (Andersen 1995). The 1995

version of Ronald M. Andersen's work is presented in his article titled 'Revisiting the Behavioural Model and Access to Medical Care: Does it Matter?' (Andersen 1995).

The HBM was originally developed in the 1950s by social psychologists working at the United States Public Health Service to explain why many people did not participate in public health programmes such as TB or cervical cancer screening (Hochbaum 1958). It is a tool that scientists use to try and predict health behaviours, and is based on the theory that a person's willingness to change their health behaviours is primarily due to their health perceptions (Boskey 2020). According to this model, the person's individual beliefs about health and health conditions play a role in determining the person's health-related behaviours, with the key factors that affect the approach to health being:

- Any barriers that a person thinks might be standing in his/her way;
- Exposure to information that prompts a person to take action;
- How much of a benefit the person thinks he/she will get from engaging in healthy behaviours;
- How susceptible the person thinks he/she is to illness;
- What a person thinks the consequences will be of becoming sick; and
- The person's confidence in their ability to succeed (Boskey 2020).

The HBM assists the health experts to look for ways that such HBMs can impact the actions people take, including behaviours that can have an impact on both individual and public health, by taking into consideration the following six constructs:

- *Perceived Severity*: The probability that a person will change their health behaviours to avoid a consequence depends on how serious they believe the consequences will be.
- *Perceived Susceptibility*: People will not change their health behaviours unless they believe that they are at risk.
- *Perceived Benefits*: It's difficult to convince people to change behaviour if there isn't something in it for them. People do not want to give up something they enjoy if they do not also get something in return.

- *Perceived Barriers*: One of the major reasons people do not change their health behaviours is that they think that doing so is going to be hard. Changing your health behaviours can cost effort, money, and time.
- *Cues to Action and Self-Efficacy*: One of the best things about the HBM is how realistically it frames people's behaviours. It recognises the fact that sometimes wanting to change health behaviour is not enough to make someone do it.

The original insights of the HBM, from Anderson and Newman, have gone through various stages, which require a constant review through the application of a practicable framework focusing on the family as a unit of analysis, to alienate the individual as the unit of analysis (Andersen 1995; Andersen and Newman 2005; Andersen, Davidson and Baumeister 2014). The exploration of the HBM has gained popularity through its extensive utilisation in healthcare services (Andersen and Newman 2005; Babalola 2014; Babalola, Adeyoju and Makumi 2013). Boskey (2020) attest that several authors including Leventhal, Stretcher and Rosenstock, Becker and many others have subsequently extended the HBM to explain differing reactions to symptoms and variations in adherence to treatment and to guide the design of interventions to enhance compliance with preventive procedures.

The researcher found Ronald M. Andersen's 1995 version of the HBM to be the ideal framework to explore what could be an ideal framework to facilitate healthcare decision-making autonomy among MW in northern Nigeria.

3.3.1 Ronald M. Andersen's 1995 version of the HBM

The purpose of Ronald M. Andersen's 1995 version of the HBM was to discover conditions that either facilitate or impede health care services utilisation and to develop a behavioural model that provides measures of access to medical care (Andersen 1995). As alluded to in the earlier section, the HBM has gone through various phases with the author continuously reviewing the model (Andersen 1995). For some work, Ronald Andersen has worked with John F. Newman as reflected in the fourth revision done in 2005 where the authors presented a theoretical framework for viewing health services utilisation in their study titled 'Societal and individual determinants of medical care utilisation in the United States. Andersen defines the key factors that influence healthcare behaviours as an individual's perceived threat to sickness or disease, the belief of consequence (perceived severity), potential positive benefits of action

(perceived benefits), perceived barriers to action, exposure to factors that prompt action, and confidence in the ability to succeed (self-efficacy) (Andersen and Newman 2005; Andersen 1995).

3.3.2 The key factors that influence healthcare behaviours

1. ***Individual's perceived threat to sickness or diseases-*** Also called 'perceived susceptibility' refers to a person's subjective perception of the risk of acquiring an illness or disease. There is a wide variation in a person's feelings of personal vulnerability to an illness or disease (LaMorte 2019). Individual beliefs about the positive outcomes associated with a behaviour in response to a real or perceived threat is one of the major predictors of health-related behaviour in the HBM.
2. ***The belief of consequence (perceived severity)*** - This refers to a person's perceptions on the seriousness of contracting an illness or disease (or leaving the illness or disease untreated). There is wide variation in a person's feelings of severity, and often a person considers the medical consequences (e.g., death, disability) and social consequences (e.g., family life, social relationships) when evaluating the severity. This is also called 'perceived seriousness', which refers to the negative consequences an individual associates with an event or outcome, for example, chronic medical diagnosis. These may relate to an anticipated event that may occur in the future, or to a current state such as a pre-existing health problem.
3. ***Potential positive benefits of action (perceived benefits)-*** This refers to a person's perception of the effectiveness of various actions available to reduce the threat of illness or disease (or to cure illness or disease). The course of action a person takes in preventing (or curing) illness or disease relies on consideration and evaluation of both perceived susceptibility and perceived benefit, such that the person would accept the recommended health action if it was perceived as beneficial (LaMorte 2019). This refers to an individual's assessment of the value or efficacy of engaging in a health-promoting behaviour to decrease the risk of diseases.
4. ***Perceived barriers to action:*** This refers to a person's feelings regarding the obstacles to performing a recommended health action. There is a wide variation in a person's feelings of barriers, or impediments, which lead to a cost/benefit analysis. The person weighs the effectiveness of the actions against the perceptions that it may be expensive,

dangerous (e.g., side effects), unpleasant (e.g., painful), time-consuming, or inconvenient, or beneficial (LaMorte 2019). This perception could be defined as a person's estimation of the level of challenge of social, personal, environmental and economic obstacles to a specified behaviour or their desired goal status regarding that behaviour.

5. ***Exposure to factors that prompt action***- Cue to action is the stimulus needed to trigger the decision-making process to accept a recommended health action. These cues can be internal (e.g., chest pains, wheezing, etc.) or external (e.g., advice from others, illness of family member, newspaper article, etc.) (LaMorte 2019).
6. ***Confidence in the ability to succeed (self-efficacy)***- This refers to the level of a person's confidence in his or her ability to successfully perform a behaviour. This construct was added to the model in the mid-1980s. Self-efficacy is a construct in many behavioural theories as it directly relates to whether a person performs the desired behaviour or not (LaMorte 2019).

Though Andersen's framework was developed to explain the factors that determine the use of healthcare services in the United States of America, it has an impact on the identification of societal healthcare services utilisation and as a determinant of individual access to healthcare services (Andersen 1995). According to Andersen (1995) an individual's access to and use of health services is considered to be a function of three characteristics:

- *The predisposing factors* which include the socio-cultural characteristics of individuals that exist before their illness such as social structure, health beliefs and demographic factors.
- *The enabling factors* which include the logistical aspects of obtaining care such as personal/family, community and other possible additional factors.
- *The need factors* which include the most immediate cause of health service use – functional and health problems that generate the need for health care services which can be differentiated into perceived and evaluated.

In this framework, the researchers identified the societal and individual factors that influence MW's access to utilisation of healthcare services available, such as organisation and general state influence on MW's ability to utilise healthcare services, due to lack of healthcare decision-

making autonomy. The geographical area and circumstances vary between any two settings (Nigeria and the United States of America, for instance). Researchers considered the adoption of this HBM theory on the basis that idealistic similarities could differ in this framework in a different setting to that in which it was developed. The health belief model is also a socio-psychological health behaviour change model developed to explain and predict health-related behaviours, concerning the utilisation of healthcare services. This framework (Figure 3.1) will be used as a guide for understanding the factors that influence healthcare-seeking behaviour among MW in northern Nigeria.

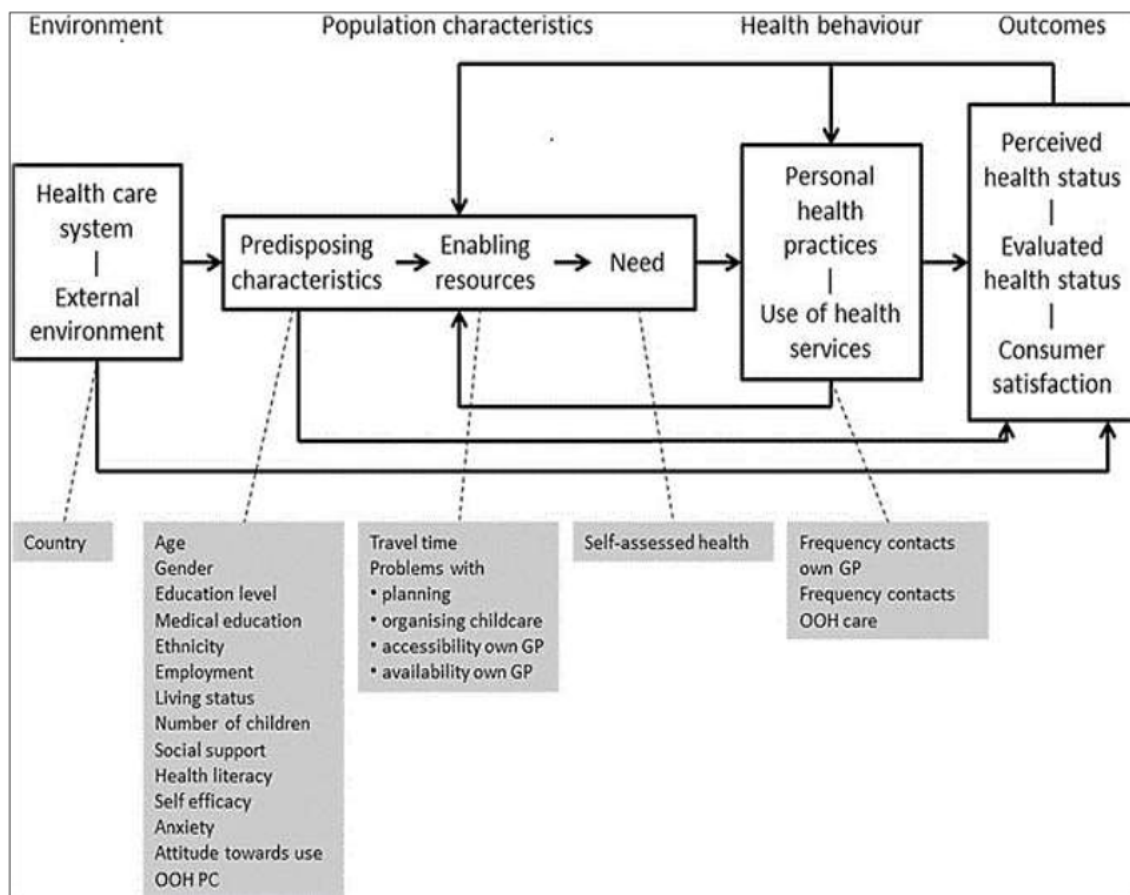


Figure 3.1: Health care-seeking behaviour (Adapted from Andersen’s Health belief Model)
 Source: Babalola, Adeyoju and Makumi (2013)

3.4 APPLICATION OF ANDERSEN’S 1995 HEALTH BELIEF MODEL

Andersen’s (1995) Health Belief Model was identified as the appropriate framework to use as the framework for the study because of the similarity of the purpose of the model to what the

researcher intended to explore in order to achieve the aim of the current study. While the purpose of Andersen's Behavioural Model was to discover conditions that either facilitate or impede health care services utilisation, in the current study there was research evidence that MW's lack of autonomy for health seeking decisions and practices impeded their health care services utilisation. The researcher anticipated that a framework to be developed as part of the study could facilitate health care utilisation. In this regard, Andersen's (1995) Behavioural Model was a useful guide for the current study. The researcher in the current study found that the application could facilitate, determine and maintain a broader understanding of the factors that influenced healthcare-seeking behaviour among MW in northern Nigeria.

Andersen's (1995) Behavioural Model suggests that an entity's accessibility to healthcare services is reliant on three basic characteristics: the predisposing, the enabling, and the need factors. The researcher in the current study explored similar characteristics regarding healthcare-seeking decision-making and practices for MW and considered the same when developing the framework to promote healthcare decision-making autonomy among MW in northern Nigeria.

An explanation of how these three characteristics would be used to guide the current study is presented in a schematic presentation in Figure 3.2. In her application of the model the researcher used Babalola, Adeyoku and Makumi (2013) as a benchmark; these researchers adapted and used a similar model as presented in Figure 3.1.

3.4.1 The predisposing factors

The Behavioural Model assumes that some groups of people are more willing to use healthcare services than others, and this could determine a visible probability by different characteristics. Remarkably, people with challenges on selected characteristics are more inclined to use healthcare services within their communities. These characteristics include demographic factors such as age, sex, parity, marital status, family size, race and social structural factors.

Other observable factors may include educational accomplishment, occupation of the head of the family, and attitudinal-belief factors. Indoctrination on the effectiveness of treatment is more likely to lead to action to access healthcare services (Andersen 1995). The researcher in the current study had to take cognisance of the factors that were responsible for lack of MW

healthcare decision-making autonomy among MW in northern Nigeria which ultimately led to poor health care seeking practices and sometimes resulted in untoward pregnancy outcomes. These factors needed to be considered when developing the framework to promote healthcare decision-making autonomy among MW in northern Nigeria.

3.4.2 Enabling factors

Enabling factors are forces that facilitate or impede individual, collective, or environmental change based on their level of availability. These include health-related skills, and resources that facilitate a behaviour occurrence. These factors also indicate a person's tendency to use medical care.

In the current study, the researcher considered the enabling factors as the circumstances that make health services accessible to MW. Generally, the prime enabling factors MW to access health services are family resources and income (economic status). In Nigeria, individuals that need adequate healthcare delivery are required to pay money to be able to enjoy quality health services. Therefore, family economic status is a significant enabling factor that determines the ability of individual MW to afford healthcare services and access to physicians' consultations, drugs, transportation costs, and laboratory investigations. Absence of enabling factors can negatively affect strategies developed to enhance a practice (Andersen 1995). Thus consideration of the enabling factors was critical for the success of the framework to facilitate healthcare decision-making autonomy among MW in northern Nigeria.

3.4.3 Need-based factors

Andersen (1995) reported that functional health problems expose the need for healthcare services for the individual. Andersen (1995) perceived that needs refer to the manner (how) people view their general health and functional state, as well as how some experience symptoms of illness, pain, and worries about their health. The author evaluated the needs for medical care, which is anchored in service delivery (Andersen 1995) and considered that over and above the extent of healthcare decision-making autonomy, it is critical that MW, MM and the entire community acknowledge the need and importance of attending health care services for health care.

3.4.4 Desired outcome behaviour

Andersen (1995) stated that the three factors (predisposing, enabling and need factors) function together to facilitate the achievement of the desired outcome. This study assessed how these factors facilitated or impeded healthcare-seeking autonomy for MW in northern Nigeria and considered them when developing the framework with a hope that the framework would facilitate improved healthcare decision-making autonomy among MW in northern Nigeria which could lead to improved health care seeking practices and ultimately improved pregnancy outcomes for MW in northern Nigeria

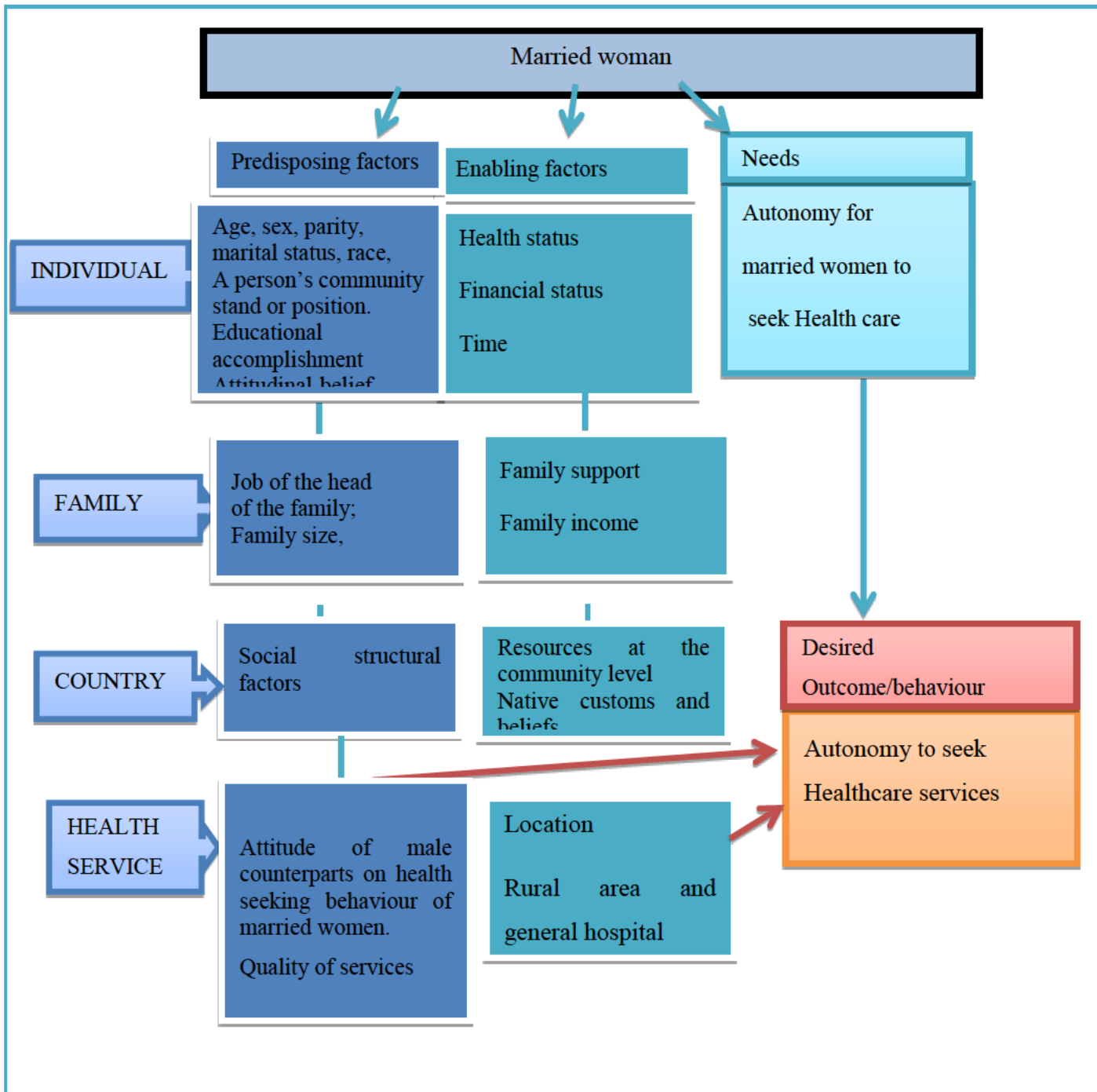


Figure 3.2: Application of Andersen's Health Belief model in the current study

3.5 CHAPTER SUMMARY

This chapter provided the theoretical framework that guided this study. The components that relate to the application as the study unfolded were also described. The next chapter will focus on the methodology adopted for this study.

CHAPTER 4: RESEARCH METHODOLOGY

4.1 INTRODUCTION

This chapter presents the design and methods for this study. Research methodology serves as the structure that is followed while attempting to achieve the objectives of a study. Therefore, a comprehensive and sequential description of the research design and the whole research process that was followed is presented.

4.2. RESEARCH DESIGN AND METHOD

Creswell (2014) states that research designs are types of investigation within qualitative, quantitative and mixed methods designs that provide a specific direction for procedures. Teddlie and Tashakkori (2009) concur that the three main approaches in social and behavioural science studies are qualitative, quantitative and mixed methods. The research design must connect the theoretical worldview, strategy of review and the research method (Mouton 2011). The selection of which method to use is guided by the research subject and the existing knowledge about it (Brink, van der Walt and van Rensburg 2012). Considering the scope of the planned research which sought to explore and describe autonomy related to MW's health seeking behaviour in northern Nigeria, a qualitative research design was adopted.

4.1.1 Qualitative research design

Polit and Beck (2021) define qualitative design as an investigation of occurrences by qualitative techniques which provides data through the collection of rich materials from a primary source. Qualitative research is a method of research that seeks to explore human experiences to understand the reasons behind the behaviour and the meanings embedded in those experiences (Holland and Rees 2010). In line with this description by Holland and Rees (2010), the use of a qualitative research design in this study enabled the researcher to explore MW and their male counterparts' experiences to understand the reasons behind their behaviour, and meanings embedded in their experiences related to autonomy with regards to health seeking behaviour for MW in northern Nigeria. According to Polit and Beck (2021), the qualitative design varies depending on the nature of the study. The method/approaches to the qualitative enquiry can be

descriptive, phenomenological, grounded theory, contextual and exploratory to name but a few. Some of these methods can be combined in one single study. In line with this, the proposed study combined the cross-sectional, contextual and descriptive approaches.

4.1.2 Cross-sectional research

Orodho (2004) states that a cross-sectional research design empowers one to get information about the condition at hand at a particular time and show the current condition of the situation under study in the desired population. The design empowered the researcher to investigate, gather information, summarise, present and interpret this information for the explanation of health seeking behaviour among MW in northern Nigeria. Women's autonomy in health seeking behaviour at the time of the study (condition at hand at a particular time) showed the existing condition of the situation under study in the Nigerian population (the desired population) and assisted the researcher to identify the critical elements to include in the development of a framework to promote autonomy related to health seeking behaviour among MW.

4.1.3 Contextual research

Burns and Grove (2009) state that contextual research forms an ideographic method of research in the sense that it is exclusively descriptive in the context of the individual location and that it focuses on specific events in naturalistic settings. The current study was contextual as it was conducted in a unique setting, the Federal Republic of Nigeria, and focused on specific events which included health seeking behaviour among MW in northern Nigeria.

4.1.4 Exploratory research

Polit and Beck (2021) state that an exploratory study investigates the full nature of the phenomenon, how it manifests, and the other factors to which it is related. Offredy and Vickers (2013) attest to this and further state that the key aim of exploratory research is to discover general information about the research topic. The current study aimed to explore deeply into the phenomenon of autonomy related to MW health seeking behaviour by getting in-depth information from the women and their male counterparts as the two critical persons that influence this practice. This exploratory qualitative approach was adopted in order to gain a better understanding of the phenomena under investigation.

4.1.5 Descriptive research

A descriptive approach offers an in-depth explanation of participants' experiences grounded on their narrative explanation (Grove, Burns and Gray 2013). The descriptive research approach defines and documents the behaviour, events, beliefs, characteristics, attitudes, structures and processes that occur in a phenomenon (Streubert and Carpenter 2011). In the current study, a series of interviews were conducted with MW and their male counterparts regarding autonomy in health seeking behaviour. This led to a description of health seeking behaviour among MW in Nigeria and the identification and description to development of a framework to promote healthcare decision-making autonomy among MW in northern Nigeria.

4.2 WORLDVIEW

A global perspective looks at the natural phenomena that encompass a set of philosophical assumptions that guide one's approach to the inquiry also referred to as a paradigm (Polit and Beck 2021). Scientists distinguish between a naturalist paradigm and a positivist paradigm. The naturalist paradigm, sometimes referred to as constructivist paradigm, is commonly allied to qualitative research and assumes that reality is not a fixed entity but rather a construction of the individual participating in the research and that many constructions are possible. The fundamental assumption of the positivist paradigm is that there is a reality out there that can be studied and known and is mostly allied to quantitative research. In line with these descriptions the researcher's position was aligned with that of a naturalistic paradigm, believing that exploring the views of both the women and their male counterparts would assist her to gain a better understanding of autonomy related to health seeking behaviour among MW in northern Nigeria to develop a framework to promote this process.

4.3 STUDY SETTING

This study was conducted in Lemu, Gbako Local Government Area of Niger State, in the northern part of the Federal Republic of Nigeria, a country that is located on the west coast of Africa. Nigeria gained its full independence on the 1st October 1960, as a federation of three regions; Northern region, Western region and Eastern region. Each of the regions retained a significant degree of self-governance. In 1963 Nigeria altered its relationship with the United Kingdom, became the Federal Republic, and promulgated a new constitution. The country

features 36 states and the Federal Capital Territory with six geopolitical zones as shown in Figure 4.1. Nigeria is the most populous country in west Africa and is ranked the seventh-largest country in the world (United Nations Department of Economic and Social Affairs, Population Division 2015). The population of Nigeria is presently 200 962 417 people according to recent statistics by WHO (2019), out of which 91 668 667 are classified as urban and 94 791 366 as rural, with women accounting for about half (49.31%) of the whole population. It was also estimated that by 2020, Nigeria would have been the third most populous country in the world (United Nations Department of Economic and Social Affairs, Population Division 2015) and the projection for 2050 is estimated to be over 350 million residents in Nigeria (WHO 2019). Nigeria is a varied country comprising many ethnic groups and diverse religions. It is stated that over 500 different ethnic clusters exist with different indigenous languages like Hausa, Nupe, Yoruba, Igbo, Tiv, Bassa, Kamuku just to mention a few (Nigeria, Federal Ministry of Health 2008; WHO 2019). The predominant religions are Christianity and Islam with a number of traditionalist religions.

NIGERIA



Figure 4.1: Map of Nigeria

Source: Nigeria National Population Commission Nigeria and International Calverton Funding (2014)

4.4 RECRUITMENT SETTING

The recruitment setting for the participants (both MW and the MM), was the rural community hall. Lemu, Gbako Local Government Area has one main community hall that is normally used as a rural community gathering places for major functions, such as celebration and festivities in Lemu, Gbako Local Government Area, Niger State, Nigeria, The community hall was under the control of the chairperson of the Local Government who was the gatekeeper for accessing

the community hall. Therefore, permission was requested from the chairperson to use the community hall and to recruit the participants from the audience in the hall for various events. (Appendices 2 and 3).

4.4.1 STUDY POPULATION

The population sample for this study was the MM and MW located in the study area. Participation was not restricted to couples so was open for divorced, separated and widowed men and women to participate in the study to facilitate rich and in-depth information gathering.

4.5 IDENTIFICATION OF THE PROSPECTIVE PARTICIPANTS AND RECRUITMENT PROCESS

The process that is used to locate and recruit participants in a qualitative study is very important for controlling bias and obtaining a representative sample. Information giving sessions to orientate the potential participants regarding the study were held for a balanced exploration with both MM and MW.

The activity process of this study began immediately after the gatekeeper permission was received from the Gbako local government chairperson in charge of the community hall of Lemu to address the community during their community gatherings in the community hall if the community events allowed that. In addition, verbal permission was obtained from the organiser of the event/function where possible to have a 15 minutes slot to address the community and invite them to more detailed information-giving sessions about the study. To facilitate planning for detailed information sessions and to manage the influx of participants, the researcher negotiated some two to three dates with the chairperson for each group (MM and MW) so that all the prospective participants had an option to choose a date and time that was more convenient to them. During the meeting, the researcher introduced herself and the research assistant to the audience, and addressed the whole audience present and invited the participants who met the inclusion criteria to a more detailed information giving sessions about the study. MM and MW were invited to meet with the researcher and research assistant either during breaks or at the end of the session to identify those who met the inclusion criteria and have some interest in joining the study. To facilitate identification of the prospective participants who met the inclusion criteria, the researcher had prepared a checklist (Appendix

4). MM and MW present in the event who met the inclusion criteria were issued with information letters (Appendices 5A, 5B, 6A and 6B) to start reading on their own about the planned study and were invited to a more detailed information giving sessions on dates and times that were agreed upon with the Gbako local government chairperson in charge of the community hall depending on their availability. The participants were invited into the information giving sessions in small groups of four to six participants for MM and 12-18 participants for MW. This was done to facilitate the collection of data collection on the same day as the information giving session for those participants who agreed to that. This grouping allowed for two to four individual interviews being conducted for MM, and two to three focus groups of six to nine MW. Separate meeting dates were scheduled for MM and MW possible such a way that data collection could commence on the same day as the detailed information giving session. The participants were advised during the briefing meetings of the minimum number of participants required, that acceptance of the participants would be on a first-come-first-served basis and that the number of participants enrolled on the study was going to be determined by data saturation.

The information letters were available in the two most commonly used languages in northern Nigeria (English and Nupe) (Appendices 5A, 5B, 6A and 6B) . The researcher also issued the consent forms so that those who, after reading the information letter, felt that they were well informed and ready to sign the consent form. The consent forms were available in English and Nupe (Appendices 5A, 5B, 6A and 6B). Depending on the number of participants in the meeting and their response the researcher requested the prospective participants to invite other members of the community who met the inclusion criteria who were interested to take part or to hear more about the study to come on the day of the information giving sessions.

On the date of the more detailed information giving session, all prospective participants who were present at the meeting were addressed by the researcher. The research assistant assisted in verifying that the participants met the inclusion criteria and assisted those who had not yet signed the consent forms to sign the consent form and scheduled the data collection sessions. Although the community hall was presented to the participants as the preferred venue, the participants were able to choose an alternate venue if the hall was not suitable for them.

Appointments for one-on-one interviews with the MM and a focus group with the MW who either opted for different data collection dates or who, because of time constraints data could not be collected on the same day, were scheduled for a date and time that was convenient for each of the participants or group of participants. Those that still needed to make up their minds regarding participation were allowed to think about it and advised to inform the researcher or the research assistant once they made their decision via an SMS or WhatsApp message. The researcher called the prospective participants in this later group to make arrangements for data collection. The scheduled times for the interview sessions and FGD if different from those that have been prearranged was communicated to the chairperson, Gbako Local Government Area of Lemu community to obtain his approval for the use of the community hall, and to safeguard against disruption of the normal functioning of the activities in the community hall, being a multipurpose hall.

4.8 SAMPLE AND SAMPLING TECHNIQUE

4.8.1 Sampling process

Sampling is a process of selecting a portion of the population, which represents the entire population (Polit and Beck 2021). The study consisted of two samples: a sample of MW and a sample of MM.

All study participants were purposively selected using a non-probability sampling method. The participants who could provide the most information based on the researcher's judgement were selected (Polit and Beck 2021). Typical case sampling together with snowball sampling type of purposive sampling method were used. Typical case sampling entails the identification of individuals that are typical representatives of those with the characteristics that have been identified, while snowball sampling relies on local knowledge to identify relevant participants and then they identify others with the same characteristics (Dzino-Silajdzic 2018). To facilitate the typical case sampling method the researcher, with the assistance of a research assistant, collected information from the prospective participants who had an interest in taking part in the study using a preselection checklist that had been developed by the researcher based on the inclusion criteria and other typical characteristics for the planned study (Appendix 4). Snowball sampling was used in the form that the participants were requested to invite other prospective participants that they knew of to join the study.

4.8.2 Sample size

According to Polit and Beck (2021), the sample size is the number of people who participate in a study. The sample size in qualitative studies is guided by data saturation, a situation which, according to Grove, Burns and Gray (2014), occurs when interviews provide no new information but only redundancy of previously collected data. The sample size in the proposed study was guided by data saturation which was monitored separately for each sample group (MM and MW). Data saturation was confirmed by interviewing two additional men for the MM sample with two additional FGDs for the MW sample. However, for the MM sample, the researcher ensured that a minimum of 12 participants were interviewed irrespective of data saturation while for the MW a minimum of four FGD was ensured.

4.8.3 Determining eligibility to participate in the study

Determining eligibility is an essential step to ensure that appropriate subjects are sampled to participate in the study. Establishing inclusion and exclusion criteria assists in this process. Inclusion and exclusion criteria are a set of predefined characteristics used to identify subjects who will be included in a research study by making up the selection or eligibility criteria used to rule in or out the target population for a research study (Salkind 2010). According to Salkind (2010) determining the eligibility of the subjects to participate in the study through proper selection of inclusion criteria optimises the external and internal validity of the study, improves its feasibility, lowers its costs, and minimises ethical concerns. Furthermore, good selection criteria ensures the homogeneity of the sample population, reduces confounding, and increases the likelihood of finding a true association between exposure/intervention and outcomes. The eligibility of the participants to take part in the study was determined by the following inclusion and exclusion criteria:

Inclusion criteria

MM and MW from the Lemu community in Gbako Local Government Area, Niger State of the Federal Republic of Nigeria a rural community, between the ages of 18 and 50 years were included in the study. The age above 18 facilitated giving of their consent to take part in the study in line with the Guideline for Research with Children in South Africa and the requirements of the Durban University of Technology Institutional Research Ethics committee.

According to the Guideline for Research with Children in South Africa, parental consent is required to conduct research with children below 18 years old (South African Marketing Research Association [SAMRA] 2015). The inclusion of participants aged between 18 and 50 years old was based on the fact that this period is considered the reproductive age for women. According to the American Society for Reproductive Medicine (2012), it is commonly understood that after menopause average of 50-51 years women are no longer able to become pregnant.

Exclusion criteria

All men and women living with spouses but not legally married were excluded. The reason was that a commonly accepted and encompassing definition of marriage was used as a basis for inclusion, namely, a formal union and social and legal contract between two individuals that unite their lives legally, economically, and emotionally (Pace 2022). In Nigeria, the Marriage Act is the primary legislation that provides for the formalisation of marriage. The only form of marriage recognised in Nigeria under the Act is monogamous marriage, **such as** marriage between one man and one woman, though most Muslims marry more than one woman, and the first woman is always recognised as the real wife.

MM and MW who had health or mental health challenges posing a risk to inclusion in the study were also excluded. The researcher who is a registered nurse and midwife by qualification with extensive experience in nursing and midwifery was able to identify these persons. Mental challenges included mental incapacitation not allowing the person to have constructive decision-making and conversation. Health challenges included any persons identified who required immediate medical or surgical care.

4.6 APPOINTMENT AND PREPARATION OF THE RESEARCH ASSISTANT

One research assistant was appointed to assist with data collection. The research assistant did not have any specific qualification but was an unemployed Nigerian and had completed standard 10 (Matriculation) school education and was able to read and write the English language. The ability to speak and write other local languages such as Nupe, Hausa, Yoruba, Igbo, Tiv, Bassa, Kamuku was an added advantage. The researcher signed a contract for three months which was the anticipated maximum period for data collection and was paid a once-off

fee at the end of data collection, the sum of which was agreed upon with him/her at the beginning of the contract. The contract included the signing of a confidentiality clause to safeguard the protection of the identity of the study participants (Appendix 9). The researcher orientated the research assistant to ensure that he/she was clear about her role which included the compilation of the demographic information for the study participants, distribution and collection of consent forms, and recording during the interviews and FGD sessions.

4.7 DATA COLLECTION

Data collection is a process of collecting information from all the relevant sources to find answers to the research problem, test the hypothesis and evaluate the outcomes, and is done using either secondary or primary methods of data collection. Secondary data is a type of data that has already been published in books, newspapers, magazines, journals, online portals etc, but which requires the application of an appropriate set of criteria to select secondary data to be used in the study to increasing the levels of research validity and reliability. Primary data in qualitative studies aims to ensure a greater level of depth of understanding and is collected using methods such as interviews, questionnaires with open-ended questions, focus groups, observation, game or role-playing, or case studies.

4.7.1 Data collection methods

Barrett and Twycross (2018) attest that the three core approaches to data collection in qualitative research are interviews, focus groups, and observation, which provide researchers with rich and deep insights into the phenomenon under study. Two methods of data collection were used for the study. One-on-one semi-structured interviews were used to collect data from MM, and FGDs were used to collect data from MW.

4.7.1.1 Focus group discussions

A FGD is a qualitative data collection method that engages a group of 6 to 12 people with shared characteristics pertinent to the specific discussion topic that is led by a trained facilitator (Dzino-Silajdzic 2018). A similar definition is provided by Eeuwijk and Angehrn (2017) who state that a FGD is a qualitative research method and data collection technique in which a selected group of people discusses a given topic or issue in-depth, facilitated by a professional external moderator. Hugé and Mukherjee (2018) attested that in research, FGD is a good way

to gather together people from similar backgrounds or experiences to discuss a specific topic of interest. The shared characteristics may relate to a particular problem, livelihood, occupation, age, social group, place of residence, or the experience of adopting or not adopting a specific behaviour promoted by a project. The discussion explores specific, predetermined topics while allowing flexibility and stimulating participants to share and discuss with each other. An FGD is generally semi-structured and is facilitated using a semi-structured interview guide to foster active participation and in-depth discussion (Dzino-Silajdzic 2018).

The strength of a FGD is that it encourages participants to talk to one another, discuss and build upon or challenge each other's opinions. The researcher was able to generate data on the number of FGDs that reached or did not reach a consensus on the issue under investigation. FGDs have several advantages, including that they are considered a low-cost method whose flexible format allows the facilitator to explore unanticipated issues. Because of their flexible design and the exchanges among participants, the discussions may lead to the discovery of attitudes and opinions that may not be revealed through methods targeting the individual, such as structured interviews, surveys or semi-structured key informant interviews. In addition, a FGD enables rapid collection of multiple perspectives on the topic under investigation, thus generating more information faster than in individual interviews. Interaction among FGD participants provides rich insights, and checks and balances, thus minimising unique or outlying opinions. FGDs are an excellent method for obtaining information from, and hearing the concerns and ideas of, communities that cannot read or write (Dzino-Silajdzic 2018).

Similar to most methods, FGDs have several disadvantages, some of which are that they may not be the best method to explore sensitive topics that may bring a sense of shame or discomfort to the participant, are susceptible to facilitator's bias (which may undermine the validity and reliability of findings), and provide limited confidentiality of information shared during the discussion. In the absence of a skilled facilitator, there is the risk of the discussion getting side-tracked by topics that may not be the primary focus, and of the discussion being dominated by one or more individuals, thus silencing other participants or simply making them agree with the most dominant person (Dzino-Silajdzic 2018).

Given the rise of participatory research in conservation over the last few decades (Bennett *et al.* 2017), it is crucial to reflect on the scope and remit of the FGD as a methodological tool.

Influenced mainly by the advantages of the FGDs, the researcher chose to use the FGD method of data collection from the MW participants. The researcher is convinced that her previous experience in working with women as a midwife allowed her to overcome all the possible risk of this method listed above as disadvantages.

4.10.1.2 Semi-structured interview

An interview is essentially a structured conversation where one participant asks questions and the other provides answers. Interviews can be structured or semi-structured. Liamputtong and Ezzy (2005) describe a semi-structured interview as being a form of in-depth interview that aims to explore the complexity and nature of meanings and interpretations that cannot be examined using positivist methodologies.

The benefits/strengths of using interviews are that they provide rich understandings gleaned from personal interaction. Open-ended questions increase the opportunity for respondents to share their points of view. The method is relaxed and comfortable for the participants but can still be contained and focused. It gives the interviewees freedom to respond in their own words and to provide as much detail as they wish, and offer illustrations and explanations. Semi-structured interviews tend to be flexible, responding to the direction which the interviewees take during the interviews. This might require adjusting the emphasis of the research as the result of significant issues emerging during the interviews. Thus, although the researcher is able to direct the conversation, by having predetermined questions on the intended topic, it remains possible to ask further questions as needs arise. The semi-structured interview allows the interviewer to guide the interview in the required direction and ensures that the interviewer obtains all the information required by allowing the interviewer to probe, and to request clarity. The method is relaxed and comfortable for the respondents but can still be contained and focused. It gives the interviewees freedom to respond in their own words and to provide as much detail as they wish, and offer illustrations and explanations (Liamputtong and Ezzy 2005)

The limitations of the one-to-one interview are that the interview requires that the interviewer must be knowledgeable about the subject, and be able to probe and exercise good control as interviewees' responses might be irrelevant to the topic. In the absence of these qualities, the semi-structured interview might get out of control or move in the wrong direction, failing to achieve the intended purpose (Liamputtong and Ezzy 2005).

The researcher used one-on-one semi-structured interviews to collect data from MM. All interviews were conducted by the researcher to guard against all that is stated above regarding interviews. The researcher, with her experience and skills as a nurse, was able to conduct and control the semi-structured interviews. The individual semi-structured interviews allowed each male participant to share his personal views and experiences without fear of intimidation by other males. This enabled each male participant to share their view of the matter including personal, sensitive or confidential information.

Each interview lasted between 30 to 45 minutes to avoid boredom but still allow enough time for a fruitful discussion. This time range allowed the researcher not only to ask the predetermined questions but also to obtain rich detailed answers as the men narrated their individual views about this subject in a way that best suited them.

4.11. Data collection tools

An FGD guide containing all the questions to ask FGD participants, as well as introductory and concluding information, was used for the MW participants (Appendices 7A and 7B). The interview with male participants was guided by an interview guide that consisted of one grand tour question and a few guided tour questions (Appendices 8A and 8B). Both the FGD and the interview guides were semi-structured, with questions phrased in an open-ended way, inviting participants to share and discuss among themselves, and helping the facilitator guide the discussion. The questions were based on the three characteristics of Andersen's (1995) behavioural model of health service utilization which are: predisposing factors, enabling factors, and need factors. The two data collection tools were written in English and Nupe (Appendices 7A-8B). Translating the tools to and from Nupe to English was done with the assistance of a language translator (Appendix 10) to ensure that no messages were altered or lost during translation. Prompt additional probing during the interviews using questions that were not predetermined was done as required.

4.12 DATA COLLECTION PROCESS

Data collection commenced immediately after receiving ethical clearance/approval from the Durban University of Technology Research committee and permission from the relevant gatekeepers who included the chairperson of the Local Government Area of the Lemu

community. All study participants were fully informed about the study during the information giving sessions and provided written informed consent to participate in the study and permission for the researcher to use an audio recorder during the interview sessions and take some field notes. In this study, the data collection was conducted in two phases. Phase one comprised the collection of data from the MM using one-on-one semi-structured interviews, and phase two comprised FGDs with the MW. The researcher employed one research assistant who spoke English and Nupe and could understand other local languages such as Igbo and Hausa to assist with the collection of demographic data from all participants and to take some field notes during FGDs. All interviews and FGD sessions were conducted by the researcher.

4.12.1 Phase 1 data collection: Interviews with the married men

One-on-one semi-structured interviews were employed to collect data from MM. The venue, time and date of the interview was negotiated with each participant. The participants decided between their places of residence and the community hall as an interview venue. The participants could choose to have an interview either in English or Nupe, and the interviews lasted for 30 to 45 minutes. This time range allowed the researcher not only to ask the predetermined questions but also to obtain rich detailed answers as the men narrated their views about women's autonomy in healthcare-seeking behaviour in a way that suited them. This method of data collection is generally used when in-depth information is required (Skinner and Zimmer-Gembeck 2007). All the interviews were done by the researcher. The research assistant was available to assist with recording. At the beginning of each interview session, the researcher welcomed the participant, introduced herself and the research assistant, verified the demographic information of the participant and ensured that they signed informed consent, provided a brief introduction of the study, assured the participant of confidentiality that all data were treated in confidence, provided a brief description of the process that was to be followed during the session, and informed them about the possible duration of the session. The research assistant pronounced the allocated participant code and the date and time for this to be captured on the recorder. The researcher began with a grand tour question and proceeded with all the questions. Probing questions were asked as required. The researcher made sure the discussion ended on a positive note, on the autonomy of MW to seek healthcare freely as the need arises. Member checking was done at the end of each session to confirm with the participant that the

information had been captured correctly. The researcher thanked each participant at the end of their session.

4.12.2 Phase 2 data collection: Focus group discussions with married women

Six to eight women were included in each focus group. Considering the views of the Dzino-Silajdzic (2018), that the discussion may be influenced by factors such as gender, age, nationality, ethnic or religious affiliation, these factors were considered when formulating the FGDs to ensure full participation of all participants. The researcher organised the venue which was the community hall. The date and time of the FGD session were negotiated with the participants in each FGD depending on the availability of the hall. The researcher ensured that all participants were aware and approved of the set date, time and venue of the FGD session.

As the participants arrived at the venue, the research assistant verified the demographic information of the participants and ensured that they had all signed the informed consent form. The researcher welcomed the participants and provided a brief introduction to the study, assuring them of confidentiality and that all information gathered would be treated in confidence. The researcher provided a brief description of the process that was to be followed during the session and informed participants of the expected duration of the session. The topic of discussion was introduced by the researcher, and questions that were general and capable of generating discussion were put forward by the researcher to the participants. The researcher made sure that all the points discussed were covered by taking notes, listening carefully, and probing occasionally while the discussion is going on. The research assistant remained in the meeting room and assisted with recording. The researcher made sure the discussion ended on a positive note, on the autonomy of MW's to seek healthcare freely as the need arose. Member checking was done at the end of each session to confirm with the participants that the information had been captured correctly. The researcher thanked the participants and released them at the end of the session.

4.13 DATA STORAGE

Data were collected and stored in a manner that ensured that participant confidentiality and anonymity was maintained throughout the research and the thesis writing process. The interviews were recorded using an audiotape and additional field notes were jotted down to

capture non-verbal cues and to authenticate the recorded information, after obtaining permission from the participant. During the information sharing sessions, the participants were advised and reminded that the interviews would be recorded and field notes would be taken before each interview commenced. At the onset of the interview, a code was assigned to the participants and recorded on the interview sheet and the field notes. The researcher pronounced the code to get it audio recorded onto the audiotape. The researcher ensured that the participants were not called by name while the interview was being audio recorded.

The collected data was kept in a safe, secure area for the research duration. All electronic data were secured by a secret code that is only known to the researcher. Immediately after all voice recorded data was transcribed and confirmed, it was removed from the audio recorder onto a disc and completely wiped off from the audio recorder. The disc was stored securely with all other hard copies of research materials in a locked cupboard. The hard copies will be destroyed by shredding and the soft copies by being wiped after five years.

4.8 DATA ANALYSIS

Data analysis provides orderly organisation and processing of the data that is collected by the researcher. Cohen, Manion and Morrison (2011) state that data analysis in qualitative research is distinguished by the merging of data collection with data analysis and also by merging of analysis and interpretation. For this reason, data analysis in the current study happened concurrently with data collection to allow interpretation of data and to monitor data saturation. This also allowed the data from the two data sets (MM and MW) to be analysed independently although similar processes were followed in the analysis of both data sets. The researcher adhered to the three principles in terms of qualitative data analysis as described by Denscombe (2010) as follows:

- Compacting extensive and diverse raw data into a succinct structure by organising oral and written data into charts and tables will provide the researcher with the opportunity to identify, compare and determine the data upon which to focus.
- Making the relationship between the research objectives and the summary clear so that the research objectives are the clear drivers responsible for its research and analytical methodologies.

- Concluding by developing a model and/or improving the conceptual basis of the research.

The researcher used thematic analysis of data. Alhojailan (2012) defines thematic analysis of data as the most appropriate data analysis method for a qualitative study that seeks to discover using interpretations by providing a systematic element-to-data analysis. Thematic analysis of data allows the researcher to associate analysis of the frequency of a theme with the whole content which confers accuracy and intricacy and enhances the research's whole meaning. Alhojailan (2012) further explains that, thematic analysis allows the researcher to determine precisely the relationships between concepts and compare them with the replicated data and to link the various concepts and opinions of the participants and compare these with the data that has been gathered in a different situation at different times to facilitate interpretation and discussion of findings. Alhojailan (2012) advised that good qualitative research needs to be able to draw interpretations and be consistent with the data that is collected considering that the participants' interpretations are significant in terms of giving the most appropriate explanations for their behaviours, actions and thoughts who in the current study were the MM and MW.

Although some computer programmes such as NVivo are available to analyse data, the researcher in the current study used a manual method of data analysis following the advice of Alhojailan (2012).

The researcher listened and re-listened to the tape-recorded information until data was clearly understood and thereafter transcribed all the data. The transcribed information in Nupe was translated into English by the researcher. Back translation from English to Nupe was also done to confirm that no information lost its meaning during translation. The transcribed data from the two data sets were analysed using Tesch's eight steps of data analysis (Creswell 2014). The eight steps are explained in section 4.8.1. All translated data was confirmed by the professional language translator (Appendix 15). The analysed data and analysis process was confirmed and approved by the research supervisors. Analysis led to the documentation and formation of themes and sub-themes that were used to present and discuss the finding in an attempt to show achievement of the study objectives, draw conclusions, construct recommendations from the

study and subsequently develop a framework to promote healthcare decision-making autonomy among MW in northern Nigeria.

4.8.1 Tesch's eight steps of data analysis

1. Preparation of data

Before the initiation of data preparation, the researcher needed to answer some questions that were dependent on the objectives of the study. However, everything was transcribed at the start to save time during the analysis. Data transcription of the tape-recorded information involved listening and re-listening to the audiotape until data was clearly understood and known.

2. Defining the unit or theme of analysis

Unit or theme of analysis means classifying the content into themes which can be a word, phrase or sentence. Transcribing word-for-word response, the transcribed information was written in Nupe and translated into English by the researcher and verified by the professional language editor. Back translation from English to Nupe was also done to confirm that no information had lost its meaning during translation.

3. Developing categories and coding scheme

This is derived from three sources: primary data, theories on a similar topic, and empirical studies. It is important to evaluate secondary sources to stimulate original ideas. To ensure consistency in the codes, the categories as per their properties with examples were defined. The researcher read and reread the transcribed interviews and the field notes to get the meaning of the information written down.

4. Pre-testing the coding scheme on a sample

Pre-testing qualitative data is important. To ensure consistency, members of the research team need to code a sample of the existing data. The researcher grouped related topics or codes that emerged and wrote them next to the appropriate segment of the text.

5. Coding all the text

After the coding consistency in the previous stage, it was important to apply the coding process to the data. The researcher clustered the codes into categories and created themes and sub-themes.

6. Assessing the consistency of coding employed

After coding the whole data set, validity and reliability were checked. Any other topic or codes that emerged were written next to the appropriate segment of the text.

7. Drawing inferences based on coding or themes

In this step, inferences were drawn based on codes and categories generated. The properties, dimensions and relationships were explored, and patterns uncovered. The researcher grouped the related topics and an emerging list of categories.

8. Presentation of the results

To present the results under each theme with conclusions the results were supported by secondary data and quotes from the developed code (Datt and Chetty 2016).

4.9 DATA PRESENTATION

Data presentation in qualitative research conservatively is presented by using illustrative quotes, which are raw data and can be compiled and analysed not just listed. This explained how the quotes were chosen and how they were labelled. These are **then** organized in tables, graphs or charts so that logical **conclusions** can be derived from the collected measurements (Adesoji, 2018) .

4.10 DATA INTERPRETATION

Data interpretation refers to the implementation of processes through which data is reviewed to arrive at an informed conclusion; it assigns a meaning to the information analysed, and determines its significance and implications. Data from each of the two data sets, which included interviews with the MM and those from the focus group with the MW were analysed independently and findings were triangulated.

4.11 TRIANGULATION

Triangulation refers to the use of multiple methods or data sources in qualitative research to develop a comprehensive understanding of phenomena which improves qualitative research validity through the convergence of information from different sources (Polit and Beck, 2021). LoBiondo-Wood and Haber (2014) defined triangulation as the use of two pieces of information to locate a third unique finding. In this study, the use of two pieces of information were data from MM and that from MW). The identified themes are discussed by the researcher and verified with relevant literature. Data interpretation and triangulation was used to guide the researcher towards making recommendations from the study. Direct quotes from the participants were used to support the discussion of the study results. The researcher used the process of triangulation with an idea that drawing data from sources that have different potential threats to validity would possibly reduce the chances of reaching false conclusions (Bergman ,2008). The results of triangulation are presented in Chapter 5.

4.12 DEVELOPMENT OF A FRAMEWORK

The findings from the data analysis were used to develop a framework to facilitate healthcare decision-making and autonomy practices among MW in northern Nigeria. The framework was reviewed and approved by 10 experts from the Lemu rural community in northern Nigeria. The experts included six midwifery specialists from healthcare institution and four community members identified with assistance from the chairperson, all from the Lemu District in northern Nigeria. Verification of the framework was done through the Delphi Technique that included three rounds of review. Details of development of the framework are presented in Chapter 7 and the final framework named Mary Paul MW Autonomy Facilitation Framework (MPMWAFF) is presented in Chapter 8.

4.13 RESEARCH RIGOUR

Research rigour is the degree to which suitable implications can be made (Polit and Beck ,2021). Rigour, according to Gerrish and Lacey (2010), refers to the strength of the study in terms of its adherence to procedure, accuracy, and consistency, that is, the truthfulness of the scientific findings. Hence, trustworthiness in qualitative research techniques indicates the level of rigour based on credibility, transferability, dependability, confirmability, and authenticity

(Lincoln and Guba 1985). These were maintained during data collection for this study, as outlined below.

Credibility denotes the confidence in the truth of the data and the interpretations provided (Polit and Beck 2021). The first step to ensure credibility was through openness and transparency to all participants about the study and its processes. Purposive sampling was used to select the interview participants. Furthermore, the researcher presented the information from the participants without manipulating it. To establish confidence in the truth of the findings, during report writing voice recordings were replayed repeatedly to ensure that all the information was transcribed. Credibility was also ensured by making sure that data from the recorded reviews were taken as is and the researcher remained as neutral as possible during the interviews to ensure that the researcher did not influence the responses by the participants. Prolonged engagement was maintained with the participants by staying in the field of study until data saturation was reached (Polit and Beck 2021). The researcher spent sufficient time with the participants during the data collection stage, which increased the level of trust between the researcher and the participants. Informal member checking was maintained during the interviews through clarification with the participants. This was achieved through the researcher summarising and re-stating the individuals' or the groups' findings during the interviews. Findings were confirmed with a participants after the final coding of themes to verify the truth of findings. The researcher used these techniques to ensure a rich, robust, and comprehensive account of the data that were collected during the study.

The researcher was the major instrument in the data collection and analysis process. The experiences, qualifications and prior knowledge the researcher brought to the research field were an important indicator of the credibility of the researcher (Patton 2002). The researcher has had over 39 years of experience in nursing practice, during which time she has assumed the roles of a registered nurse, registered midwife, paediatric nurse and BNSc nurse and has led many quality and patient safety initiatives in her nursing career. This enriched the researcher's experience in quality and patient safety. The researcher had also engaged in a master's research programme which focused on factors influencing access to an utilization of ANC by Lemu community in the Gbako Local Government Area of Niger State, Nigeria (Paul 2018). The researcher's supervisor and co-supervisor are highly experienced in the supervision

of postgraduate degrees and were actively involved in the data collection and analysis phase of the study.

Dependability or suitability refers to the stability (reliability) of data over time and conditions, such as evidence that is consistent and stable (Polit and Beck 2021). In this study, dependability was ensured by adhering to the principle of research and documentary evidence. All the interviews were conducted in the same manner with the use of an interview guide. This ensured that similar findings could be achieved if the study is ever be repeated. A dependability audit was conducted examining the process used to collect data, the accuracy of the data collected and how it was kept (Lincoln and Guba 1985). A review path was maintained through the safekeeping of raw data of each interview transcript for future reference. Although the researcher coded the interviews herself, the data and analyses were checked for discrepancies by the research supervisors.

Confirmability refers to objectivity, that is, the potential for the similarity of interpretation between two or more independent people (Polit and Beck 2021). Brink, van der Walt and van Rensburg (2012) described confirmability as accurate reporting of the real meaning of data as provided by the participants. The researcher recorded the interviews and kept field notes, both of which served to confirm the accuracy of the data reported using verbatim statements by the participants which assisted in confirming the study findings should this be necessary at a later stage. To ensure an audit trail, the data collected will be stored for five years.

Transferability refers to the extent to which data can be practically applied to other settings (Polit and Beck 2021). The researcher ensured that all the steps that were followed to conduct the study were documented so that whoever might want to learn from the study could evaluate the applicability of the data to another context.

Authenticity refers to the extent to which the researcher can honestly and authentically show various realities (Polit and Beck 2021). The researcher ensured this by using the direct narrative voice of the participants so that the feeling and tone of the participants could be conveyed as their lived experience.

4.14 ETHICAL CONSIDERATIONS

Ethical considerations refer to moral values that are concerned with the degree to which research procedures adhere to professional, legal and social obligations to the study participants (Polit and Beck 2021).

The research proposal was reviewed and approved by the Durban University of Technology (DUT). Ethical clearance was obtained from the ethical committee of DUT (REC 181/21) (Appendices 1A and 1B). Letters to the chairperson Gbako Local Government Area, Lemu, was written requesting permission to conduct the research study in the community of Lemu. This was done to ensure that the study met all ethical standards (Polit and Beck 2021). Permission was obtained from all gatekeepers for the data collections in the selected settings (Appendices 2A, 2B, 3A and 3B).

The rights of the participants were protected in fair treatment and privacy was maintained throughout the study. Besides, the participants were informed that their participation was voluntary and they could drop out at any time if they wished to do so, without being subjected to any form of prejudice.

The participants were given all the details of the study and were asked to sign an informed consent form as a confirmation that they were provided with relevant information and that they were participating voluntarily (Appendices 5a, 5b, 6A, and 6B).

The participants were assured of their anonymity, privacy, and confidentiality of the data that was collected. The information that was collected was, and will be for five years, only accessible by the researcher (Polit and Beck 2021). All data that were collected were locked up in a cupboard and will be kept for five years and destroyed thereafter. Before commencement of the interview the researcher confirmed with the participants that they agreed to have the interview recorded.

The participants were assured of confidentiality and anonymity throughout the data collection process.

4.15 CHAPTER SUMMARY

This chapter discussed the research methodology that guided this study, including design, setting, details on how the theoretical framework guided the study, sampling process, sample size, inclusion criteria, exclusion criteria, data collection process, data collection instrument and storage, data analysis, research rigour, and ethical considerations. The following chapter provides the findings of the study.

CHAPTER 5: PRESENTATION OF FINDINGS

5.1 INTRODUCTION

Chapter 5 presents the findings of data analysis of the study. The researcher begins this chapter with a brief overview of the recruitment and the data collection process because there were important situations encountered during these processes that are critical to the study findings. The study findings include sample realisation, demographic data for the study participants, and the themes and sub-themes that emerged from data analysis are presented. The themes and sub-themes are grouped according to the elements of the HBM which was the chosen theoretical framework to guide the study and are supported by verbatim statements from study participants. In addition, the findings on triangulation of selected elements of data are presented in this chapter. Samples of data transcription and analysis records are included as part of this thesis (Appendices 15A-16B).

5.2 OVERVIEW OF THE RECRUITMENT AND DATA COLLECTION PROCESS

The aim of the study was to develop a framework to promote healthcare decision-making autonomy among MW in northern Nigeria and this research study had seven objectives that were set out to achieve this aim. These objectives **were as follows:**

- Describe the process of healthcare decision-making and autonomy practices among MW in northern Nigeria.
- Determine and describe the untoward outcomes experienced by MW due inability to make own healthcare decision.
- Establish whether the male counterparts are aware of untoward outcomes experienced by MW due inability to make own healthcare decision.
- Determine the perspectives of male counterparts regarding healthcare decision-making and autonomy practices among MW in northern Nigeria.
- Determine the perspectives of MW regarding healthcare decision-making and autonomy practices among MW in northern Nigeria.
- Explore possible strategies to promote healthcare decision-making autonomy among MW in northern Nigeria.

- Develop a framework to facilitate healthcare decision-making and autonomy practices among MW in northern Nigeria.

The study necessitated that data be collected from MM and MW. One central site was selected for recruitment and data collection. Community events that took place in the community hall were targeted to reach the targeted population. This compelled that the researcher involved the general community from Nigeria (all those who were present in the community event in the community hall on the day of information giving session) in the information sessions, rather than just the targeted population. The opportunity to get to know the feeling and opinions of the general public about healthcare decision-making autonomy among MW in northern Nigeria enriched the researchers understanding of this phenomenon. Although it was not part of the study plan to get to know the feeling and opinions of the general public about healthcare decision-making autonomy among MW in northern Nigeria, the importance of these findings necessitated that these be highlighted in this presentation of the study findings.

5.2.1 Encounters and observations during recruitment

Recruitment commenced after the researcher had received full ethics approval and gatekeeper permission from the chairperson of the community hall. The initial information giving sessions were provided to the whole audience that was present in a rural community event held in the community hall in the Lemu, Gbako Local Government Area, Niger State, Nigeria. A total of three information giving sessions were conducted for the general community. The aim of these were to inform the general public about the planned study and to invite prospective participants to the more detailed information giving session. The researcher requested a 30 minutes slot in the meetings that were already scheduled to take place in the community hall. All three were community meetings initiated by the community leaders to discuss community development projects in the area. Present in these meetings were the chairperson, the community leaders and the general community, which included elders and men and women of varying ages, some of whom were within the study inclusion criteria (MM and MW from the Lemu community between the ages of 18 and 50 years).

The elderly men and women who appeared to be above the targeted population were more vocal during these three sessions. They raised their concerns regarding the safety and value of inclusion of their people in research projects. Their main concerns were the value of the

intended research for the Lemu community, and the potential risk of affecting norms and traditions in the area which had the potential of destabilising peace and prosperity in the area. Their main concern was the exclusion of the elderly community who, according to them, are responsible for the welfare and have a better understanding of what is good for the community, particularly what is good for women and children.

The targeted MW population were very quiet during these sessions even when prompted by the researcher to speak. However, they were noted talking quietly to each other in low voices without being heard by the audience in the hall. The targeted MM population on the other hand were also very vocal stressing their support of the concerns raised by their elders. Their other concerns were the fact that there would be separate different sessions for MM and MW. At first they viewed this as an ulterior motive on the part of the researcher to brainwash the MW in the absence of their male counterparts. They stated that in their opinion this was going to cause a lot of instability in their families and the community at large.

In each of the three meetings, the researcher was successful in addressing all the public concerns so that at the end of the session the public were supportive of the plan that a particular population would be targeted, and agreed that they could participate in the study if they so wished. All participants who were willing to take part in the study and those requiring more detailed information met with the researcher and the research assistant at the end of the community meeting. Depending on time and the choice of the participants, information giving sessions for the targeted group took place either the same day of the general meeting or on another day that was decided upon by the prospective participants. A total of 13 specific information giving sessions were conducted, three of which were for combined groups of prospective MM and MW participants (Figure 5.1), six for the prospective MM participants only, and four for the prospective MW participants. The participants were requested to invite other participants to be screened for inclusion criteria.

During the first few information giving session directed at the targeted population without the other members of the community, the response rate was at first very poor. However, with subsequent information giving and recruitment sessions, attendance and volunteering on the part of the study participants to participate in the study improved to such an extent that there

were more willing participants than what the researcher anticipated. It is for this reason that a large number of participants (55) were included in the study.

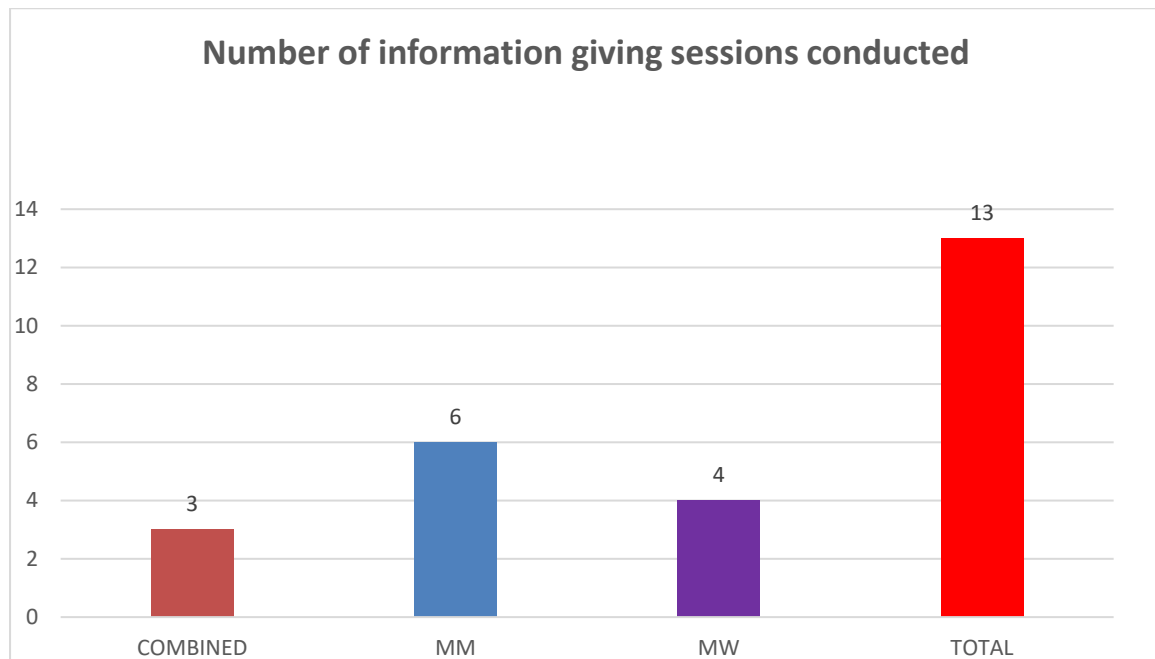


Figure 5.1: Presents the number of information giving sessions

5.3 SAMPLE REALISATION

Data collection was accomplished over a period of eight weeks from December 2021 till January 2022. The sample sizes for both participant groups was guided by data saturation which was monitored separately for each sample group. The researcher had planned to have a minimum of 12 participants for the MM sample and a minimum of four focus group made up of 6-8 participants each for the MW sample irrespective of data saturation. However, this study yielded 55 willing participants comprised 30 MM and 25 MW participants (Figure 5.2). The findings on sample realisation are quantified and are presented in tables and graphs in order to make a better understanding of this information. Simple calculations were used which included total sums and percentages.

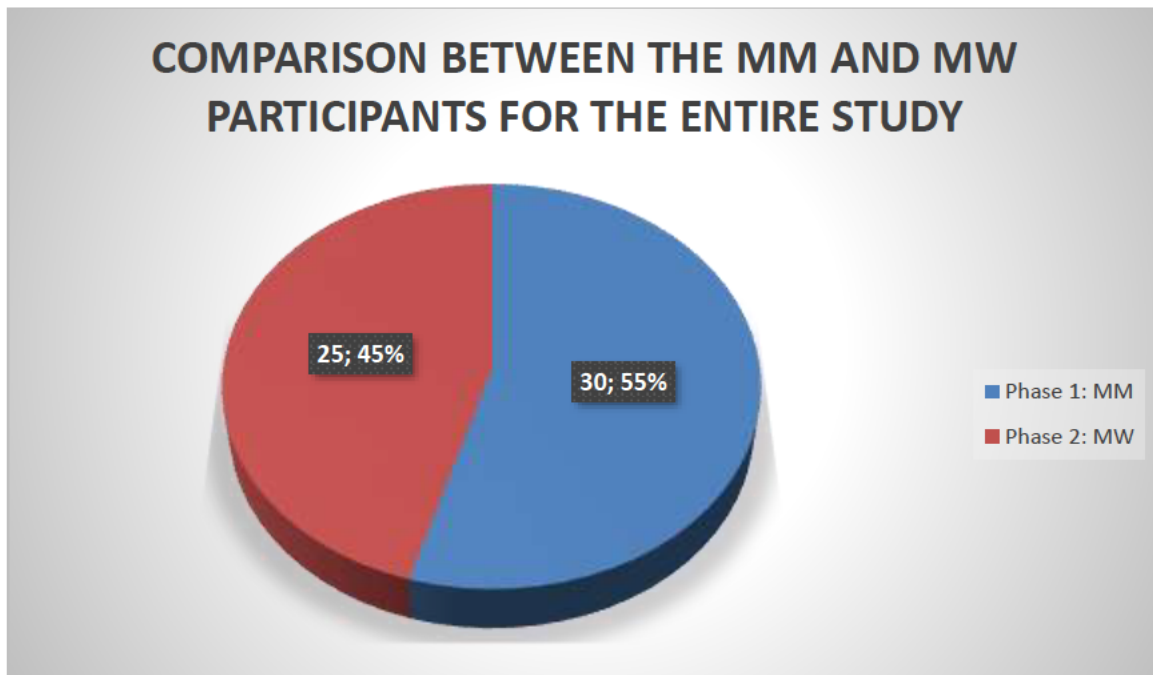


Figure 5.2: Comparison between the MM and MW participants

5.3.1 Phase 1: Sample size for MM

Phase 1 involved interviewing a total of 30 MM. Initially participants were not eager to speak and not much information was gained from those interviews. However, eventually the participants who joined the study were more open and started talking more openly. A minimum of one and a maximum of six interviews were conducted per day. This was dependent on the availability of the participants and the venue where the interviews were conducted. The researcher was able to do more than one interview for participants who lived close to each other and for those who chose to be interviewed in the community hall. All interviews except three were carried out in the community hall. Data saturation was attained after 22 interviews. The original plan was to confirm data saturation with a further four interviews. At the point of data saturation more and more MM were coming forward requesting to take part in the study. On the last day of the interviews with MM, the researcher was left with just two last interviews to do. However, there were six MM available all of whom met the inclusion criteria. The researcher decided to do all six thus using eight participants to confirm data saturation for this group. Table 5.1 presents the schedule for interview sessions conducted with MM participants showing the date, number of sessions, and data saturation.

Table 5.1: Schedule for interview sessions conducted with MM

Date	Day	No interview	Total to date	Venue	Data saturation
1/12/2021	1	1	1	Participant's Home	
7/12/2021	2	3	4	Community Hall	
14/12/2021	3	2	6	Participants' Home	
30/12/2021	4	5	11	Community Hall	
5/01/2022	5	4	15	Community Hall	
13/01/2022	6	4	19	Community Hall	
20/01/2022	7	3	22	Community Hall	Reached
20/01/2022	7	2	24	Community Hall	
27/01/2022	8	6	30	Community Hall	Confirmed
Total	8 Days	30 Interviews	30 Interviews		

5.3.2 Phase 2: Sample size for MW

Phase 2 involved FGD sessions with MW. One FGD was conducted per day to allow analysis before the next session. A total of eight FGD sessions were conducted with a minimum of six and a maximum of eight participants in each group. Data saturation was reached after six FGD sessions and confirmed with two additional sessions. A total of 25 MW participants were involved. Table 5.2 presents the schedule for FGD sessions with MW showing the date, number of group sessions, age grouping, number of participants, and data saturation.

Table 5.2: Schedule for FGD sessions with MW

Date	Day	Session No	Age	No of participants	Accumulative no
4/12/2021	1	1	Combined group	6	6
11/12/2021	2	2	Below 25	6	12
18/12/2021	3	3	25-35	7	19
20/12/2021	4	4	Above 35	7	26
7/01/2022	5	5	Below 25	7	33
15/01/2022	6	6	25-35	8	41
22/01/2022	7	7	Above 35	7	48
30/01/2022	8	8	25-35	8	56
Total	8 Days	8 Sessions		56	56

The first group discussion session comprised six participants as follows; three MW under 25 years of age, one between 25 and 35 years and three above 35 years of age. The researcher noted that during this session the younger MW, in particular those below age 25 years, were

quiet and the discussion was monopolised by the older MW in the group particularly those above 35 years. Thus, from the second group discussion session onwards, the MW were grouped according to age to facilitate free discussion and to minimise a selected age group monopolising the discussion. The three categories included:

- Thirteen participants who were aged below 25 years and were in two groups, one with six and the other with seven participants;
- Twenty-three participants who were aged between 25 and 35 years old and were in three groups, one with seven and the other two with eight participants each; and
- Twenty participants who were above 35 years of age and were in three groups, one with six and the other two with seven participants each. Figure 5.3 is a graphical presentation of the number of participants per age group.

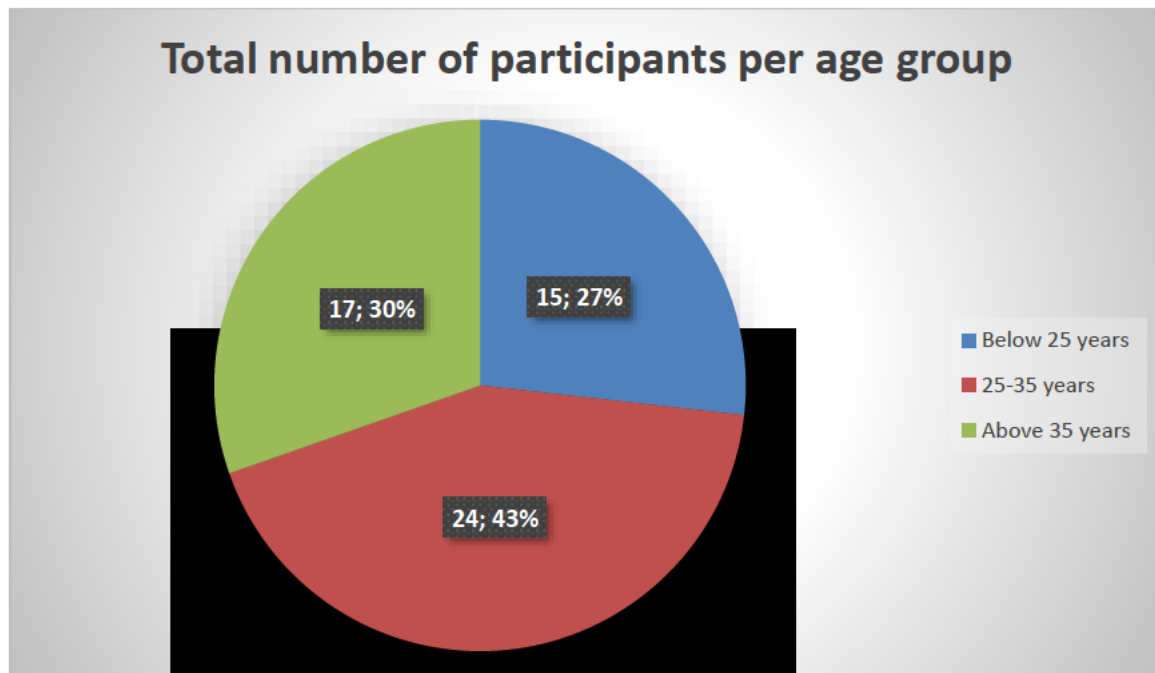


Figure 5.3: Graphical presentation of the number of participants per age group

5.4 DEMOGRAPHIC DATA

The demographic characteristics for the two groups (MM and MW) were quantified using simple calculations which included total sums and percentages in order to improve understanding of this information. Tables are also used to summarise the information. The

information gathered for the two groups differed based on its relevance in the current study as presented in section 5.4.1 and 5.4.2

5.4.1 Demographic data for Phase 1 participants (MM)

Thirty MM black African participants, between the ages of 20 and 50 years of age were included in the study. Further details on findings on demographic characteristics for this group of participants are presented in Table 5.3. In summary the demographic characteristics reflected the following for the majority of the participants:

- 90% (N=24) were between the 25 and 35 years old.
- 87% (N=26) spoke Nupe.
- 87% (N=26) had no formal education.
- 53% (N=16) were self-employed either as farmers or traders.
- 83% (n=25) were in polygamous marriages of between two to three wives.
- 90% (N=27) belonged to Islam religion.
- 60% (N=18) did not own private transport but depended on the local public transport.

Table 5.3: Demographic data for the MM participants (n=30)

Data Element	Number of Participants				Total
Ethnicity	Black Africans: (100%; n=30)				(100%; n=30)
Age	<25years (10%; N=3)	25-35 years (80%; N=24)	>35years (10%; N=3)		(100%; n=30)
Language	Nupe (87%; N=26)	Hausa (10%; N=3)	Igbo (3%; N=1)		(100%; n=30)
Level of Education	None (87%; N=26)	Primary (10%; N=3)	Secondary (3%; N=1)	Tertiary/University (0%; N=None)	(100%; n=30)
Employment status	Unemployed (40%; N=12)	Self employed (53%; N=16)	Employed (7%; N=2)		(100%; n=30)
Living Arrangement during work	Staying at home (87%; N=26)	Living away from home to be close to work (13%; N=4)			(100%; n=30)
Marriage status	Monogamy (17%; N=5)	Polygamy (83%; N=25)			(100%; n=30)
Religion	Islam (90%; N=27)	Christianity (10%; N=3)			(100%; n=30)
Private transport	None (60%; N=18)	Bicycle (27%; N=8)	Motorbike (10%; N=3)	Car (3%; N=1)	(100%; n=30)

5.4.2 Demographic data for Phase 2 participants (MW)

All MW (100%; n=25) were black African women between the ages of 18 and 50. Further details on findings on demographic characteristics for this group of participants are presented in Table 5.4. In summary the demographic characteristics reflected the following:

- 88% (N=22) spoke Nupe.
- 92% (N=23) lacked the autonomy to seek healthcare, as health seeking decisions were either by husbands 28% (N=7) or parent-in-law 72% (N=18).
- 88% (N=22) were uneducated.

Table 5.4: Demographic data for the MW participants(N=25)

Data Element	Number of Participants				Total
Ethnicity	Black Africans: (100%; N=25)				(100%; N=25)
Age	<25years (27%; N=15)	25-35 years (43%; N=24)	>35years (30%; N=17)		(100%; N=25)
Language	Nupe (88%; N=22)	Fulani/Hausa (8%; N=2)	Igbo (4%; N=1)		(100%; N=25)
Level of Education	None (88%; N=22)	Primary (8%; N=2)	Secondary (4%; N=1)	Tertiary/University (0%; N=None)	(100%; N=25)
Employment status	Unemployed (80%; N=20)	Self employed (12%; N=3)	Employed (8%; N=2)		(100%; N=25)
Living Arrangement	Alone without a husband (0%; N=None)	With in-laws without a husband (28%; N=7)	With husband only (20%; N=5)	With Husband and in-laws (52%; N=13)	(100%; N=25)
Marriage status	Monogamy (12%; N=3)	Polygamy (88%; N=22)			(100%; N=25)
Religion	Islam (92%; N=23)	Christianity (8%; N=2)			(100%; N=25)
Responsible for health seeking decisions	Self (0%; N=None)	Husband (28%; N=7)	In-laws (72%; N=18)		(100%; N=25)
Transport to clinic	Walk (68%; N=17)	Public (24%; N=6)	Private (8%; N=2)		(100%; N=25)

5.5 OVERVIEW OF THEMES AND SUB-THEMES

Similar themes and sub-themes emerged from the two data sets for MW and MM, therefore data from both phases is given concurrently, with emphasis placed where the data complement

or contradict each other. Six themes and several sub-themes emerged from the analysis of both data sets (Table 5.5). The themes and sub-themes were grouped according to the various elements of the HBM as the theoretical framework that was used to guide the study which included the predisposing factors, enabling factors, need-based factors, and desired outcome behaviour. The majority of the themes and sub-themes related to the predisposing and enabling factors.

Table 5.5: Themes and sub-themes

Themes	Sub-themes	Grouping according to the elements of the HBM
1. Community awareness about autonomy of MW	1.1 Awareness of MM regarding importance of autonomy of MW to visit healthcare centres 1.2 Package of services	<ul style="list-style-type: none"> • Predisposing factors • Enabling factors
2. Traditional and cultural beliefs	2.1 Traditional beliefs, norms and values 2.2 Peers and community influence regarding autonomy 2.3 Reliance on traditional birth attendants	<ul style="list-style-type: none"> • Predisposing factors • Enabling factors
3. Financial issues	3.1 Cost of transportation 3.2 Cost of treatment and other supplies 3.3 Employment status	<ul style="list-style-type: none"> • Enabling factors
4. Communication and transparency between the healthcare workers and the community	4.1 Information consigning the right of MW to access or to take decision on their own to seek healthcare services 4.2 Information regarding relevant health issues 4.3 Information regarding importance of autonomy 4.4 Information of services provided	<ul style="list-style-type: none"> • Enabling factors
5 Safety of mothers and children	5.1 Access to health care services 5.2 Collaboration and partnerships between healthcare workers and community	<ul style="list-style-type: none"> • Need-based factors • Desired outcome behaviour
6. Preservation of societal values culture and traditions	6.1 Peace and harmony within families 6.2 Harmony between traditional and health care practices	<ul style="list-style-type: none"> • Desired outcome behaviour • Desired outcome behaviour

5.6 PRESENTATION OF FINDINGS

5.6.1 Theme 1: Community awareness related to autonomy of MW

Due to home system norms, the majority of Phase 1 (MM) and Phase 2 (MW) participants did not have a solid understanding of what autonomy is all about, and MW were also unaware of their freedom to seek healthcare.

5.6.1.1 Sub-theme 1.1: Awareness of MM regarding importance of MW autonomy to visit healthcare centres

The information acquired by Phase 2 (MW) participants, as well as Phase 1(MM) participants, revealed that they were unaware of the necessity of autonomy in allowing their spouses to attend and obtain healthcare services. Participants in Phase 2 (MW) made the following statements:

We don't have proper orientation that is supposed to inform us about the importance of autonomy and freedom for our wives to visit healthcare centre.(MM 2)

I am not aware of any government right for women (especially MW) to go out of the house freely, either to seek for healthcare or visit. NO! in this community we believe women are under their husband authority, if my wife is sick or need something it is my duty as husband to get what she need for her. (MM 6)

In this community most households believe that MW can't take decisions for themselves, they must take instruction from their husband or an elder in the family who stand as head of the family, like mother in-law, father in-law. (MM 3)

The Phase 2(MW) participants acknowledged that they were unaware of the value of autonomy or the right of MW to seek healthcare on their own, because as a married woman, you must obey whatever your husband says.

Due to the organisation of the family clan, whatever you need as a wife you inform your husband and he gets it for you, the pattern has been long in the family and cannot be change because if you don't obey your husband it can lead to divorce. So to keep your marriage, if you are not granted permission you can't seek for any healthcare; be it sickness, pregnancy, delivery or post-delivery. (Participant in FG 1)

We don't know anything about our right to take own decision to seek healthcare or visit healthcare centres. We don't go out unless if the husband goes with you, some of us are here because our elderly women are also here. (Participant in FG 3)

If we and our husband are given proper orientation of the importance of autonomy, it will save life, because we are not aware and our husbands are not aware even when you need urgent medical attention as a wife and husband is not around you can't take

decision on your own to seek for medical help, this lead to some women dead in this community, so we think our husbands need more awareness on autonomy of women to seek healthcare. (Participant in FG 2)

5.6.1.2 Sub-theme 1.2: Package of services

The Phase 1(MM) participants stated that they were unaware of the services given by healthcare providers; they acknowledged that healthcare centres exist but that they did not visit them due to their traditional beliefs.

We are not given proper health education on awareness of services provided at the health centre in the community by the healthcare workers, because we don't visit the centres for any services and likewise don't permit our wives to visit the healthcare centres for any services provided, we believe in our traditional healers, it worked faster for us. (MM 4)

I don't allow my wife to take decision by herself, I do this because I feel the male nurses will examine my wife in the hospital, which is against my religious practice, I am okay with my traditional and local treatment so I don't give permission to my wife to seek healthcare. (MM 8)

I believed in traditional healing, and know little about services provided but don't believe in it. (MM 5)

Participants in Phase 2(MW) agreed with MM's assessment of a lack of understanding about healthcare centre operations.

Majority of us are unaware of the services provided in the clinics and the importance of it. (Participant in FG 3)

Some of us are aware of the services, but our husbands and elders in the family don't permit us to seek for the healthcare services, no freedom for us as women, we only follow instruction from our husband and head of the family. They feel the money to be used to seek healthcare should be used to buy herbals. (Participant in FG 2)

5.6.2 Theme 2: Traditional and cultural beliefs

Both Phase 1(MM) and Phase 2(MW) participants discussed cultural norms and social issues that influenced their autonomy in seeking health care. Three sub-themes developed from the theme, namely: (i) Traditional beliefs, norms, and values. (ii) Influence of peers and community on autonomy (iii) Reliance on traditional birth attendance. It was perceived that the majority of these cultural beliefs had a significant impact on MW's autonomy/freedom to seek healthcare and also prevented husbands/MM from freely granting their wives permission to seek healthcare services available in the community. Both MM and MW were bound by cultural beliefs.

5.6.2.1 Sub-theme 2.1: Traditional beliefs, norms and values

Participants in phase 1(MM) and those in phase 2 (MW) stated that the Lemu community's cultural beliefs, norms, and values regarding seeking health care, particularly during pregnancy, sickness, or any other health challenges, required them to follow certain rituals, visit traditional healers, and be attended to by traditional birth attendants during delivery and sickness. The quotes below exemplify this.

There is a general belief in the community that traditional medicine and healers are stronger in giving treatment to sick people and caring for women in pregnancy, Labour, delivery and children, because of this belief, norm and value we feel no need of going to seek for healthcare services, to me is a waste of money and time. (Participant in FGD 4)

In this community we believe traditional medicine heal faster and cheaper than orthodox drugs, I don't permit my wife to visit healthcare centres for any of the services even though services are available in this community. (MM 8)

I believe on my culture strongly, the people of old did not have orthodox medication they believe in the culture and gods of the land to heal them of any health challenges, and they survive and die in good old age, so I and my family don't visit clinic, cannot permit my wife to seek for healthcare. (MM 9)

The statements of Phase 2 (MW) participants were identical to those of Phase 1 participant (MM), indicating that they shared the same cultural beliefs.

Most of the beliefs held by this community discourages our husbands from allowing us to seek healthcare. (Participant in FG 2)

As a wife, I/we need to obey our husbands so that it will not lead to divorcing me for another woman. In this community we are bound to the cultural norms, beliefs and values to keep our marriage. (Participant in FG 1)

In this community we have norms that don't permit us to disclose any health challenges, like pregnancy because we believe witchcraft exist and is worsen when they know you have health challenges, they use that medium to kill and no woman will want to die. So we don't want to visit clinic to prevent exposing our self's to dangers. (Participant in FG 3)

In addition, some of the participants believed in witchcraft and were afraid of being charmed if they sought medical help in a clinic or hospital, which may result in them losing their wives or their infants. The quotes below exemplify this.

Another strong reasons for our husband and elders not allow us to go to clinics and hospitals on our own is to safeguard us against wishcraft. They fear that other people including family enemies might get to know too early that we are pregnant and bewitch us before the pregnancy is strong enough to withstand witchcraft (Participant in FG 1)

It is not safe for a pregnant women to be amongst too many people especially during the earlier months as she might catch evils pirit and all other witchcraft that might harm her and the baby. It is therefore my responsibility to make sure that she does not mix with too many people, like in the clinics and hospitals, so I just cannot allow her to go freely there, no, no, she cannot just decide on her own, I will never allow that! (MM23)

5.6.2.2 Sub-theme 2.2: Peers and community influence regarding autonomy

The Phase 1 (MM) participants stated that the older men in the household discouraged them from allowing their wives to seek healthcare. They lacked faith in the services rendered by healthcare workers saying that their services are unnecessary, stating that such services did not exist during their own lifetimes and their wives and children survived. The young participants had little control over their wives; they are affected by their elders, mothers-in-law, grandmothers, and friends who adhere to traditional taboos and treatment. They made the following remarks:

According to the older men in the house, they believed in the community culture and that health challenges are from God, so there will be no problem or any complication when women are sick, pregnant or to deliver. There is local remedy to use to control any situation that arises, so majority of us don't give autonomy to our wife to seek for healthcare. (MM 10)

Phase 2(MW) participants agreed with the statements made by MM that they were influenced by the elders. Many of them stated that they as well were influenced by older women in their homes and some of their friends; even though some of them did not believe this, the majority did.

In this community we have problem with our father/mother in-laws and our own husbands to obtain permission for seeking for healthcare even though the services are available in the community. (Participant in FG 8)

Some of us are aware of the healthcare service provided in the community, my own husband permits me, he follows me, wait for me and bring me back home. But many of the MW lack autonomy to seek healthcare even in difficult situations. (Participant in FG 3)

5.6.2.3 Sub-theme 2.3: Reliance on traditional birth attendance and healers

Because of cultural beliefs and some examples they had witnessed in women seeking health care in clinics and who had died, many MM believed in traditional birth attendants/healers and use their services for their wives and children. The quotes below exemplify this.

We think some of the MW prefer traditional birth attendance to the healthcare centres, because we the husband don't give them autonomy to seek for healthcare services, we believed in our traditions and culture. (MM 12)

Some women who were sick and about to give birth went to clinics and died as a result of complications, according to the MM, as represented by this excerpt

My brother's wife was very sick and they took her to hospital against my brothers permission, guess what happened, she died living the new born baby an orphan and this was not the first time this happened a number of MW lost their lives in the hands of these nurses, I really do not trust them anymore. (MM 7).

It is worse when a person is too sick, usually either the woman or a baby sometimes even both will die and the excuse would be she had a complication such as bleedin high blood pressue a fit or something of that sort (MM1)

The MW in Phase 2 stated that traditional birth attendants/healers are skilled, culturally strong, informed, and have been trained by the Niger State Ministry of Health to address minor health concerns.

We are comfortable with using the traditional birth attendant in delivery and treatment of sickness for us and our children. We feel it's safer because they understand our culture and traditions, they can easily intervene if things go wrong and control any complication. (Participant in FG 7)

Majority of us uses traditional healers whenever we are sick or to deliver, because they are living close to our residence or right inside the same house, so we rely on them. (Participant in FG 2)

5.6.3 Theme 3: Financial issues

Both MM and MW brought up the topic of money. The expense of transportation, therapy, and other supplies, as well as employment status, are all financial concerns. It was made worse for MM and MW because the majority of them were unemployed; most of the men were farmers who were unemployed, while the women were full-time housewives who only worked menial jobs to get by. The few of them that were employed but had occupations that paid very little.

5.6.3.1 Sub-theme 3.1: Cost of transport

The Phase 1 (MM) participants agreed that financial constraints had an impact on them, such as not allowing their wives to seek healthcare on their own. Both MM and MW complained about transportation costs, with some claiming that they do not live in Lemu village but in neighbouring villages and do not have personal transportation. Those who work have low-paying jobs and are sometimes without pay for months. As can be seen in the following remarks, transportation is quite expensive.

The village where I stay is a little far away from Lemu, transportation is expensive. I am unemployed only doing little farm work so I cannot afford the transportation fare, I decided not to give her permission to seek healthcare even though I am aware of the

services, but to visit the traditional birth attendant/healers living close to us in the same village. (MM 11)

For me, it is not only the cost of transport or distance, but because of consultation fees, drugs and services generally, it is cheaper with the traditional healers and faster, so I don't give autonomy to my wife to seek for healthcare. (MM 9)

The following statements from MW participants confirm the cost of transportation, distance, consultation fees, drug costs, and other services:

As you can see many of us are unemployed, we depend on our husbands for everything we need and the husband are also unemployed, it's difficult for us to seek or access healthcare, though we know it's available but because of our religious bias and financial constraints we decide to trust in God and our culture. (FG 3)

Because of lack of finance, for both us and our husbands, most of us are not permitted by our husbands to seek for healthcare. (FG 1.

5.6.3.2 Sub-theme 3.2: Cost of treatment and other supplies

The Phase 1(MM) participants complained **as below** about financial difficulties that prevented them from allowing their wives to seek healthcare by themselves

I don't allow my wife to seek for healthcare services because of the cost, traditional medicine is cheaper and always available. (MM 10)

The cost of consultation, laboratory tests and drugs are very expensive. Because of this I don't permit or grant autonomy to my wife to seek for healthcare, I feel there is no need as I don't have money I just get her herbals to take without spending any money. (MM 8)

I and my wife know about healthcare but because of the cost I don't give her autonomy to access the care provided, only when I have money and I go with her. (MM 12)

The MW claimed that they found it difficult to obtain healthcare on a regular basis, confirming what phase 1 participant (MM) said about the affordability of services wher they stated that financial difficulties prevented them from allowing their wives to seek healthcare by themselves.

Because of finances, most of us MW in the community don't have autonomy to seek healthcare, majority of us deliver at home been attended to by the traditional birth attendant and consult traditionalist when sick. We don't visit healthcare centres for any services our husbands don't permit us. (Participant in FG 1)

Many of us, don't seek for healthcare due to lack of means to pay for the services. (Participant in FG 5)

I personally pay for some services while my husband pays for some. When I don't have and my husband too I stay back until end of the month when I get pay. (Participant in FG 3)

5.6.3.3 Sub-theme: Employment status

The majority of the MM claimed that they were unemployed as a result of their lack of education, and that they relied solely on the revenue generated by their farming vocation, which is seasonal and provides a very poor and uncertain income. **The following statements attest to this:**

Unemployment is a barrier to us MM preventing us from permitting our wives to seek healthcare in this community. (MM 7)

Because of lack of employment, either by Government or self, some of us depend on the elderly men in the house, so we are not allowed to permit our wives to seeking health care due to lack of finance. (MM 6)

I think why some of us MM don't give autonomy to our wives to seek healthcare is because majority of us only get little money from our farm product, which is not enough for feeding the family members, then how can they pay services in the health centres. (MM 5)

I personally feel that we MM lack knowledge on the importance of autonomy to seeking health care and know we need to save the life of women. (MM 4)

Phase 2 (MW) participants stated that it was difficult for them to seek healthcare because their husbands did not give them the liberty to do so owing to financial constraints caused by unemployment.

The majority of families in this community have financial difficulty, the husband who is the head of the family (and the whole family is dependent on him) is unemployed, don't have the means, and only has his farm crops to depend on to cater for the family. Therefore we don't seek for healthcare, even though the clinics are available in the community. (Participant in FG 2)

You could have a working husband, but if he does not believe in you going to the clinic, he will not give you money. (Participant in FG 6)

5.6.4 Theme 4: Communication and transparency between the healthcare workers and the community

According to the data gathered in this study, MM in Phase 1 stated that there is a lack of communication between them and community health workers about the importance of giving their wives autonomy in seeking health care, and that a lack of proper communication and transparency leads MW to seek care from the wrong places, such as herbal medication stores, religious places (churches), traditional healers, and traditional birth attendants during childbirth. The majority of these persons are not medically trained, which has resulted in several complications with some MW losing their lives as a result.

5.6.3.4 Sub-theme 4.1: Information consigning the right of MW to access or to take decisions on their own to seek healthcare services

According to the findings of this study, there was a lack of adequate communication addressing the autonomy of MW to seek and receive healthcare treatments on their own. This was expressed by both phase 1 (MM) and phase 2 MW participants, as described in the following statement.

We are not aware of the services provided by the healthcare workers in the community, especially the importance and benefit of it, because we don't visit clinic for any healthcare services. As MM we don't know our wives have the right from government to seek for healthcare (MM29).

Our cultural beliefs bound us to our husbands, so if our husband were well informed they may give us autonomy to seek healthcare services. (Participant in FG 7)

Some of us know about the healthcare services in the community, but we don't have any right to seek for the care, because our husbands don't permit us to do so.
(Participant in FG 2)

Both the local government health department and community health workers, according to Phase 1 participants (MM), do not provide them with adequate information about the importance of women's autonomy in seeking health care, and that healthcare workers do not have enough time to do home visits to educate them and their wives on the importance of autonomy in seeking health care. Healthcare workers are always busy in clinics with in- and out-patients.

No information regarding women's right to seek healthcare. We believe a woman has no right to go out of the house without the knowledge and permission from the husband, once you are married you are bound to the authority of your husband. Autonomy can be given if we are well informed. (MM 5)

As husbands no information about what will happen to our wives, complication or benefit of seeking health care as a result of lack of autonomy to seek healthcare. Majority of us are farmers, only few have low level of education, so we don't give freedom to women to seek healthcare, neither can they take decisions on their own.
(MM 4)

5.6.3.5 Sub-theme: 4.2 Information sharing to MW and MM regarding relevant health issues

The survey discovered that MW and MM in the neighbourhood were not given health information. The majority of Phase 1(MM) participants claimed that information about pertinent health issues was not communicated with them since they did not visit the community's available health care facilities. This is confirmed by the Phase 2(MW) participants in the following quotation:

I think if our husbands are well informed by the health workers in the community of the result of any health challenge, and also know that relevant issues of health can be prevented and can be treated to save life, it will encourage them to give us autonomy to seek healthcare services. (Participant in FG 7)

The participants in Phase 1 (MM) stated that, as husbands they need to be informed about the complications or outcomes of certain health issues that their women face, particularly during pregnancy, delivery, and postpartum, as well as the treatment that may be offered to them to save their lives. This was expressed by several MM as follows.

Personally, if the health workers in the community can convince us on how they can help our wives to survive from any health challenge I think that will help us to be able to give them autonomy to seek healthcare and access the services. (MM 3)

Some of us have the knowledge of those relevant health issues, but as we said earlier, our culture binds us to many things in this community, so we don't allow our wives to take decisions by themselves to seek healthcare or for any other thing. Decisions for whatever the women wants to do is taken by the husband as long as she is married. (MM 2)

Some of us are afraid to release our wives to seek for healthcare because of some taboos. Women must not go out but stay at home always, especially when pregnant, because of evil spirits who move around early in the morning, when the sun is hot, and in the night. (MM 1)

5.6.3.6 Sub-theme 4.3: Information regarding importance of autonomy of MW

As a Phase 2 participant MW said, the health workers in the community do not tell MW and MM about the importance of autonomy. The MW made the following statements:

From our own observation, the health workers also believe in the community cultures, tradition and practice them, so if they partake and practice it how can we get autonomy. We feel they have autonomy because they are educated and got jobs to do, but we are not educated and have no job to do, we are full house wife. We need to know more about the importance of autonomy and likewise our husbands. (Participant in FG 3)

The health workers need to visit us and our husbands at home to health educate us on the importance of autonomy. Occasionally when a woman is seriously sick or about to deliver and the situation becomes very bad at the point of death, that is when the husband decides to take the woman to the hospital and most women die before getting to hospital or immediately she gets to the hospital. We need all the information about

autonomy and what it's all about, especially our husbands and the elderly fathers and mothers in the house, they are the ones that take all decisions. (Participant in FG 4)

Our husbands need to know about the importance of autonomy, how it can help us MW to have freedom to visit healthcare centres when need arises and also to save our lives from death. (Participant in FG 1)

Phase 1 (MM) participants agreed that a lack of information about the importance of autonomy and MW's inability to make independent decisions about whether or not to attend and access healthcare services has caused a lot of pain; some of them have lost their wives due to illness and childbirth, as evidenced by the following quotes:

Many of us MM don't allow our wives to seek healthcare because we are not aware of the importance of autonomy. (MM 12)

I have five children only one was delivered in the hospital with a lot of complications. Because of this experience I stopped my wife from visiting and accessing healthcare, though other men permit their wives to access healthcare but I will not, I don't give autonomy to my wife. (MM 10)

5.6.3.7 Sub-theme 4.4: Information for services provided in the hospital

According to remarks made by MW who participated in Phase 2, information is only acquired from other women in the community who used the clinic, healthcare centres and hospitals. Otherwise they are not aware whether these institutions provide full healthcare services everyday or not thus cannot just go any day of time when they are free. The following quotes were made by MW who participated in Phase 1:

We have responsibilities to follow our husbands to farms to help them to work, or to accompany them to the market to help them sell farm products, so cannot just go to the clinic any time to seek for healthcare. Unfortunately we do not have information regarding the nature of services, days and times to be able to request permission from our husbands to attend (Participant in FG 5)

I am a primary school teacher, I go to work early and close late in the afternoon when the clinic has closed so I don't know about the services being provided because I do not get an opportunity to meet with nurses to get such information (Participant in FG 3)

We don't know anything about the services that are provided at the clinic because we hardly visit the clinic, we cannot just go without our husband's consent. (Participant in FG 1)

The phase 1 (MM) participants noted that it was difficult to get information about the clinic's schedule, time to visit, and how the clinics run because of inadequate communication, and the fact that the majority of them don't have televisions or phones to acquire information.

Clinic operation days, hours and service days are not known to most of us, I do not remember anyone sharing that with me. (MM 3)

You sometimes hear neighbours telling you that they get the information about the clinic services and times either from the television or radio which is a problem for us who are poor and do not have access to media, phones and newspapers. You take a chance you go to the clinic only to find that it is closed or the services you are looking for are not offered on that day and the whole day is wasted for nothing. . It is so frustrating . (MM 2).

5.6.4 Theme 5: Safety of mother and children

The MM participants verbalized that all they were doing by denying their wives decision making autonomy was to ensure the safety of their wives and children The two sub-themes that emerged in association to this were Access to healthcare services, and collaboration and partnerships between healthcare workers and the community.

5.6.4.1 Sub-theme 5.1: Access to health care services

In this community, it was evident that there were factors that influence access to health care services such as clinic days, operating times, financial issues and many others. Thus the MM participants felt there were no guarantees that their wives would get services when they go to the clinics.. Both Phase 1 (MM) and Phase 2 (MW) participants commented on these, as confirmed by the following statements:

It is much safer to get your family to visit the traditional healer or birth attendant rather than going to the clinic and end up getting no help because she came on a wrong day or time (MM 20)

At the clinic you do not get attended to unless you have money to pay for services or if you get attended you do not get any treatment, it becomes a waste of time and effort, thus my husband does not allow me to just go without his permission. (Participant in FG3)

My husband will kill me if I waste time going to the clinic without his permission only to come back and tell him I did not get help (Participant in FG 7)

5.6.4.2 Sub-theme 5.2: Collaboration and partnerships between healthcare workers and the community

Some of the MW and MM verbalized that the healthcare workers do not do home visits in order to health educate the community on the importance of autonomy to seek health care, and the right to use the services available in the community. They indicated that collaboration and partnership between the community and the health workers could resolve some of the issues that they had regarding decision making autonomy

Maybe it would be better if the nurses would come out to the community to address us about all these teachings that they are giving to our women so that we also know and get the opportunity to ask them questions regarding all our concerns (MM 20)

The nurses in this community know our culture and fully understand our standpoint. If they now have different information that they are better educated they must come to the community and work with us otherwise all their efforts will not materialize (MM 22)

Some MW concur with the statements by the MM above, as seen in the following statements:

I think it would help if the nurses would come to the community to address our husbands and elders, maybe they can even form partnerships to work together. (Participant in FG 5)

I think what is important is working together. The nurses and the community should work together and have platforms where they can share ideas. Otherwise if it is just us MW who are conveying messages to our husbands, they will never listen. (Participant in FG 1)

5.6.5 Theme 2: Preservation of societal values, culture and traditions

Both Phase 1(MM) and Phase 2 (MW) stated that there were societal, cultural and traditional influences that prevent them from seeking health care services in the community. The two sub-themes that emerged from the theme were peace and harmony within families, and harmony between tradition and healthcare practices.

5.6.5.1 Sub-theme 6.1: Peace and harmony within families

According to the study participants, to maintain peace and harmony in the family, wives need to be obedient to their husbands. Freedom is not for women because they are bound to their husbands' rules and regulations. They are expected to stay at home unless the husband or elders in the house permit them to go out to do whatever they want to do, going out without permission from the husband is a sign of disobedience and can lead to divorce. The following statements were made by the MM:

As a MM in this community, we make sure our wife obeys whatever we tell them, if we say don't access health care services but traditional services, if they refuse, there will be no peace and harmony in the house. (MM 29)

To There is no way I can tolerate a women who disobeys me because without obedience there is no peace in the house, my wife knows that what I say goes (MM 25)

The MW interviewed in this study, stated that societal values, culture and tradition is not new in their community but have existed from existed the time of the elders and forefathers and is meant to ensure peace and harmony in the society as long as they as MW obeyed these. This was evident from the following statements made by MW:

Because of societal values, cultural and traditional beliefs in the community, we are under our husband's authority, therefore we must respect our husband beliefs to promote peace and harmony in the family. What they say, we do, if we don't, the gods of the land will torment us. (Participant in FGD 8)

It is just a normal thing for us that what our husband says goes. I believe it is what keeps us together as husband and wife and there is always peace and harmony in our house.I know whatever that he does is out of love for me and my childtren. (Participant in FGD6)

5.6.5.2 Sub-theme 6.2: Harmony between tradition and healthcare practices

The majority of the study participants agreed that collaboration and partnership between the community and health care workers will result in harmony between tradition and healthcare practices. This was evident in the following statements by some of the participants:

I think the clinics should find a better way to communicate messages to us as husbands. Giving messages through our wives will not help. In my opinion, the two parties should get together where people in the community that are responsible for the welfare for MW and children will come together to discuss issues that need to be resolved MM. (MM 18)

It is not that we do not support working with the clinics, the problem is contradictions between our beliefs and theirs. It is critical that we get together to find ways to create harmony between tradition and health practices. (MM26)

We appreciate that they are trying to help but they also need to take cognisance of that we also do not want to lose our culture and tradition, it is much valuable to us, it is what makes us who we are (MM3)

MW agreed with the statement made by the MM.

I do not think our husband mean bad for not allowing us decision making autonomy, I think the major problem is lack of harmony between tradition and health care practices. (Participant in FG 8)

I am sure things will work much better if there can be harmony between tradition and healthcare practices. (Participant in FG 7)

5.7 ADDITIONAL INFORMATION FROM THE PARTICIPANTS

During the interviews and FGDs, participants were requested to propose strategies that could promote MW autonomy to making health seeking decision. The proposals from the two groups were summarised into two main strategies, namely:

- *Strategy 1:* Awareness of MM and other community members regarding importance of autonomy of MW to make decisions to visit healthcare centres; and

- Strategy 2: Collaboration and partnerships between health care workers and community as a means to create a platform where critical information regarding health care related issues can be discussed.

5.7.1 Awareness of MM and other community members regarding importance of autonomy

The majority of the participants from both groups indicated that awareness of MM and other community members regarding importance of autonomy of MW to make decisions to visit healthcare centres would help improve the situation in the Lemu rural district regarding autonomy for MW.

This was evident in the following statements by some of the MM and MW participants:

Perhaps it will make a difference if all men in the community including our elders are made aware of the importance of MW decision making autonomy because this is something new in our community for us mwomen and childtrn should be under the care and guidance of men and elders . (MM 16).

Surely if our husbands are made aware in a proper way they will understand, they love us and want what is best for us (Participant in FG2)

5.7.2 Collaboration and partnerships between healthcare workers and the community

The majority of the MW participants proposed that collaboration and partnerships between healthcare workers and the community would be another strategy to strengthen women's autonomy. Healthcare workers can assist in providing the information particularly to the MM and elders regarding why it is important that each and every MW should have autonomy to make own healthcare seeking decisions for themselves and for their children. A number of MW stated that it is often easier for MM to accept when the information or advice is given to them by healthcare professionals rather than when it is given by their wives. The MW stated that MM are not able to distinguish between the truth and their wives wanting to satisfy their own hidden agenda.

Definitely , working together should help. For me I think just giving einformation is not enough it is llike nurses instructing our our husband on what to do , they might not

like that. They all should get together in some forums or meetings where they will engage and discuss these matters in a collegial manner (Participant in FG 6)

New developments are best discussed in a proper forum to allow that each party share its views. This community needs to establish partnership with the nurses so that they can discuss all matters pertaining to the health of the community. (MM 19)

5.8 TRIANGULATING FINDINGS ON DATA ANALYSIS

Further analysis included triangulation of findings in order to enhance understanding and interpretation of the data. Triangulation was done for the findings on demographic characteristics and the themes and sub-themes.

5.8.1 Demographic characteristics

Triangulation on demographic characteristics focused on establishing similarity the characteristics of participants. Table 5.6 presents findings on this regard, showing that there was a great similarity between the two groups.

Table 5.6: Comparison between the demographic characteristics of MM and MW

Demographic Characteristic	MM (100%; n=30)	MW (100%; n=25)
Ethnicity	Black Africans: (100%; n=30)	Black Africans: (100%; n=25)
Age	25-35 years (80%; N=24)	25-35 years (43%; N=24)
Language	Nupe (87%; N=26)	Nupe (88%; N=22)
Level of education	None (87%; N=26)	None (88%; N=22)
Employment status	Self-employed (53%; N=16)	Unemployed (80%; N=20)
Living arrangements	Staying at home (87%; N=26)	With husband (20%; N=5) + With Husband and in-laws (52%;N=13) = With Husband 72% N=18)
Marriage status	Polygamy (83%; N=25)	Polygamy (88%; N=22)
Religion	Islam (90%; N=27)	Islam (92%; N=23)
Private transport	None (60%; N=18)	Walked to clinic (68%; N=17)
Responsible for health seeking decisions	Not asked	Husband (28%; N=7)+ In-laws (72%; N=18) = (25; n=100%)

5.8.2 Triangulating of themes and sub-themes

The information gathered from the participants that resulted in the themes and sub-themes were triangulated to check evidence of similarities or discrepancies. Hardly any discrepancies were noted.

5.8.2.1 Reasons for lack of autonomy for MW to make own health seeking decisions regarding health seeking behaviour

Both groups (MM and MW) declared that traditional, cultural and religious beliefs were the main factors that influenced the situation in the Lemu rural district regarding autonomy for MW. The men denied their wives autonomy because tradition, culture and religion put them in a position of power, responsibility and authority over them as heads of the house to decide what is good or not good for their wives as a way of taking care of them.

This was evident in the following statement by one of the MM participants:

From the time of our fathethers, tradition, culture and religion has kept this community together, we cannot now just throw that out . (MM 21)

The MW on the other hand felt obliged by tradition, culture and religion to respect and accept that they had no autonomy, and that the decision for health seeking behaviour rests solely with their husband or parents-in-law when husbands were not around.

This was evident in the following statement by one of the MW participants:

As a MW you have some obligations, you are bound by law and tradition to do as how others do , you cannot all of a sudden be different, that will not be taken kindly by all in the community and will put you your husband and your entire family in shame. (Participant in FG 4)

The few MW who verbalised that they were not happy that they did not have autonomy to make their own decisions highlighted that it was tradition, culture and religion that created the situation. Thus, they were obliged to accept that it was how things are meant to be.

I for one do not have any problem with it, it is how things are done . I am happy for my husband to decide what is good or not good for me, it is his responsibility as a man and a sign of love for me and his family(Participant in FG 5).

It is so sad when a man just do not care and allows his wife to do as she pleases (Participant in FG 1)

5.8.2.2 Importance of autonomy for married women to make own health seeking decisions

It was mostly the MM participants who highlighted several times that they were not aware of information which if they knew would have made them act differently. This included the importance, frequency and timing of visits to health institutions, the adverse events emanating from not visiting, delayed or infrequent attendance, and the benefits of early and regular attendance.

This was evident in the following statement by one of the MM participants:

For me I still think the major setback is lack of information, I strongly believe that if we were better informed about all these things we will reconsider we are all human and would like what is best for our wives and children. (MM 3)

A few MW also indicated the lack of crucial health information that could have pushed them to force the situation so that they could attend health care services early and regularly, even though they had no autonomy. This was information regarding availability of healthcare services.

This was evident in the following statements by one of the MW participants:

Basically, all what is happening is due to lack of information, for me communication is the key. (Participant in FG 2)

5.8.2.3 Confounding factors that influence women's health seeking behaviours

Both groups (MM and MW) agreed that there were other factors apart from autonomy that were responsible for the health seeking behaviours of the MW, namely, tradition, culture and

religion. In addition, other factors such as financial status, distance from the health facility, previous experiences, and attitudes of healthcare workers, were also highlighted.

This was evident in the following statements by some of the MM and MW participants

The cost of consultation, laboratory tests and drugs are very expensive, because of this I don't permit or grant autonomy to my wife to seek for healthcare. I feel there is no need as I don't have money. I just get her herbals to take without spending any money.
(MM 15)

Many of us are unemployed, we depend on our husbands for everything we need and the husband are also unemployed. It's difficult for us to seek or access healthcare, though we know it's available, but because of our religious bias and financial constraints we decide to trust in God and our culture. (Participant in FG 8)

5.9 TRIANGULATING OF THEMES AND SELECTED DEMOGRAPHIC CHARACTERISTICS

5.9.1 Level of education and importance of autonomy

It was not easy to establish how the level of education influenced the views of the participants regarding the importance of autonomy for the MW, because almost all participants except two participants had either no education or primary school level only. However, it was important to note that one of the two participants who had secondary school level of education (who was a MM) indicated that it was important that the MW be allowed autonomy to make their own decision regarding health care behaviours. The second participant was female (MW) and was in a FGD which made it difficult to determine her individual view in this regard.

This was evident in the following statement by the one MM participants

I think we as the community should consider changing how we do things, We cannot be always stuck in the past. MW are matured enough to know what is good for them I think we should consider allowing them decision making autonomy particularly during with regards to health seeking decisions (MM 3)

5.9.2 Employment status, financial status and importance of autonomy

The majority of the MW who were unemployed were adamant that MW should not be allowed autonomy for health seeking decisions, stressing that it was the requirement by their tradition, culture or religion. Furthermore, MW indicated that their financial status compelled them to respect their husbands' authority as the husbands were responsible for paying for health care services and other financial needs.

This was evident in the following statements by some of the MW participants:

As you can see many of us are unemployed, we depend on our husbands for everything we need and the husband are also unemployed. It's difficult for us to seek or access healthcare, though we know it's available, but because of our religious bias and financial constrains we decide to trust in God and our culture. (Participant in FG 5)

Because of lack of finance, and dependency on our husbands, most of us cannot risk going against their will. (Participant in FG2)

5.9.3 Living arrangement and importance of autonomy

There was no significant correlation between the living arrangement and the opinions of the MW participants regarding the importance of autonomy for MW in making health care decisions. The majority of the MM participants who were residing in extended families, where the wife was staying together with parents-in-law in the presence or absence of the husband, strongly supported the denying of women's autonomy to make own health seeking decision. They indicated that the responsibility for health seeking behaviour should rest either with the husband as the head of the house and in their absence, such decision powers should rest with their parents as elders of the house.

This was evident in the following statements by one of the MM

In this community most households believe that MW can't take decisions for themselves, they must take instruction from their husband or an elder in the family who stand as head of the family, like mother in-law, father in-law, We the young MM also depends on and take instruction from the elders, father, mothers. (MM 23)

5.10 CHAPTER SUMMARY

The study findings derived from the examination of data from Phase 1 and Phase 2 participants were provided in this chapter. Themes and sub-themes that arose during the analysis were presented and supported with direct quotations. Chapter 6 will discuss the findings of the study.

CHAPTER 6: DISCUSSION OF FINDINGS

6.1 INTRODUCTION

Chapter 6 presents the discussion of the findings as a result of data analysis. The researcher used relevant literature to support the discussion. Anderson and Newman's HBM, which is the theoretical framework that guided the study, is used to guide the discussion. The discussion aims to present achievement of six of the seven study objectives that were set for the study as presented in Chapter 1 of this thesis. The seventh objective, which was to develop a framework to facilitate healthcare decision-making autonomy among MW in northern Nigeria, is not included in this discussion, as it had not been achieved at this stage. The chapter also includes discussion of the findings on triangulation of selected findings from data analysis, which assisted in confirmation of selected related concepts.

6.2 OVERVIEW OF THE RESEARCH DISCUSSION

The researcher begins by reviewing literature to compare findings regarding selected aspects of the study. This is followed by a discussion of selected observations and encounters during the information given sessions in the light of relevant literature. The researcher had to take cognisance of these as, apart from these aiding in the researcher's better understanding of the situation of health seeking behaviour and autonomy among MW in northern Nigeria, they were critical elements to be considered when developing the framework to facilitate healthcare decision-making and autonomy practices among MW in northern Nigeria. The researcher believes that the framework will be better accepted if it takes cognisance of the views of the general community.

The latter section of the discussion is on findings from data analysis. This section discusses the findings on demographic characteristics and the major themes and sub-themes that emerged from data analysis. The discussion of findings from data analysis is presented in four sections, namely:

- *Section A* discusses the findings on participants' demographic characteristics;
- *Section B* discusses the study findings in relation to the study's objectives;
- *Section C* connects the factors identified in the form of major themes and sub-themes to the three factors of the health HBM; and
- *Section D* discusses findings on triangulation of selected study findings.

6.3 SUPPORT FOR THE RESEARCHER'S DECISIONS ABOUT SELECTED ASPECTS OF THE STUDY

The current study was conducted with 55 participants consisting of 30 MM and 25 MW from the Lemu rural district of Niger State in northern Nigeria. The researcher in this study was concerned about the health seeking autonomy for MW in northern Nigeria of where challenges existed in its conceptualising and measuring (Osamor and Grady 2017). Several authors attest to the finding that women's autonomy in decision-making is positively associated with the area where they live, their age, employment and level of education, and that women from rural areas often have less autonomy than those from urban areas regarding decision-making (Osamor and Grady 2017; Acharya *et al.* 2010; Patil and Farooqui 2016). A number of societies still have strong social structures that rigidly define the roles of men and women, usually encoded in religious, tribal, and social traditions which define the circumstances under which women have or do not have autonomy to make decisions regarding their own health (Osamor and Grady 2017). The researcher had observed that a similar situation prevailed in the Lemu rural district in Northern Nigeria.

Acharya *et al.* (2010) refer to autonomy as the ability to obtain information and make decisions about one's own concerns, being a behaviour that facilitates access to material resources such as food, land, income and other forms of wealth and social resources such as knowledge, power, prestige within the family and community. Patil and Farooqui (2016) view women's autonomy as the control of women over their own lives, materials, access to knowledge and information, and having equal say with their husbands or partners on matters affecting themselves and their families. According to Patil and Farooqui (2016), women's autonomy can be equated with a woman's control over her life, the authority to make independent decisions, freedom from constraint on physical mobility, and the ability to forge equitable power relationships within families.

Research evidence suggests that women in developing or low-income countries often have limited autonomy and control over their health decisions (Osamor and Grady 2016). Women's autonomy is an indicator of women's empowerment, and, in terms of health care decision-making, it is extremely important for better health outcomes particularly those related to maternal and child health (Acharya *et al.* 2010). Osamor and Grady (2016) concur, stating that autonomy is essential for decision-making in a range of health care situations, from health care seeking and utilisation to choosing among treatment options. According to these authors, autonomy that supports health care decision-making is associated with better health outcomes and enabling autonomous decision-making and respecting women's autonomy are laudable goals.

Gender-based power inequalities can restrict open communication between partners about reproductive health decisions as well as women's access to reproductive health services which in turn can contribute to poor health outcomes (Osamor and Grady 2016). For this reason, the researcher chose to include both the MW and MM as participants in the study. This was to ensure that the views of both genders were included when developing a framework to facilitate healthcare decision-making and autonomy practices among MW in northern Nigeria. In line with the inclusion criteria, the participants in the current study were MW and MM from the Lemu rural district in Gbako Local Government Area, Niger State of the Federal Republic of Nigeria, between 18 and 50 years of age.

The age of the participants had no significant indication in the study finding except that, as indicated in the previous chapter, the age bracket between 18 and 50 years old was selected simply because of this being the reproductive age. According to the American Society for Reproductive Medicine (2012), it is universally understood that after menopause (the average age of which is 50-51 years) women are no longer able to become pregnant. The age of 18 years and above was selected in order to facilitate giving of consent to take part in the study by the participants in line with the Guideline for Research with Children in South Africa SAMRA (2015). Thus, participants could give consent without needing to request parental approval. Osamor and Grady (2016) attest to that, women's age and family structure are the strongest determinants of women's authority in decision-making with older women and women in nuclear households more likely than other women to participate in family decisions. Having a wider mix of participants from the very young (18 years) to the much older (50 years) assisted

in excluding 'age' as a confounding factor for lack of women's health seeking autonomy as there were no obvious differences in the responses based on their ages.

The study was conducted in the geographical area where the researcher had personally observed the lack of women's autonomy, some cases of which resulted in a health-related adverse outcomes emanating from delays in seeking healthcare, delays in reaching healthcare, and delays in accessing healthcare. In the three delays model, Thaddeus and Maine (1994) highlight that these delays are contributory factors to poor health outcomes leading to maternal deaths and these can be either client, system or provider related.

The area where the study was conducted was rural, with most people being employed as farmers or traders with a medium level of education. All these factors could have contributed to the observed lack of women's autonomy for health seeking decisions. Osamor and Grady (2016) concur that women's autonomy in decision-making is positively associated with the area where they live, their age, employment and level of education, and women from rural area have little autonomy in decision-making. Acharya *et al.* (2010) partly agree, stating that several socio-cultural factors such as education, age, and income, affect women's autonomy, independent of the country or culture in which they live.

6.4 SELECTED OBSERVATIONS AND ENCOUNTERS DURING INFORMATION GIVEN SESSIONS

Busija *et al.* (2018) advise that, when working with a group of people that is new to you, it is best to try to fully understand their culture and any issues that affect their ability to understand and use the information you will give to them. Guided by this view, the researcher considered all relevant observations and encounters during information given sessions, recruitment and data collection processes.

The researcher observed during the community address that the elderly men and women who appeared to be above the age of the targeted population were more vocal during these sessions. This was in keeping with the statement by HelpAge International (2009) that older people are an asset to their families, communities and society. They contribute as carers, advisers, mediators, mentors and breadwinners although these invaluable contributions are frequently unrecognised. Busija *et al.* (2018) present a similar notion when they state that the experiences

of Blacks and African communities vary widely by state, city or even by block; these communities are ethnically, socio-economically and culturally diverse. Thus, the researcher should ensure a clear understanding of the community as a whole as well as its history, cultural traditions and trends of the local communities with whom the researcher seeks to connect or understand better (Busija *et al.* 2018).

The elders raised their concerns regarding safety and the value of inclusion of their people in this research project. Their main concerns were the value of the intended research on the Lemu rural district, and the potential risk of affecting norms and traditions in the area, which could destabilise peace and prosperity in the area. Their main concern was the exclusion of the elderly community who, according to them, are responsible for the welfare of the community, and have a better understanding of what is good for the community, particularly the women and children. Sheikh and Paul (2018) agree that community structures significantly and positively influence community participation in any projects. Busija *et al.* (2018) concur that elders have many roles in contemporary indigenous communities with their three key roles being to maintain cultural identity by passing down knowledge and traditions; providing social support and acting as role models; and caring for the younger generations. Of the variables that influence community participation in a project, Kanthiti and Njera (2016) highlight the anticipated benefits to be the main factor that significantly influence people's participation in a project.

The targeted MW population were very quiet during these sessions even when prompted by the researcher to speak. However, they were noted to be talking quietly to each other without being heard by the audience in the hall. Black and African populations place a strong emphasis on showing respect to elders and authority figures; they traditionally treat elders with great respect and believe that either the father or the mother should be the ones that take the role of the decision maker within families (Komen 2020).

However, the targeted MM population were also very vocal in stressing their support regarding the concerns raised by their elders. Their other concern was having different sessions for MM and MW. At first, they viewed this as an ulterior motive on the part of the researcher to brainwash the MW in the absence of their male counterparts. This reaction supports the idea that most communities view men as the head of the house, and as decision makers and protectors of women and children. Economists believe that the family decision-making process

should be the outcome of conscious choices of each spouse where the decision-making power of each spouse is determined by economic as well as non-economic factors, but Deb (2015) states that the gender status is in fact a vital aspect that influences the decisions of men and women in any family. According to Deb (2015), the factors that influence the power that husbands or wives wield in a family determines the decision-making process of the unit.

Isiugo-Abanihe and Obono (2011) point out that men were the main decision makers in traditional society, but as the economic and political system underwent changes with the forced incorporation of the rural economies into the international labour market, working class poverty was created, and the roles and responsibility of men in Nigerian family life were transformed. The authors assert that, although there are contexts in which the conduct of men in caring for their wives and children is self-sacrificial and heroic, there are areas of social interaction in which men misuse their dominant status in society. Busija *et al.* (2018) observe that the way one communicates with an individual or audience should be influenced by one's cultural norms, faith and other social factors. It was through this consideration, among others, that the researcher was able to convince the community and win their trust that conducting the proposed study and subsequent development of the framework was going to benefit this community.

6.5 SECTION A: LINKING PARTICIPANTS' DEMOGRAPHIC CHARACTERISTICS TO HEALTH SEEKING BEHAVIOUR AND AUTONOMY AMONG MARRIED WOMEN

Selected demographic characteristics were common across the two groups of participants (MM and MW). For this reason, the demographic characteristics for both groups are discussed together in this section.

Age, level of education, employment status, marital status, sex, race, and social structural elements are some of the demographic characteristics that were gathered for both groups. There is research evidence that these often reflect a person's community stand or position, leading to particular expectations in terms of healthcare decision-making and autonomy in seeking health care services. According to Paul (2018), and Schoevers and Jenkins (2015), rural communities often have distinct demographic characteristics, such as age, education, and family structure that distinguishes them from other communities.

There was a strong indication from the study findings that the majority of the participants belonged to the same cultural group. All participants in the current study were Black Africans and, in line with the inclusion criteria, they were all from the Lemu rural district in Gbako Local Government Area. This was also evidenced by the majority speaking the same language, Nupe (MM 86.7%; n=26 MW 96%; N=22). Swierad, Vartanian and King (2017), in their study on the influence of ethnic and mainstream cultures on African Americans' health behaviours, highlighted the importance of both ethnic and mainstream cultures in shaping their health behaviours. According to these authors, ethnic and mainstream cultures influence the need to be understood in the context of other psycho-socio-environmental factors that affect individuals' health behaviours. The authors advise that it is important to examine ways in which people can optimise their health by taking advantage of the diverse values, beliefs, and practices that exist in their ethnic and mainstream cultures.

The majority of the participants in both groups (MM 87%; N=26 and MW 88%; N=22) had no basic education. These findings are supported by the United States Department of Agriculture (2021) who state that despite the gains made in educational attainment over time, there is still wide geographic variation in educational attainment within rural areas thus making rural communities have lower levels of education. Research shows that the majority of MW in the Lemu rural district have a poor level of education and are unemployed (Abideen, Adewale and Adeola 2013; Nigeria, National Bureau of Statistics 2017; Paul 2018). The high level of lack of education in this community could be partly responsible for the lack of health seeking autonomy among MW in this study. Furthermore, these findings, coupled with the lack of autonomy for health seeking behaviour in Lemu rural district, support the notion that empowerment is a bottom-up process which encourages women to focus on their empowerment through the process of analytically evaluating their own conditions and outlining changes in society (Batool and Batool 2018). Women's autonomy is conditioned largely by gender stratification and patriarchal authority in the society in which they live, but education of either the **men or women** or both can increase **women's** autonomy (Khan et al. 2006). Batool and Batool (2018) support the indirect role of education in women's empowerment and encourage actions that favour opportunities for women to earn money for their economic independence and enhancement of their self-esteem. Regardless of their level of education exposure, most residents in African countries, particularly the northern portion of Nigeria and

several Asian countries, hang on to their traditional values, beliefs, and customs, which are passed down from generation to generation (Okechukwu, 2013; Bonono and Ongolozogo, 2012).

With regard to religion, the majority of the participants belonged to the Islamic religion (MM 70.7%; N=27 and MW 90%; N=23). Islamic culture refers to cultural practices common to historically Islamic people. Islamic culture represents many distinct Muslim cultural groups such as the Asian Muslims, the Middle Eastern, the African, the European and the American Muslims, all of whom with their own divergence in customs and traditions, some of which may be more motivated by culture than by religion (Quran Reading, 2018).

The majority of the participants were between 25-35 years old (43%; N=24). This age bracket is consistent with the marriage age in Nigeria, and the reproductive age of 18-55 years as stated by the American Society for Reproductive Medicine (2012). According to this Society, a woman's best reproductive years are in her 20s and fertility gradually declines in the 30s, particularly after 35 years. In Nigeria women as young as 12 years get married, although this is controversial and is regarded in some circles as child marriage (Girls not Brides 2013). The UNICEF attests that Nigerian children are vulnerable to a wide range of abuses and harmful traditional practices, and that the country has the largest number of child brides in Africa with 23 million girls and women having been married as children. According to UNICEF the national legal framework for child protection is the Child Rights Act 2003, but to date, only 23 of 36 states have adopted the Act and its implementation is patchy with many local authority bodies unaware of their duties under the law. While the Child Rights Act stipulates the minimum age for marriage to be 18 years, the Matrimonial Causes Act is silent on the minimum age for marriage in Nigeria except that in Section 18 (1) the minimum age for marriage when consent is not required is 21 years. One of the recommendations made by the Senate Committee on the Review of the Constitution stipulates that citizens must be of full age to get married and defines "full age" as the age of 18 years and above (Girls not Brides 2013).

The majority of the participants (MM 83%; N=25 and MW 88%; N=22) were in polygamous marriages. The two fundamental norms which underpin the conjugal contract in a polygamous marriage are that a husband has the responsibility to provide for the economic needs of the family, and wives in turn must obey their husband and support him in economic endeavours

(Trócaire 2017). According to Trócaire (2017), these two responsibilities influence the distribution of power between a husband and wife/wives within the home and position women in a subordinate position in which they are dependent on men to provide for their needs, which in turn places them in an unequal bargaining position regarding a variety of needs within the household.

Concerning living arrangements; which for the MM determined whether they stayed at their homes meaning returned home everyday after work or they were staying away from home, for the purpose of being closer to work, the majority of the MM participants (87%; N=26) were staying at home with their wives. For the MM this was to establish whom they were living with, whether in a nuclear family or with parents-in-law. The majority of MW (52%; N=13) were staying with husbands and parents-in-law. Another 20% (N=5) of the MW participants confirmed were staying with their husband only (without parents-in-law), thus making 72% (N=18) staying with husbands. The proportion of participants not living with their husbands (28%; N=7) did not live alone, but were living with the parents-in-law. Thus, none of the MW in the current study were living alone and had autonomy to make own health seeking decisions. When the husbands were available they took the role of a decision maker, and when they were not available the parents-in-law took over this responsibility. Okonkwo and Ezumah (2017) state that men play an important role as heads of households; they are custodians of the interests of their lineage, protectors and providers of their families, and they are, therefore, the ones who make the majority of decisions pertaining to family life and society in general. According to these authors, the socialisation process makes Nigerian men influential and dominant in all spheres of life, giving them the final say on various family issues. They are at the centre of decision-making in domestic and reproductive health matters.

Concerning employment status, the majority of the MM were either self-employed (60.1%; N=16), mostly as traders, or unemployed (30.3%; N=12). The majority of the MW (80%; N=20) were unemployed. This confirmed the poor financial status that most of the families experienced. In a study conducted in Enugu State in Nigeria, participants indicated that their husbands felt that going to the hospitals would result in a waste of scarce resources, which could be used to meet other pressing matters (Okonkwo and Ezumah 2017). According to the United States Department of Agriculture (2017), median household income in rural areas is much lower than in urban areas, and this lower income correlates to higher poverty rates,

particularly in places where residents live in households with below-poverty income. Chowdhury (2015) found that women's level of autonomy increases with the increase of age, that urban women are more autonomous than their rural counterparts are, and that working and educated women are more likely to be associated with most of the dimensions of autonomy. Furthermore, women's economic status also has an impact on their decision-making power (Chowdhury 2015).

6.6 SECTION B: DISCUSSION OF FINDINGS IN RELATION TO THE OBJECTIVES OF THE STUDY

The discussion in this section is to demonstrate the achievement of the first six of the seven study objectives:

- To describe the process of healthcare decision-making and autonomy practices among MW in northern Nigeria.
- To determine and describe the untoward outcomes experienced by MW due inability to make own healthcare decision.
- To establish whether the male counterparts are aware of untoward outcomes experienced by MW due inability to make own healthcare decision.
- To determine the perspectives of male counterparts regarding healthcare decision-making and autonomy practices among MW in northern Nigeria.
- To determine the perspectives of MW regarding healthcare decision-making and autonomy practices among MW in northern Nigeria.
- To explore possible strategies to promote healthcare decision-making autonomy among MW in northern Nigeria.

6.6.1 The process of healthcare decision-making and autonomy practices among married women in northern Nigeria

The study findings confirmed a lack of MW's autonomy for health seeking decisions in the Lemu rural district. This resulted in either no or delayed access to health care. Latunji and Akinyemi (2018) define healthcare-seeking behaviour as any action or inaction undertaken by individuals who perceive themselves to have a health problem or to be ill, for the purpose of finding an appropriate remedy. These authors further explain that health-seeking behaviour can

also be described as an illness behaviour or sick-term behaviour situated within the broader concept of health behaviour, which encompasses activities undertaken to maintain good health, to prevent ill-health, as well as dealing with any departure from a good state of health. Furthermore, the National Academies of Sciences, Engineering, and Medicine (2005) defines access to health care as the timely use of personal health services to achieve the best possible health outcomes.

Gulliford *et al.* (2002) claim that access measured in terms of utilisation is dependent on the affordability, physical accessibility and acceptability of services, and not merely adequacy of supply, and that the extent to which a population gains access to health care services depends on financial, organisational and social or cultural barriers that limit the utilisation of services. Therefore, availability of services, and barriers to access, have to be considered in the context of the differing perspectives, health needs, and material and cultural settings, of the diverse groups in society (Gulliford *et al.* 2002). The majority of the participants in the current study had a poor financial status, mostly due to their level of education and employment status. This had an impact on the process of healthcare decision-making and autonomy practices. Either the husband would not allow it, or the women herself would opt not to attend health care services due to financial constraints, or opt for cheaper routes such as using home remedies or the complementary health care provided by local traditional healers and herbalists. In their study on determinants of health care seeking behaviour during pregnancy in Ogun State, Nigeria, Akeju *et al.* (2016) confirmed that the inability of most Nigerian women to pay for maternal health services drives them to alternatives such as the use of local herbs and consultation with traditional birth attendants.

In most countries, the government has put several strategies in place to improve access to health care services, some of which include free healthcare policies (Maphumulo and Bhengu 2019). However, despite the undeniable benefits of free healthcare policies, the problem of women's access to health care services remains, particularly reproductive healthcare services in rural areas because barriers other than cost continue to limit women's access to healthcare (Beaujoin *et al.* 2021).

Poor access to health care has serious implications for health outcomes. There is research evidence that in most sub-Saharan African countries such as Nigeria, Burkina Faso and many

others, the influence of factors such as lack of transportation, distance from health centres, poor provider-patient relationship, lack of respectful maternity care, or socio-cultural practices, impact access to health care services. Another factor recently highlighted in the literature is women's lack of decision-making power in the household regarding healthcare-seeking practices mainly because the decision to seek reproductive healthcare or to use family planning services usually rests with husbands or other members of the family (Beaujoin *et al.* 2021).

The overall findings by Divakaran (2013) suggest that health care utilisation is not only influenced by autonomy factors, but socio-economic factors such as residing in rural areas, poverty, financial status, level of education, distance from health care centres etc. also play a role. Based on the findings from the current study, a similar situation exists in the Lemu rural community.

The participants in the **current study** agreed that there was either no or limited knowledge of healthcare decision-making autonomy in the Lemu rural district, owing to the fact that only a few of them were familiar with the concept 'autonomy'. The MM participants acknowledged that they were unaware of the importance of accessing healthcare services; for them there were other traditionally/religiously accepted ways through which their wives could get health care services, which according to them were safer, cheaper and more acceptable. Most of the MW were aware of the importance of attending healthcare services, were mostly constrained by either their husband's or parents-in-law's control and had no right to seek healthcare without permission. Nonetheless, other factors such as transport difficulties, financial constraints etc. influenced MW's access to healthcare services.

According to Van der Hoeven *et al.* (2012), urban and rural communities have distinct characteristics in terms of healthcare-seeking behaviour, socio-economic characteristics, health status, health beliefs, the prevalence of non-communicable and infectious diseases, and individual decision-making when seeking healthcare services. Furthermore, these researchers discovered that, even when participants had autonomy in seeking health care, they still faced challenges, particularly working class MW.

6.6.2 Untoward outcomes experienced by married women due to the inability to make their own healthcare decisions

Many people face barriers that prevent or limit access to needed healthcare services, which may increase the risk of poor health outcomes and health disparities (Office of Disease Prevention and Health promotion 2020). Research evidence confirms a similar situation in Nigeria (Okonkwo and Ezumah 2017; Osamor and Grady 2017; Patil and Farooqui 2016). Studies on reproductive health issues have shown that the higher the status or autonomy of women, the higher the health service utilisation and vice versa (Nahrgang n.d.). The MW in the current study reported that they generally did not attend or attended late or poorly for healthcare services during pregnancy childbirth, post-partum and for childcare services, due to autonomy related and socio-economic reasons. Most of them indicated that their husbands and parents-in-law and other family/community members recommended traditional healers, traditional birth attendance or faith-based healers for healthcare services. Others stated that they often used herbs prepared or recommended by elders instead of going to healthcare services. Nahrgang (n.d.) concurs that in some developing countries, ill women need their husbands' approval before they can go out to seek medical treatment. The MW attested to a number of adverse events affecting both women and babies such as prolonged and obstructed labour, heavy bleeding before during or after delivery, fits during pregnancy, mothers and newborn babies requiring to be hospitalised, premature deliveries including loss of lives (maternal deaths, still births and neonatal deaths) of mothers, babies, or both. However, the majority of the participants in this study, particularly the MM, did not associate these adverse events to no or delayed access to health care as being caused by lack of women's autonomy. Instead, these were linked to myths and misconceptions such as evil spirits, bewitchment, and punishment from God. Where these complications happened in healthcare institutions, adverse events were blamed on negligence and ineffectiveness of staff in the health care institutions. According to Nahrgang (n.d.), women's lack of autonomy in decision-making about their own health care and on how to use household resources can be as much of a barrier to accessing reproductive health services as the absence of essential health system delivery functions such as the availability, quality and affordability of services.

6.6.3 Married men's awareness of untoward outcome experienced by married women due inability to make their own healthcare decisions

The majority of MM in the current study indicated that they were not aware of untoward outcomes experienced by MW due to their inability to make their own healthcare decisions. They also proposed that increased awareness of MM in this regard could influence their decisions regarding autonomy for MW regarding health-seeking decisions. Falade-Fatila and Adebayo (2020) attest to that lack of male involvement in pregnancy related care is one of the contributing factors to maternal death, the majority of which are pregnancy related. Such deaths are a public health burden in developing countries including Nigeria. Men's behaviour can significantly affect the health outcomes of women and babies. According to Falade-Fatila and Adebayo (2020), lack of participation of men in antenatal, postnatal, new-born or post-abortion care may be because they do not benefit from any information given by health providers regarding the health of the mother and the baby, or about their roles in it. Arising from their study, Falade-Fatila and Adebayo (2020) recommend:

- Review policy related to reproductive health to strongly emphasise the need for involvement of male partners in reproductive health issues and pregnancy related care;
- Organise enlightenment programmes about pregnancy related care for men, and they should also be involved in the design and implementation of maternal health services; and
- Educate men regarding pregnancy related care, including specific issues such as accompanying their partners for clinic visits and supporting new-born care.

In line with these recommendations by Falade-Fatila and Adebayo (2020), both MM and MW participants in the current study recommended collaboration and partnerships between healthcare workers and the community as a means to create a platform where critical information regarding healthcare related issues can be discussed.

6.6.4 Perspectives of married men and married women regarding healthcare decision-making autonomy practices among married women in northern Nigeria

The fourth and fifth objectives of the current study were to determine the perspectives of MM and MW regarding healthcare decision-making autonomy practices among MW in northern Nigeria. MM in the current study were against healthcare decision-making autonomy for MW.

They verbalised that their tradition, culture and religion demanded that health care seeking decisions be the responsibility of MM and elders. This concurs with the observation by Osamor and Grady (2017) that in some societies, religious, tribal, and social traditions define the circumstances under which women have or do not have autonomy to make decisions regarding their own health. The MW in the current study accepted that, as women, they did not have autonomy to make their own healthcare-seeking decisions. Similarly to the MM, the majority of MW accepted this as normal traditional, cultural and religious practice. A few who were not happy about the lack of MW autonomy still accepted it as they felt objecting to it could jeopardise the security of their relationship with their husbands.

According to Neuber (2020), perspective plays a significant role in decision-making, and most of the time decisions are associated with a perceived benefit and a perceived cost. The impact of influencers for a particular perspective can vary greatly depending on circumstance, mood, pressures, anticipated benefits, and anticipated costs. Nicholson (2018) concurs that the perspective through which we are viewing a choice (sometimes called a reference point, or frame of reference) can also influence the ultimate decisions that we make. The perspectives of the MM participants in the current study were that in order to safeguard the safety of women and children, selected critical decisions had to be taken by either men or elders in the family. And that of the MW was that they needed to comply with this approach in order to maintain peace and prosperity within their families. Nicholson (2018) advises researchers to look at options from multiple perspectives and from both a gain and loss perspective, which helps to balance out one's motivations and so make better choices that help ensure the likely occurrence of the things that are most important and satisfying. This decreases the likelihood of "tricking" oneself into concluding that one option is better than the other simply by the way one is thinking about it and not because it is actually better.

6.6.5 Explore possible strategies to promote healthcare decision-making autonomy among married women in northern Nigeria

The study participants shared their opinions regarding the strategies that could promote healthcare decision-making autonomy among MW in the Lemu rural district in northern Nigeria. These included: 1) awareness of MM and other community members regarding importance of autonomy of MW to make decisions to visit healthcare centres, and 2)

collaboration and partnerships between healthcare workers and the community as a means to creation of a platform where critical information regarding health care related issues can be discussed.

Information and information exchange are crucial to the delivery of care on all levels of the health care delivery system such as the patient, the care team, the healthcare organisation, and the encompassing political-economic environment levels (National Academy of Engineering and Institute of Medicine Committee on Engineering and the Health Care System 2005). An improvement in patients' ability to assume greater control and responsibility for care decisions enabled by information and communications would advance patient-centred quality health care. Therefore, it is necessary that at the patient level, individual patients, family and community be empowered to assume a much more active and controlling role in decision-making and in implementing their own health care to bring about a shift from hospital/clinic-based clinician-directed care to home-based, clinician-guided self-care (National Academy of Engineering and Institute of Medicine Committee on Engineering and the Health Care System 2005). According to Nahrgang (n.d.), women's autonomy refers to a woman's ability to make and execute independent decisions pertaining to personal matters of importance to their lives or their family, even though men and other people may be opposed to their wishes. Contrary to the definition of autonomy, the MW in the current study did not support engaging in behaviours that were not approved by their husbands and other members in the community.

The importance of collaboration and partnerships between healthcare workers and community is evidenced in research showing that when patients and healthcare providers listen and communicate with each other they are likely to develop a shared understanding that is likely to improve future decision-making and quality of care patients receive (Kennedy *et al.* 2017).

The researcher of the current study agreed with the already stated strategies by the study participants, but also identified a few additional strategies, the majority of which related to the role of healthcare services in the promotion of autonomy for MW regarding healthcare seeking decisions and behaviours. These are discussed and supported with literature in the section below and include:

- Strengthening collaboration and partnerships between health care workers and the community.

- Collaboration with other role players including religious organisations, traditional leaders, traditional healers and traditional birth attendants.
- Healthcare workers understanding community values and tradition and taking cognisance of these when developing/renewing policies and planning for health care services.
- Ensuring that healthcare services are user friendly and accessible to the; and
- Allowing the community to provide input into the plan for the provision of healthcare services.

6.6.5.1 Strengthening collaboration and partnerships between healthcare workers and the community

One other gap identified by the study participants was poor communication between health care institutions and the community. The President of the European Patients' Forum (Greco 2021) highlighted the importance of clear, timely and accessible public health communications and advised that while there must be an impetus to increase health literacy at a grassroots level, current conditions could be ameliorated by establishing clear communication channels between patients and their healthcare professionals. Community engagement is a powerful vehicle for bringing about environmental and behavioural changes that improve the health of the community and its members, through working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the wellbeing of those people (Centres for Disease Control and Prevention [CDC] 2013). This often involves partnerships and coalitions that help mobilise resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programmes, and practice. Involving people like community leaders helps with this in that the leaders can use their positions, influence, and ability to make changes within their organisation and the greater community (CDC 2013). Blank and Langford (2000) point out that creating a successful community partnership is a complex, challenging, and time-consuming task that requires partnerships to engage in a thoughtful process to define a vision and clear goals, have effective governance and management structures to ensure that programmes operate efficiently, and ensure that the partnership is responsive to community needs.

6.6.5.2 Collaboration with other role players including religious organisations, traditional leaders, traditional healers and traditional birth attendants

The researcher concluded from the findings of the current study that religious organisations, traditional leaders, traditional healers and traditional birth attendants are interested and affected parties in the subject under study, namely, healthcare decision-making autonomy practices among MW in northern Nigeria. An interested and/or affected party is defined as any person or organisation interested in or affected by an operation or listed activity, and any organ of state who may have jurisdiction over any aspect of the operation or activity (University of South Africa [UNISA] 2013). Generally, health care involves the participation of a number of stakeholders including patients, family, and a diverse team of other stakeholders. Morley and Cashell (2017) agree with this and indicate that involvement of all these team members in a cooperative and coordinated way is essential to providing exceptional care. Ndemanu (2018) highlights religious and traditional leaders as other critical role players because they are perceived to be the custodian of people's morality in society. Ndemanu (2018) observes that religion is inextricably linked to culture, especially in the African context, and that traditional religions continue to have tremendous influence on Africans in their thought processes, belief systems, and worldviews. Ndemanu (2018) argues that traditional and religious leaders in Nigeria appear to have little understanding of their position as respectable members in the society .

6.6.5.3 Health care workers understanding of community values and tradition and the importance of taking cognisance of these when developing/renewing policies and planning for health care services

The findings from the study indicated that culture, tradition and religion were some of the contributory factors to lack of MW autonomy. Husbands and parents in laws were reluctant to allow the MW to make their own decisions on when, where and how to attend healthcare services due to their fear the MW's decisions or health services provided would conflict with cultural, traditional or religious beliefs. These findings necessitate that healthcare workers should have a clear understanding of community values and traditions so that they are able to take cognisance of these when developing/renewing policies and planning for healthcare services. Kennedy *et al.* (2017) provide three reasons for why healthcare providers'

understanding of their patients' healthcare beliefs, values, and preferences is an important feature of patient-centred care:

1. Acquiring a better awareness of a patient's health beliefs may help healthcare providers identify gaps between their own and the patient's understanding of his or her health situation, thus leading to treatment choices more acceptable to the patient's expectations and needs;
2. Healthcare providers' skill at perceiving and understanding patients' beliefs is also an important aspect of compassion which equates to perceptions of higher quality care and more effective communication; and
3. Research has shown that patient satisfaction, commitment to treatment, and perceived outcomes of care are greater when the healthcare provider and patient achieve a shared understanding on issues such as the patient's role in decision-making, the meaning of diagnostic information, and the treatment plan.

Several authors concur that with the increase of religious diversity, understanding religious values and spiritual beliefs of patients in health care organisations may improve the quality of healthcare services (Berry *et al.* 2011; Markani, Yaghmaei and Fard 2013). According to Markani, Yaghmaei and Fard (2013), spiritual care is an essential part of holistic care, which requires nurses and other health care professionals to adapt their practice to improve the quality of healthcare services provided to the community. The influence of religion on patient care requires nurses to adapt their care based on the religious practices of their patients and to provide culturally sensitive nursing care (Omu, Al-Obaidi and Reynolds 2014). The participants in the study by Omu, Al-Obaidi, and Reynolds (2014), which examined religious faith and psychosocial adaptation among stroke patients in Kuwait, emphasised the positive influence of religion on patients' wellbeing, regardless of their religion. The participants shared that through religion patients gain strength, hope, self-confidence and mastery, with a sense of partnership. Another study by Cheraghi, Manookian and Nasrabadi (2014), which aimed to identify common experiences of Iranian Muslim and Armenian Christian patients regarding dignified care at the bedside, found that both Muslim and Christian patients mentioned that providing care to patients required healthcare professionals to be aware of patient's values, beliefs, customs, expectations, preferences, habits and lifestyle. Healthcare professionals'

understanding of these needs allows them to provide the religious and spiritual care required by the patients (Cheraghi *et al.* 2014).

6.6.5.4 Ensuring that health care services are user friendly and accessible to the community to promote use

The MM findings from the study indicated that at times the health care services were not user friendly and accessible to the community. The study participants indicated previous encounters with health care services as some of the reason that the MM were reluctant to freely allow their wives to use local health care services. The quality of services has received little attention in many African countries, yet, improving quality of health services is vital to improving the abysmal level of health in Africa (Adindu 2010; WHO 2012; WHO 2018). Adindu (2010) states that quality in African health care systems has become a major concern due to seemingly intractable poor health indices in most countries. Yet, importance of healthcare in the lives of people makes quality critical, regardless of where services are provided – in the hospital or in the community. The findings from this study indicated that past experiences with health care services such as untoward outcomes, adverse events, ill-treatment by health care providers etc. resulted in husbands and relatives not being keen for their MW to attend health care services with fears of the MW encountering similar problems. There is evidence that apart from users being reluctant to use healthcare services, poor quality health services are holding back progress on improving health in countries at all income levels. The WHO (2018) states that the situation is worst in low and middle-income countries and includes, but is not limited to, inaccurate diagnosis, medication errors, inappropriate or unnecessary treatment, inadequate or unsafe clinical facilities or practices, or providers who lack adequate training and expertise. In the foreword in the *Health Systems in Africa: Community Perceptions and Perspectives*, Dr Margaret Chan, who is WHO Director-General, highlighted that the inequalities in the health status of people between and within countries has been a cause for concern for health managers and providers over time. When comparing the key health indicators in the world, uneven distribution of health across countries, within countries, and between population sub-groups, e.g. rich and poor, men and women, become evident. Furthermore, there are differences between rural and urban areas in coverage of key health services such as skilled attendance at birth, immunisation, and diagnosis and treatment of common diseases. Dr Chan advises that these inequities can be avoided through the adoption and implementation of relevant health and

development policies that seek to minimise variations of health indicators associated with socio-economic status (WHO 2012).

6.6.5.5 Allowing the community to provide input into plans for the provision of healthcare services

MW's autonomy in healthcare decision-making is influenced by socio-demographic and socio-cultural factors. Women's age and lack of education also influences their ability to make independent healthcare decisions, thus MW, particularly in rural areas, require specific empowerment programmes to enable them to be more autonomous in healthcare decision-making. Women's autonomy via education requires more social science research to determine the disparities between each stratum. MW can use community resources, challenge conventional norms and values, and obtain economic resources with the help of a solid and complete approach. In time, this will lead to MW having more autonomy in decision-making. They can also participate in cohort activities, which are another facet of women's empowerment, and they can be encouraged in entrepreneurship, including teaching them simple vocations. The MW of the Lemu rural district require a specially developed empowerment programme, according to the study. Gender-stratified settings are common, and women's lack of autonomy is mostly due to traditional causes (Jejeebhoy 1995). Several authors (including Nahrgang n.d.) support the notion of allowing the community and other family members to provide input into the plans for the provision of health care services. Nahrgang (n.d.) advises that targeting husbands in addition to wives to provide input into the plans for the provision of maternal and childcare health services could yield potential benefits due to the importance of couples' communication and joint decision-making.

6.7 SECTION C: DISCUSSION BASED ON ANDERSON'S HEALTH BELIEF MODEL (HBM)

The researcher used the HBM to get better understanding of findings from the data analysis. The decision to use the HBM as a theoretical framework to guide the study was informed by the fact that several authors have used the HBM in their studies to investigate and understand human behaviour (Glanz and Rimer 2005; Stretcher and Rosenstock 1997; Boskey 2020), and all concur that the model is designed to predict human health-seeking behaviour. This decision is also supported by the proposal by Akeju *et al.* (2016) that health care decisions can be

explained by use of the Health Belief Model, which states that individuals weigh the potential benefits against the psychological, physical and financial costs when making decision to seek care.

According to Glanz and Rimer (2005), the underlying concept of the original HBM is that health behaviour is determined by personal beliefs and perceptions about a disease or the strategies available to decrease its occurrence. This model is also used to predict which people would or would not use preventive measures and to suggest interventions that might reduce clients' reluctance to access healthcare. Boskey (2020) states that a person's individual beliefs about health and health conditions play a role in determining the person's health-related behaviours, and that some of the beliefs that influence health seeking behaviour are the key factors that affect the approach to health. According to Stretcher and Rosenstock (1997), the HBM has six constructs which represent the perceived threat and net benefits. These are perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues of action and self-efficacy. In the current study, these are used to better understand MW's autonomy regarding health seeking behaviour in the Lemu rural district. Figure 6.1 is a schematic presentation of how, according to the study findings, each of six constructs influenced MW autonomy regarding health seeking behaviour in the Lemu rural district. The model provides the existing situation as described by the participants and according to literature, and what could remedy the situation (improve MW autonomy). The researcher considered that the cues of actions are modifying factors influenced by individual perceptions, which determine the existing likelihood of action (behaviour).

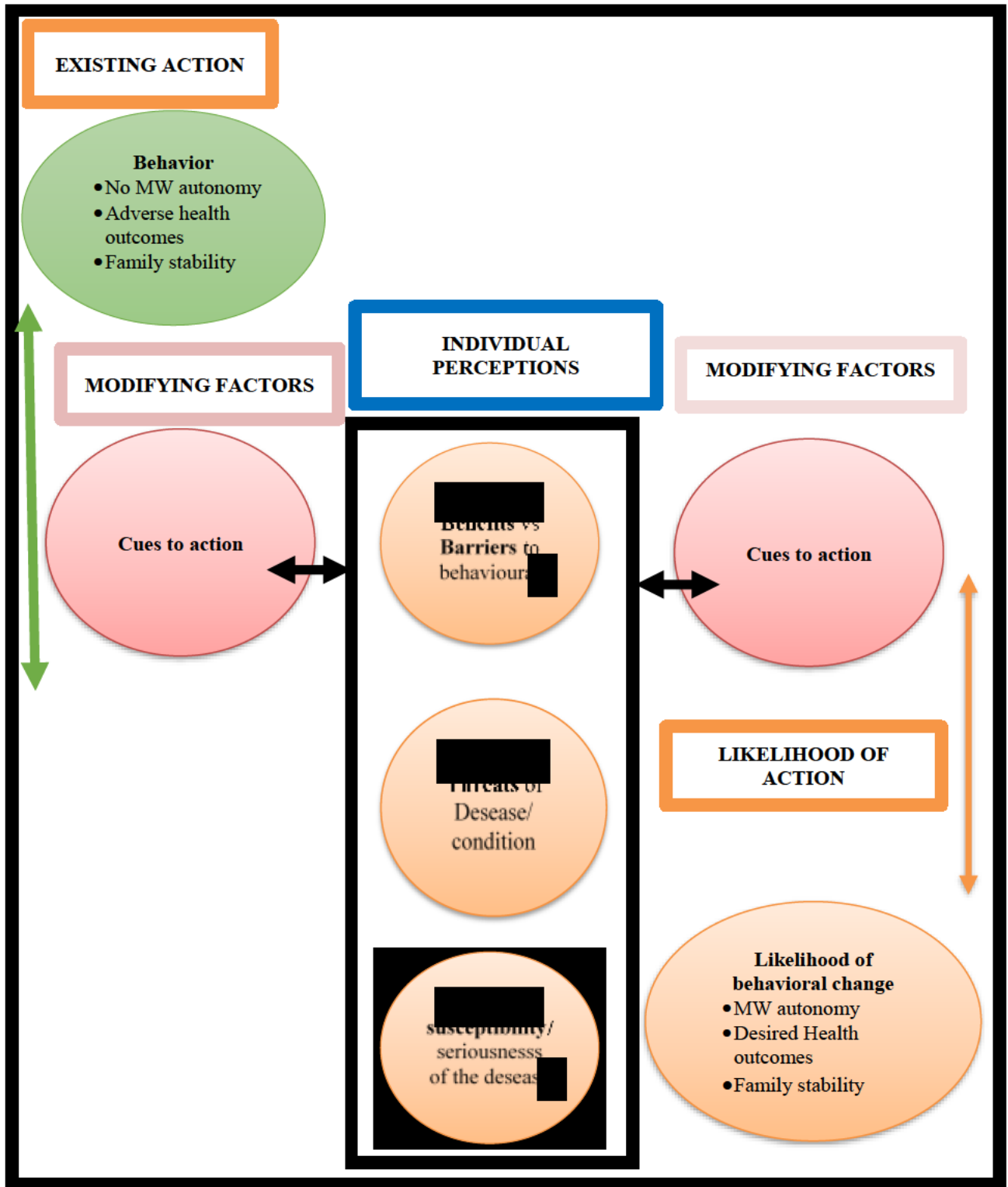


Figure 6.1: Schematic presentation of how the six constructs influenced MW autonomy regarding health seeking behaviour in the Lemu rural district
 Source: Adapted from Stretcher and Rosenstock (1997)

6.7.1 Individual perceptions

Individual perceptions have a strong influence on behaviour (Fleming 2020). Perceived severity, perceived susceptibility, perceived benefits and perceived barriers are the different forms of perceptions that, according to the HBM, influence an individual's health seeking behaviour (Boskey 2022). The findings from the current study revealed that, even when MW were aware of the severity of their health conditions, of their susceptibility to illness and/or complications, and of the benefits of attending health care services, this did not motivate them to attend health care services. Instead, they either opted to seek health care services from traditional healers or awaited approval by their husbands or parents-in-law before seeking medical help. Akeju *et al.* (2016) state that in most African societies including Nigeria, the status of women is low and families are patriarchal, with men responsible for key decisions including control over property. The patriarchal culture gives women little or no power to decide when they become pregnant, or how, when, and where to seek care during complications. Therefore, women enter into marriage, child bearing and child rearing within a cultural milieu of male-dominance where men view their wives as one of their possessions. Similarly, the findings from the current study revealed that the perceived barriers were mostly related to a lack of autonomy by MW who had to rely on approval by husbands and parents-in-law for health seeking decisions. The marital relationship for women in marginalised and impoverished communities involves the relations between wives as daughters-in-law and their husbands' parents/family; thus making the husbands' family members, particularly mothers-in-law, responsible for shaping women's health seeking behaviours (Das 2017).

The majority of MW were complacent with this arrangement as it was an acceptable practice in the community and has been practised over the generations. However, several MW participants indicated that even when they were aware of the severity of their conditions, their susceptibility to risks and adverse events, the benefit of attending health care services and risks of not attending, they could not do anything about it except to follow what was customarily practised in the area. Although a number of them were not happy about their lack of autonomy they were nevertheless compelled by tradition, family values and dependence to conform to these practises.

However, a number of MW and MM indicated lack of knowledge regarding perceived severity, perceived susceptibility, and perceived benefits.

The findings from the current study showed a number of factors being responsible for the poor utilisation of health care services by MW from the Lemu rural district in northern Nigeria over and above lack of healthcare-seeking decision making autonomy. Some of these included financial constraints, myths and misconceptions about health care services and many others. The majority of these were also the reasons for lack of healthcare-seeking decision making autonomy in this rural district. A number of barriers became evident even before commencement of the study at the time of recruitment and information giving sessions, where the elders and male counterparts verbalised perceived threats if the MW were allowed autonomy for health seeking behaviour. The attitude of elders and male counterparts were some of the barriers to MW autonomy. The perceptions of the MM and their lack of knowledge about the benefits of affording their wives autonomy were some of the barrier on the side of MM.

MW themselves appeared to have limited information regarding the benefits of women's autonomy regarding health care seeking behaviour. What was most important to them was respect for their husband and elders, which for the majority of them provided a sense of security and protection.

The priority for this community appeared to be on family values and tradition with little or no cognisance of what the benefits of affording the MW autonomy could be. This was compounded by lack of information regarding the impact of this on health outcomes.

6.7.2 Modifying factors

LaMorte (2019) describes the cues to action as being exposure to factors that prompt action. This is the stimulus needed to trigger the decision-making process to accept a recommended health action, which can be internal or external. The current study explored the factors that were responsible for existing behaviour of the MW in the Lemu rural district. The findings from the study were that the internal factors had little or no influence on MW's autonomy for health seeking behaviour. Even where a risk was identified, MW indicated they would wait for important others (husband or in-law) to make the decision. Because of this approach, many complications and adverse events can arise due to non or late access to health care. A number

of external factors such as culture and tradition, lack of information and perceptions of elders and husbands prevailed. These were compounded by the level of education, financial status, living arrangements etc. Akeju *et al.* (2016) observe that while patriarchy is a culturally entrenched factor that subjugates women, lack of financial empowerment further compounds women's inabilities to determine where, when and how they may seek care during pregnancy. Das (2017) concurs, stating that numerous factors such as financial status, levels of formal education, autonomy within marital relations, and so on, affect health seeking behaviours of women, and husbands' role interconnects and overlaps with these factors. Both the MW and MM had some ideas regarding the factors that could facilitate improved autonomy for MW. These, according to literature, are the cues of action that could enhance MW autonomy.

6.7.3 Likelihood of action

The HBM recognises the fact that sometimes wanting to change a health behaviour is not enough to actually make someone do it. Cues to action and self-efficacy are necessary to get an individual to make the leap to action. Cues to action (external events) move someone from wanting to make a health change to actually making the change (Boskey 2022). LaMorte (2019) describes this as the level of a person's confidence in his or her ability to successfully perform a behaviour. Whether a person performs the desired behaviour or not is influenced by a number of factors, some of which include but are not limited to, individual perceptions and modifying factors as describe in sections 6.6.1 and 6.6.2 above. The findings from the current study show that other factors such a status of women in the community, traditional and cultural practices, and religious beliefs, have a stronger influence on women autonomy than individual perceptions by MW themselves. This provides a stance for the researcher to develop a framework to promote MW autonomy. The proposed framework is setting specific in that it takes into consideration both MW and MM members of the community

6.8 FINDINGS ON DATA TRIANGULATION

Selected study findings were triangulated to get a clearer picture regarding the problem being investigated. The section below discusses and supports the findings on triangulation with relevant peer and non-peer reviewed literature.

6.8.1 Findings on triangulation of selected information by study participants that led to themes

6.8.1.1 Reasons for lack of autonomy for MW to make own decisions regarding health-seeking behaviour

Traditional, cultural and religious beliefs were the stronghold that influenced the situation in the Lemu rural district regarding autonomy for MW, resulting in MM denying their wives autonomy. MW were obliged by tradition, culture and religion to respect and accept decisions by husbands and elders. Pascale and Primavera (2020) state that in most traditional marriages, both husbands and wives are comfortable with the idea that the husband is dominant. Often both partners have a set of expectations about how each partner should behave and they find their respective roles to be natural and even preferred, while they might admit to themselves that their relationship is imbalanced. The partner is willing to live with things as they are because that is how they see the way of the world (Pascale and Primavera 2020). These authors further state that what is most important, and will make couples happy in any marriage whether traditional and modern, is that the couple's perspectives are in harmony.

A number of confounding factors influenced women's health seeking behaviours. A few flagged in this study were tradition, culture and religion beliefs, financial status, distance from the health facility, previous experiences, and attitudes of healthcare workers.

6.8.1.2 Importance of autonomy for married women to make their own health-seeking decisions

The study participants acknowledged that autonomy for MW to make their own health seeking decisions could be important. However, limited information regarding the importance in this regard and regarding other health care information affected their decisions. They felt that they needed more information from the health care workers to be able to make better informed decisions. Nikbakht Nasrabadi, Sabzevari and Negahban Bonabi (2015) are of the view that empowerment is a process through which individuals, societies, and organisations gain the control of their important matters, and facilitates the ability to choose appropriate strategies for controlling the resources required for reaching favourable consequences.

6.8.2 Findings on triangulating of themes and selected demographic characteristics

6.8.2.1 Level of education and importance of autonomy

It was not easy to establish how the level of education influenced views of the participants regarding the importance of autonomy for the MW because almost all participants except two had either no education or primary school level only. Nonetheless, the view of one of the two participants who had secondary school level of education was that it was important that the MW be allowed autonomy to make own decision regarding health care behaviours. According to Flagg, Bisakha, Kilgore and Locher (2014), education provides an avenue for exposure to more egalitarian ideas and can debunk many gender stereotypes, and those who are highly educated may tend to have higher status jobs and work more hours leading to an increase in the likelihood of sharing responsibility for household tasks and decision-making. Education plays a positive role in the women's lives by enhancing their participation in the family's power distribution (Agha and Tarar 2018). Agha and Tarar (2018) conducted a study in a less developed area in Pakistan on the the influence of women's education on their autonomy. They found that women with graduate level education performed better in the family's power distribution than women with primary or secondary level education, and that they had more frequent participation in family's decisions and visited healthcare facilities more often.

6.8.2.2 Employment status, financial status and importance of autonomy

The unemployed MW based their decision that MW should not be allowed autonomy for health-seeking decisions on the fact that it was required by their tradition, culture or religion. In addition, the MW indicated that their financial status compelled them to respect the husband authority as the husbands were responsible for paying for healthcare services and other financial needs. Ruskin and Dwini (2018) agree that work, especially paid work, enhance women's autonomy, particularly their household autonomy. Ruskin and Dwini (2018) explained that this assumption does not work in one causal direction but both ways, where women work due to their high level of autonomy, but also their employment status increases their autonomy.

6.8.2.3 Living arrangement and importance of autonomy

The majority of the MM participants were residing in extended families and indicated that the responsibility for health seeking behaviour should rest with the husband as the head of the house or in their absence, their parents as elders of the house. There is research evidence that in developing countries, paid employment and having a greater number of living children are all positively associated with women's autonomy in decision-making with women's age and family structure being the strongest determinants in this regard (Acharya *et al.* 2010). Therefore, older women and women in nuclear households are more likely than other women are to participate in family decisions. This makes younger women in extended families have less autonomy in decision-making (Acharya *et al.* 2010).

6.9 CHAPTER SUMMARY

Chapter 6 presented a discussion of findings from data analysis and interpretation. Relevant literature was used to support the discussion. In this chapter, the researcher presented the achievement of the first six objectives of the study. The information presented in this chapter will guide the achievement of the final objective, which is to develop a framework to facilitate healthcare decision-making autonomy among MW in northern Nigeria. The next chapter will present the framework developed on the basis of results obtained.

CHAPTER 7: DEVELOPMENT OF A FRAMEWORK TO FACILITATE HEALTHCARE DECISION-MAKING AND AUTONOMY PRACTICES AMONG MARRIED WOMEN IN NORTHERN NIGERIA

7.1 INTRODUCTION

This chapter presents details regarding development of the framework to facilitate healthcare decision-making and autonomy practices among MW in northern Nigeria. Development of the framework was the seventh and final objective of the current study. A preliminary framework is presented on how it was reviewed and modified based on the input by the relevant experts till a final framework was achieved.

7.2 UNDERSTANDING THE FRAMEWORK AND ITS USE

Several authors define and describe a framework differently depending on the purpose for its use. The two closely related descriptions that best described the framework in line with what the researcher intended to use it for were those by Lutkevich (n.d.) and Conley (2016). Ben Lutkevich, a technical writer for WhatIs.com, describes a framework as a real or conceptual structure intended to serve as a support or guide for the building of something that expands the structure into something useful (Lutkevich n.d.). Conley (2016), a founding partner of an innovation firm and a former tenured professor at IIT's Institute of Design in Chicago, describes a framework as a basic structure of something, a set of ideas or facts that provide support for something and a simple visual structure that helps organise the information and ideas of a problem so that it can be worked on more effectively.

According to Lutkevich (n.d.), a framework is generally more comprehensive than a protocol and more prescriptive than a structure; it is often a layered structure indicating what kind of programmes can or should be built and how they would interrelate. It often includes actual programmes, a set of functions within a system and how they interrelate; the layers of an operating system; the layers of an application subsystem; how communication should be

standardised at some level of a network; and so forth (Lutkevich n.d.). According to Conley (2016), a framework assists in figuring out what the problem or area of opportunity is, thus enabling an understand of a problem in a new way and creating the basic structure that gives focus and support to the problem you are trying to solve.

As described by Lutkevich (n.d.), the researcher needed to develop a structure/framework to serve as a support or guide for facilitating MW's autonomy in healthcare decision-making to attend health care services. The researcher's intention was to assist in improving maternal and child outcomes in northern Nigeria. Using the information gathered from both participant groups (MM and MW), the researcher was able to ascertain what the problem or areas of opportunity were. This enabled the researcher to understand the problem witnessed in the Lemu rural community in a new way and create a basic structure to give focus and support to the problem in question.

Conley (2016) advises that organisational problems are not like textbook problems where everything is structured for you in advance. Therefore, the first step in any project should be to research and frame the problem to aid in better understanding the problem before beginning ideation. The framework design should be a simple visual structure that helps organise the information and ideas of a problem to facilitate working on it more effectively and is often composed of a relevant list of categories developed from initial research that should be a part of every new project and should focus on an area that is relevant to possible solution directions for the problem (Conley 2016). In this description on how to make a framework to structure the project by Conley (2016), the first step is conducting research to gather the content for the framework. In line with this provision by Conley (2016), the researcher conducted the research and data was collected from MM and MW, analysed, interpreted and supported by literature to give a better understanding of the problem.

Conley (2016) advises that research should be followed by identification of the categories of information as the basis of the framework. At the beginning of the development of the framework, guided by the themes and sub-themes that emerged from data analysis and the HBM as the theoretical framework that was use the guide the study, the researcher was able to identify three broad categories as both the major cause of, and possible solution to, resolving the problem.

The framework highlights three main problem areas that are responsible for lack of MW's autonomy and possible areas of opportunity to resolve this as being: communication, collaboration and respect. The findings from data analysis further revealed several factors that compounded the problem which included community awareness about autonomy of MW, traditional and cultural beliefs, financial issues, communication and transparency between the healthcare workers and the community, safety of mothers and children, and preservation of societal values culture and traditions. The two critical factors that hindered autonomy for MW were: lack of awareness regarding importance of autonomy of MW to make decisions to visit healthcare centres, and lack of collaboration and partnerships between healthcare workers and community. Thus, these factors formed the basis in developing a framework. As stated by Conley (2016) the developed framework describes a set of ideas or facts that were evidenced by the study findings to have a potential to facilitate healthcare decision-making and autonomy practices among MW in Northern Nigeria identified as being communication, collaboration and respect.

According to Conley (2016) the next step after identifying the categories should be to organise the categories visually into a diagram. The framework is presented in a simple diagram that organises the dimensions for the process that should be undertaken by all relevant parties (health care workers and community members) to facilitate healthcare decision-making and autonomy practices among MW in northern Nigeria. Communication, collaboration and respect are the three main categories for the framework that are visually presented in diagram form as shown in Figure 7.1, thus enabling understand of the problem in a new way and creating the basic structure that gives focus and support to the problem in question.

7.3 DESCRIPTION OF THE PROBLEM AND FOCUS AREAS FOR IDEATION

Conley (2016) advises that as a last step, the framework should be used to describe the problem and focus areas for ideation

7.3.1 Description of the problem

The participants declared that most of their decisions regarding MW autonomy for health seeking decisions and practices resulted from lack of awareness. These findings confirmed poor communication and lack of community involvement as the major causes of lack of MW

autonomy to make health seeking decisions and resultant health seeking practices. The MW participants declared that they were unaware of the services offered in local healthcare services because such information was not communicated to them by healthcare providers. Similarly, the MM also declared that they were not aware of untoward maternal and child care outcomes experienced by MW due to their inability to make their own healthcare decision as no one communicated this information to them. According to Vermeir *et al.* (2015), poor communication can lead to various negative outcomes including discontinuity of care, compromise of patient safety, inefficient use of valuable resources, dissatisfaction in patients, overworked physicians, and economic consequences, often hidden. Butler and Sheriff (2021) state that a good health system engages fairly and respectfully with everyone who seeks care, and it recognises that its patients and plan enrollees come with a range of previous experiences with the health care system, as well as different literacy levels, language fluency, and cultural norms. According to Butler and Sheriff (2021), it is the responsibility of system managers and front-line providers to ensure that everything from examination room interactions to provider training is guided by good communication techniques. Furthermore, Butler and Sheriff (2021) caution that good communication goes beyond just language and should include being sensitive to cultural differences even in interactions with a common language, from understanding conventions regarding eye contact to physicians appreciating ways in which lifestyle and culture as these can influence the relative effectiveness of alternative treatment plans (Butler and Sheriff 2021).

7.3.2 Focus areas for ideation

As detailed in the previous section, the three focus areas for ideation were communication collaboration and respect.

7.3.2.1 Communication

The findings from the study revealed some actions and desions by MM, MW and other members of the community were as a result of lack of awareness about the implications of such. Thus, devising ways to create awareness for the community at large regarding the importance of the autonomy of MW to make decisions to visit healthcare centres became a priority area for the framework.

Tiwary *et al.* (2019) attest that effective health provider-patient communication is vital as it is associated with favourable health outcomes such as increased patient satisfaction, compliance, and overall health status, and that poor communication can result in various negative outcomes such as decreased adherence to treatment, patients dissatisfaction and inefficient use of resources. According to Tiwary *et al.* (2019), communication during the medical interaction between the health practitioner and the patient has a pivotal role in creating a positive health impact that includes drug adherence, future decision-making on interventions, and modifying the health behaviours of the patient. These authors further declare that clear communication is vital in the proper treatment of the patient especially against the background of rampant illiteracy in developing countries.

The Youth Empowerment Souldution (YES) is an example of one organisation that has community engagement as its key critical component to increase the public's awareness. A critical component of the YES programme is community engagement and a key to community engagement is to increase the public's awareness of YES. YES advises that information that could be shared with the community through community engagement can include what the programme is about, how it will affect the lives of people, how it can improve the community, what are the specific plans for the programme and how the community can help. The YES describes four critical tips for increasing community awareness: (1) hosting a community events or forums, (2) honouring community members or organisations that have accomplished outstanding work to improve the community, (3) use logos on marketing materials such T-shirts, hats or other, and (4) reaching out to networks. Similarly, community engagement was considered the key strategy to increase the public's awareness regarding the importance of MW autonomy in the framework.

In line with the above evidence on the importance of communication, the researcher highlights in the framework open and continuous communication between all relevant stakeholders. The study findings reflected fears on the part of the community, with MW fearing disapproval by their spouses and elders. However, such fears were not communicated to spouses and elders, instead they became submissive. The MM and elders discouraged their women from attending healthcare services because they feared for the safety of their women and children in the healthcare services due to previous experiences. There was evidence presented of healthcare workers not communicating with the community the benefits of MW autonomy, risks of lack

of autonomy and outcomes of poor health seeking practices,. There was also evidence of resources available to MW not being communicated to the community. In the framework the researcher makes a provision for these to be addressed through communication and engagement.

7.3.2.2 Collaboration and partnerships between health care workers and community

The researcher looked at the problem of lack of autonomy for MW from a broad point of view. Considering today's ever more interconnected and fast-paced world, Lang and Whittington (2022) state that it is important that not only the long view but also the broad view should be taken into account when developing a framework or a strategy. A broad view encompasses the full spectrum of opportunities and threats that are emerging on all sides. According to the authors, the shift to a broad view of strategy has three key implications for leaders:

- Leaders have to focus on anticipating contextual changes that might significantly and rapidly reshape the business environment and they will have to work with others to co-create value as they do that.
- Leaders have to imagine different time horizons and use them not just to make plans for the future but also to gain broader perspectives on the present.
- Leaders need to prepare themselves to rapidly adapt to changing circumstances, by constantly working on their agility and creating new options for themselves.

The findings from the study revealed that collaboration and partnerships between healthcare workers and the community can create platforms where critical information regarding health care related issues could be discussed. This could be one way for improving awareness of all the community members regarding the importance of the autonomy of MW to make decisions to visit healthcare centres and subsequently improve health-seeking practices. Therefore, the framework emphasises collaboration and partnership between healthcare workers and the community. The researcher considered that all relevant stake holders such as the health sector, MM, MW, the community, religious leaders, traditional leaders, healers and birth attendants have the potential to either resolve or escalate the problem.

7.3.2.3 Respect

The findings from the current study reflected that the Lemu rural community had some customs, cultural perspectives and traditions that they adhered to which influenced their health seeking behaviours and decisions about MW autonomy. Davenport (2021) explains that respect refers to due regard for the feelings, wishes, rights, or traditions of others. The author explains that respect is very important because sometimes the survival of the group depends on their respect for the leader. Thus, one person's respect or disrespect towards a spouse can determine whether the marriage will last, and shared respect or the lack thereof for the teacher can mean the difference between a calm learning environment and chaos. In any long-lasting relationship, mutual respect involves a degree of deference for the other person, which we show in our words and actions or by abstaining from something. This explanation provided by Davenport (2021) supports the findings from the current study where the MW respected their spouses and elders irrespective of any other circumstances. This type of respect is described by Salazar (2019) as family respect where members of the family understand and respect each other within the family and follow a set of rules of coexistence irrespective of the implications. When it comes to providing health information to clients, healthcare workers assume the role of a teacher and should ensure that the environment where teaching takes place is as calm and conducive as possible to allow learning and acceptance to take place. Respect in such situations becomes critical. Respect refers to the act of tolerating, accepting, and considering another person, even though there may be differences between them or the way they think. Some examples would be respect for parents, men and women equally, teachers, older people, other's religious beliefs, respect for people of different sexual orientations, etc. The three types of respect put forward by Salazar (2019) supports the importance of respect between the healthcare workers and the community. These are:

- Social norms respect which refers to the ability to respect all the norms that govern society such as respect for courtesy rules, working hours, other people's belongings, letting them speak and listen, and respecting others' opinions.
- Culture respect which refers to the ability to recognise that there are other beliefs and be able to respect them by not trying to impose our beliefs on others, avoiding making judgements about the opinions of others, etc.

- Respect for human beings which refers to the ability to comply with legal norms, respect laws, etc.

According to Salazar (2019), the attribute of respect is a two-way street; it is about reciprocity, meaning we get back what we give – if we respect others, they will give same respect back. Therefore, if healthcare workers respect the community they will be respected by them and vice versa.

7.4 PRELIMINARY FRAMEWORK TO PROMOTE AUTONOMY

A framework to facilitate healthcare decision-making and autonomy practices among MW in northern Nigeria was developed. The framework was named Lemu Community MW Autonomy Facilitation Framework (LCMWAFF). Figure 7.1 is a visual presentation of the preliminary framework that was developed and subjected to three rounds of expert review.

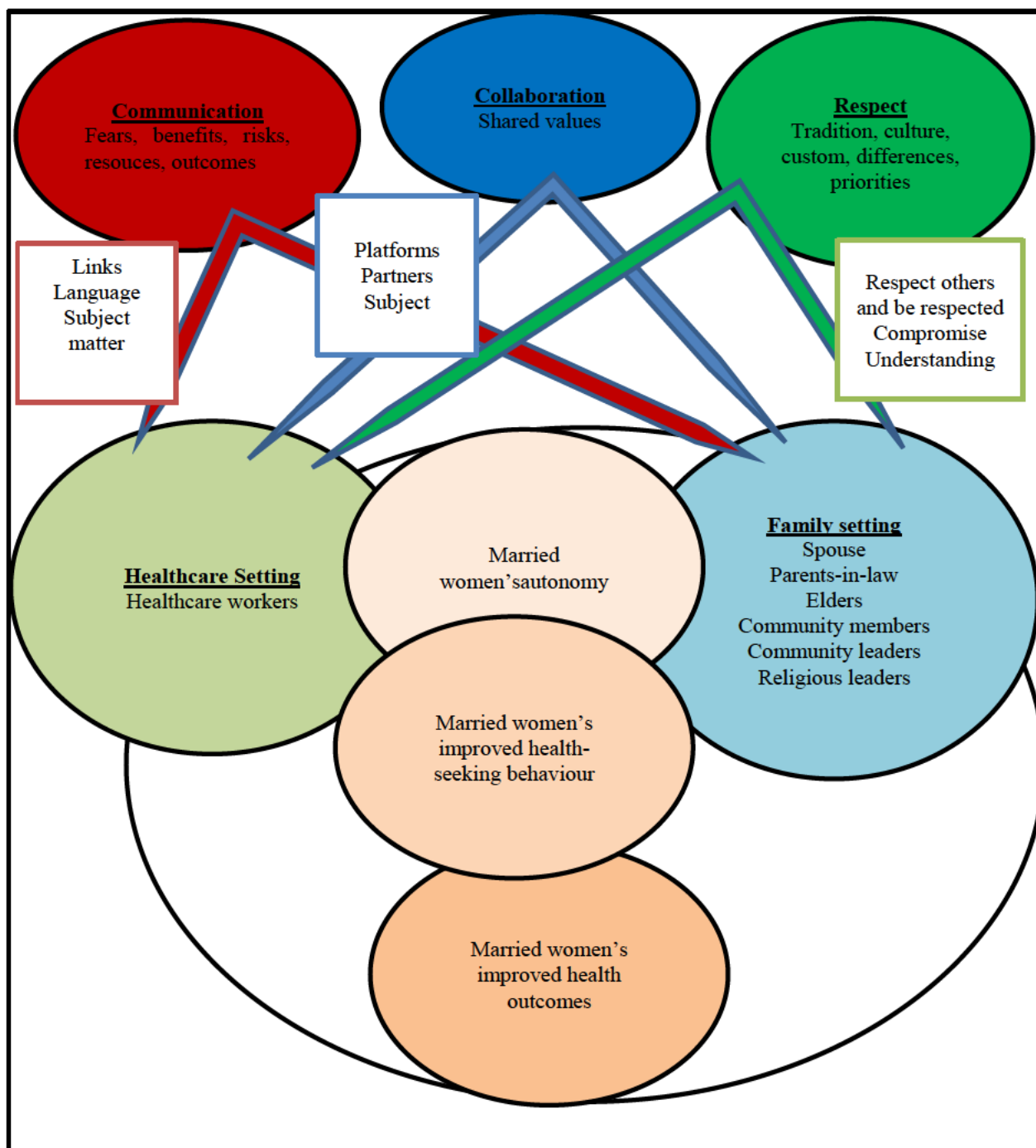


Figure 7.1: Lemu Rural Community Married Women Autonomy Facilitation Framework (LRCMWAFF)

7.5 THE EXPERT REVIEW PROCESS

This section describes the process in which a number of experts were invited to analyse the developed framework. By following the Delphi technique, a total number of ten experts (six from the field of maternity and child care and four from the community) were requested to

conduct a critical analysis on the structure and the relevance of the framework (Appendices 12A and 12B).

7.5.1 The Delphi technique

The Delphi method or Delphi technique also known as Estimate-Talk-Estimate or ETE, is referred to **be** the Corporate Finance Institute (2020) as a structured communication technique or method, originally developed as a systematic interactive method of forecasting which relies on a panel of experts. Bugajenko and Scalia (2021) describe the Delphi technique as a technique consisting of several rounds of individual and anonymous questions to each expert, followed by a group discussion after every round which allows participants to reflect and adjust their opinions. The process is usually repeated until a consensus is achieved. Discussions can happen either in person or via a series of paper or online questionnaires. In the case where paper or online questionnaires are used, a written summary of all responses is distributed to everyone after each round, instead of a group discussion. Bugajenko and Scalia (2021) attest that the Delphi technique is useful for situations that allow for a range of scenarios or opinions, such as estimating the duration of tasks, identifying project risks and forecasting their probability, or allocating the resources.

In the current study, this analysis occurred over three distinct rounds of review, with feedback from each round serving to modify the material to be analysed in the consecutive round.

7.5.1.1 Expert review process: Round 1 (preliminary round)

The preliminary version of the framework was shared with experts and they were invited to make comments. A structured comments sheet was prepared (Appendix 13A and 13b). The experts were invited to submit their comments via email and advised that the review process would continue until consensus was reached (Appendix 14). The comments from all the experts was summarised by the researcher and if there were no conflicting suggestions, the comments were factored into the framework. If there were conflicting suggestions, all experts were invited to a meeting to discuss the conflicting suggestions. Once consensus was reached the experts were invited to a Zoom **online** meeting to view the final document.

7.5.1.2 Expert review process: Round 2 (intermediate round)

Comments from experts were summarised by the researcher and shared with all experts involved. The overall impression was that the experts were satisfied with most aspects of the framework. The comments from the experts are summarised in Table 7.1. The experts proposed amendments to the framework. These included:

- **Naming of the framework to allow usage in other settings**

The expert recommended a change in naming of the framework. The name ‘LRCMWAFF’ somehow restricted the use of the framework to this one rural community. The experts recommended that the name of the framework exclude ‘Lemu Rural Community’. The name was changed to Mary Paul MW autonomy facilitation framework (MPMWAFF).

- **Language used to present the framework**

The experts proposed that the framework be made available in one or more of the local languages to facilitate use and understanding by local residences was available. Their view was that having the framework in English could impede its understanding by the local people who were not highly educated. The framework was translated into Nupe to make sure that it was available in at least one local language (Appendix 14).

- **Inclusion of all relevant stakeholders**

The experts identified other relevant stakeholders that were not featured in the framework and proposed that these be included. The stakeholders included religious and other relevant community organisations, traditional birth attendants and traditional healers. The experts indicated that these organisations and people were very influential in health care practices for the community. This recommendation was accepted and deemed fit for the framework as it aligned with recommendations by Mattessich and Rausch (2013) that collaboration between the health sector and other sectors might generate new opportunities to improve health care. These authors state that, because of the large role that social and economic factors play in shaping the health of communities, there is a need for collaboration for leaders from all sectors that influence health work together to improve the health of all communities. The suggested

stakeholders were included among the existing stakeholders to form part of the collaboration and partnership.

An amended document was shared with all experts together with the summary sheet and requested to review the amended framework and submit any further comments via email. The response from the experts indicated that all experts approved the amended framework with no further suggestions for amendment.

7.5.1.3 Expert review process: Round 3 (final round)

Seeing that consensus had been reached, all experts were invited to a collective ZOOM meeting where the final framework was presented. The intention of this meeting was twofold: to confirm that there were no further comments, and to present the final version of the framework. The meeting was held on 12 February 2022 chaired by the researcher. All ten experts attended the meeting. This round of review became the final round, thus the framework became the final framework. The final framework is presented in the next chapter.

Table 7.1: Summary of reviewers' comments during the three rounds of review

TOPIC TO COMMENT ON	REVIEW ROUNDS (Include total number of reviewers)		
	1: Preliminary	2: Intermediate	3: Final
Name of the framework	Adjust name to allow usage in other settings (x:6 reviewers)	Approved amended naming of framework (x10 reviewers)	No additional comments
Relevant of structure for end user	Approved by all reviewers	No additional comments	No additional comments
Language clarity	Translate the framework into local language (x4 reviewers)	Approve versions (x10 reviewers)	No additional comments
Relevance of content to address problem	Include other stake holders such as traditional healers and birth attendants (x5 reviewers)	Approved amended version (x10 reviewers)	No additional comments
Sufficiency of information to address problem	Approved by all reviewers	No additional comments	No additional comments
Additional comments/suggestions	No additional comments	No additional comments	No additional comments
Concesus	No	Yes	Yes

7.6 CHAPTER SUMMARY

In this chapter the researcher presented development of the the framework. The various steps from preliminary development to finalisation of the framework were presented. The next

chapter presents the final framework which can assist in facilitation of autonomy for MW in the Lemu Rural Community in Niger State, Nigeria.

CHAPTER 8: A FRAMEWORK TO FACILITATE HEALTHCARE DECISION-MAKING AND AUTONOMY PRACTICES AMONG MARRIED WOMEN IN NORTHERN NIGERIA

8.1 INTRODUCTION

The previous chapter presented the development of a framework to promote autonomy for MW, developed as part of this study. Steps followed in developing and finalisation of the framework including review by expert through the Delphi technique were presented. Chapter 8 presents the final version of the framework and recommendations for implementation. The framework presented in this section is an improved version after the three rounds of review by the ten experts, and thus is the final framework recommended to be used to facilitate healthcare decision-making and autonomy practices among MW in northern Nigeria.

8.2 MARY PAUL MARRIED WOMEN AUTONOMY FACILITATION FRAMEWORK (MPMWAFF)

The MPMWAFF is a framework that was developed to facilitate healthcare decision-making and autonomy practices among MW in northern Nigeria which was the seventh and final objective of the current study. The framework is original work based on the findings from the current study conducted with MM and MW in the Lemu rural community in northern Nigeria. The study was conducted in response to anecdotal evidence observed by the researcher, and supported by several studies, that lack of autonomy for MW remained a challenge in this rural community including other parts of Northern Nigeria. The framework was verified and supported by ten experts as presented in section 7.5 of the preceding chapter and is named after the researcher of the current study (Mary K. Paul) who was responsible for developing the framework.

8.3 Components of Mary Paul's Married Women Autonomy Facilitation Framework MPMWAFF

The MPMWAFF is centralised around three elements: the health care setting, the community setting and the MW themselves. That the individual and his or her multiple environment is a dynamic, interactive system, in which each component simultaneously affects and is affected by the other (Weiss-Gal 2008) confirms that a person's environment is the surroundings in which a person grew up in, their mindset, attitude, lifestyle choices and behavioural patterns. Of all these factors, the biggest factor that affects human behaviour and influences persons' lives and resultantly affects the quality of lives, is the environment, because it often affects the choices and decisions that people make. The MPMWAFF locates MW in the middle of the equation between the healthcare sector on the one hand and the community sector on the other hand. While the MW is responsible for her life and related decisions, the two parties have the potential to influence her quality of life as they are responsible for the health care and family needs of the MW. Factors within the family setting/community and those within the healthcare setting have a strong influence on MW's healthcare-seeking behaviour. According to Keles (2012) an individual's quality of life is the total sum of the individual's life and how the individual handles each area of their life. One's attitude and disposition to life, lifestyle choices, and behavioural patterns, as well as environment, can all have an impact on one's quality of life.

The MPMWAFF highlights three interrelated concepts, namely: communication, collaboration and respect. These are critical to influence MW's autonomy and subsequently their healthcare seeking behaviour. The author of the MPMWAFF believes that harmony between both the healthcare setting and the family setting is important and this can be achieved through collaboration, communication and respect. Mattessich and Rausch (2014) attest that collaboration between the health and community development sectors has gained increased attention as a means of accelerating progress to improve community health. According to these authors, the results from their national survey and case examples show that cross-sector collaboration to improve community health occurs in all regions of the United States and that such collaboration has, in many cases, succeeded in producing positive measurable outcomes. Mattessich and Rausch (2014) recommend that improved communication links and tools that increase organisations' capacity to measure their impacts on social determinants of health can

help evaluate and support the movement of cross-sector community health work to a new and exciting level. While Mattessich and Rausch (2014) agree that collaboration between the health and other sectors might generate new opportunities to improve health, the authors advise that there is a need to understand the degree to which such cross-sector collaboration already occurs, whether it has positive effects and if so, the factors that underlie successful cross-sector health-improving initiatives.

At the centre of the framework are the MW. Their survival is dependent on their health-seeking behaviours and their perceptions, particularly regarding their role in life. People's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns are all the influences that can affect a person's life (Lifestyle n.d.). To avoid delays and resultant complications, MW should be able to make their own decisions regarding seeking and attending health care. Early and regular health care attendance will provide opportunities for early detection and management of conditions responsible for maternal and child mortality.

Surrounding the MW is the health care sector and the community. The two have an influence on the wellbeing of MW. Influences that can affect a person's life relates to factors that can have an impact on the individual's quality of life. Problems are created for the MW when these factors operate in isolation. Often MW have to choose which factor – the health care sector or the community – to use or trust. While attending the services of the one there are delays in accessing the other, particularly when the two do not approve/support each other's services. Which one to choose between the two is influenced by a number of factors ranging from previous experiences, access, etc. What compounds the problem is that within the community setting there may be many other structures that operate in isolation such as traditional healers, faith organisations etc.

The framework emphasises collaboration and communication between all relevant stakeholders within the healthcare institutions and within the community. The first step is awareness of each other, where healthcare workers need to be aware of relevant stake holders that exist in the community and vice versa. They all need to be aware of each other and how each operates, their strengths, their shortcomings, common and conflicting areas, and areas for possible collaboration. Thereafter, they need to create possibilities for collaboration by creating

platforms where all organisation meet and share information pertaining to management and referral of patients between each other, discuss challenges, share good practices, and find solutions to problems. Working together and cooperating benefits women because they are not then forced to choose between the two or hide from the one utilisation or the other. Through open and continuous communication they are able to establish positive collaboration and engagements and eventually have a common vision not just regarding autonomy for MW but other community needs and service provisions.

In addition, the framework includes respect as an essential requirement to make sure that the health sector and all other relevant parties within the community sector are able to partner and collaborate and communicate effectively. Mattessich and Rausch (2014) advise that the three factors that most strongly influence successful collaboration between health and community sectors are:

- 1) skilled leadership
- 2) mutual respect and understanding among partner organisations
- 3) shared vision and common goals.

Similarly the researcher highlights respect as a critical component of the framework and includes mutual respect and understanding among partner organisations which the researcher believes will result in shared visions and common goals for all parties involved. Within the community there are family members (spouses and parents-in-law), the elders, other community members, religious and traditional leaders, religious and other community organisations, traditional healers and traditional birth attendants. They all have an influence on MW's autonomy in varying degrees. Therefore, they all should be part of the partnership and collaboration to facilitate MW's autonomy for health seeking decisions and practices. Although the goal is to promote MW's autonomy, the researcher acknowledges that the community might require time to adjust from their current practice which restricts autonomy for MW. Therefore, it is critical that person responsible for decision-making whether this be the MW, a husband, or parent-in-law, should be well informed regarding the impact of their decisions regarding autonomy for MW. This can be achieved by creating platforms where healthcare workers meet and share information with all community members. Through engagement and collaboration

the MM and women will get to know the healthcare workers better including the services that they provide. They will get to know the benefits of early and regular attendance for health care, and develop confidence in services provided by the healthcare workers. This can prompt them to relax the restrictions regarding MW autonomy. There are several important factors that influence decision-making, including past experiences, a variety of cognitive biases, an escalation of commitment and sunk outcomes, individual differences such as age and socio-economic status, and a belief in personal relevance (Dietrich 2010). Dietrich (2010) adds another influence on decision-making which is the belief in personal relevance, because when people believe what they decide matters, they are more likely to make a decision.

Figure 8.1 presents the final framework developed to facilitate healthcare decision-making and autonomy practices among MW in Northern Nigeria, which was the seventh and final objective of the study. The visual image is available in both English and Nupe. The Nupe version is attached as Appendix 14.

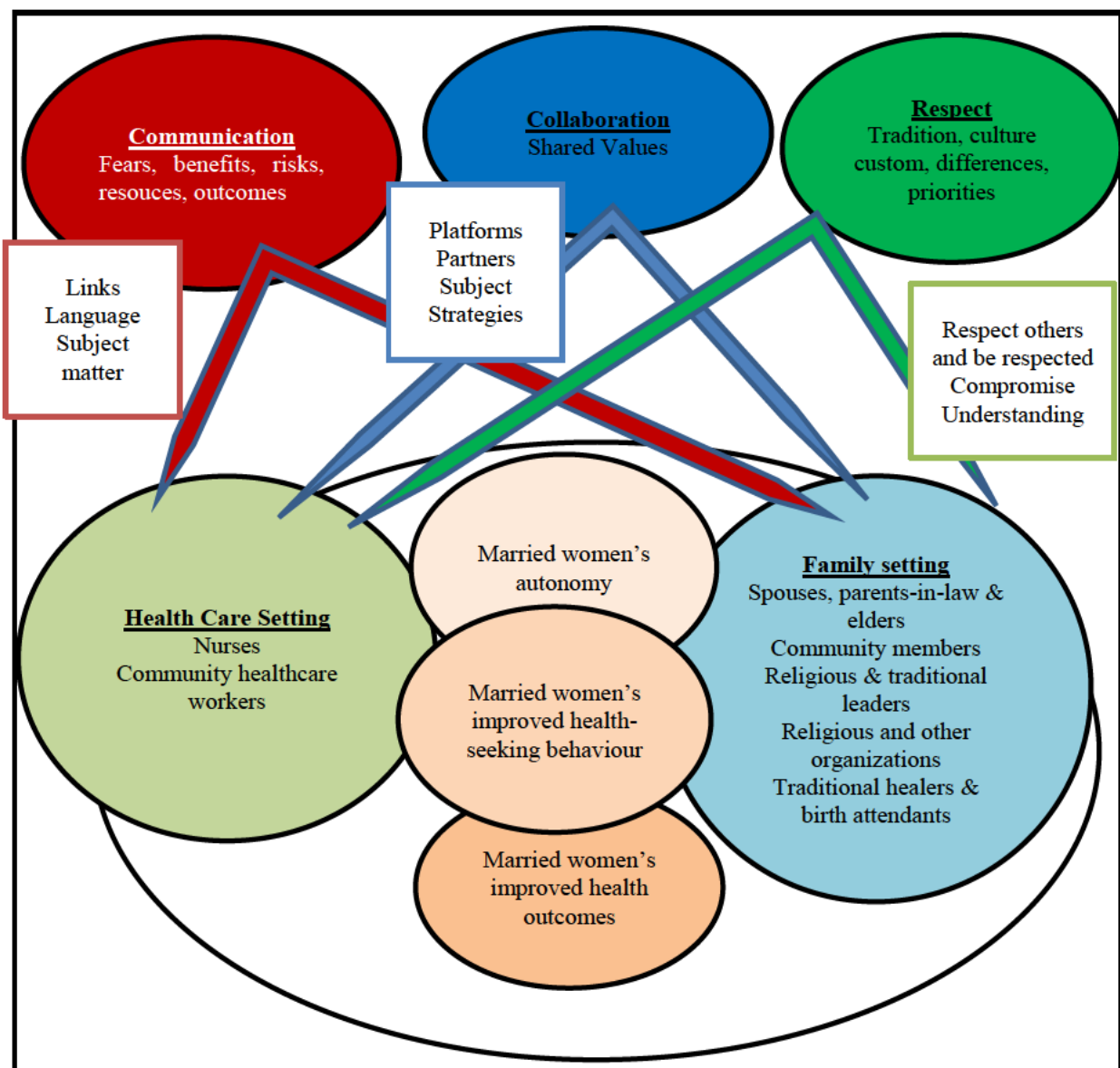


Figure 8.1: Mary Paul's Married Women Autonomy Facilitation Framework (MPMWAFF)

8.4 Implementation of Mary Paul's Married Women Autonomy Facilitation Framework (MPMWAFF).

There are certain considerations that need to happen for implementation of the framework, as presented below.

Collaboration

With regards to collaboration, it is important that four critical issues are considered: partners, platforms, matters/subjects, strategies.

The first step is *identification of partners* to collaborate with. This can be done by the health care sector and members of the community. The partners within the health care institutions should include not just nurses but other relevant structures such as social workers, counsellors, psychologists etc. Similarly, partners in the community should be fully representative of the entire community and relevant structures. Possible representatives from the community should include spouses, parents-in-law and elders, community members, religious and traditional leaders, religious and other organisations, traditional healers and birth attendants, etc. The *subject and or matters* to be discussed in the collaborations should take cognisance of the community needs. *Platforms where collaboration happens* can be either in the community or health care institutions. What is important is that where these happen should be convenient and comfortable for all parties. A variety of *strategies to implement and sustain collaborations* should be decided upon by all parties. These can include creating health institution committees, and community forums as platforms where regular meetings can be held with representatives from the identified structures. Furthermore, adhoc events like open days could be coordinated by health care workers. Parties can invite other relevant parties to their regular meetings and social events so that they get to know each other better and feel that they belong together.

Communication

Open and clear communication is the one strategy that will facilitate autonomy for MW in healthcare decision-making and practices. Both parties should ensure open and ongoing communication. The three critical considerations regarding communication are: creating communication links, language and subject matter.

Several *communication links* can be used, such as face-to-face meetings, media (local radio and television stations), local newspapers, distributing information education material (flyers and pamphlets). It is prudent that the *language used* for communication be simple, clear and understandable to the persons being communicated with. Thus for the benefit of the community, all communication should be in local languages. *Subject matter* discussed during communication should take cognisance of the priorities and needs of the community.

Respect

To be effective, respect should be a two-way process with all parties having respect for each other irrespective of colour, level of education, nationality or creed. Respecting others goes hand in hand with compromise and understanding. Coming down to the level of the people that you serve is a positive sign of respect, but in return they will also come to accept and respect you. It is very important in this framework that health care workers should practice respect and in addition show understanding of situations at hand such as the state of MW autonomy, the traditional and cultural beliefs and so on. This will promote acceptance by the community and their willingness to listen and adapt. The community and all other respective parties in return, should show respect and be willing to listen to messages from the healthcare sector.

The findings from the current study discovered there is a triad of responsibility between the people within the health care setting, those in the family/community settings, and the MW to facilitate MW autonomy.

8.4.1 Responsibilities of healthcare workers

Healthcare workers are the number one custodian of the framework. By virtue of their pledge of service, their scope of practice, and legal obligations, they are advocates for the patients and are responsible for the total health of the community. The framework targets mostly healthcare

workers who are nurses although other healthcare workers will be able to use the framework. Nurses in most countries pledge their services at the beginning of their nursing profession. South African nurses pledge themselves to the service of humanity, and that the total health of their patients will be their first consideration (South African Nursing Council XXXX). The nurses in Ghana pledge to share in the responsibility of other professions and citizens for promotion of health (Nurses in Ghana 2021). In addition, the South African Government prescribe in the scope of practice for professional nurses a number of acts or procedures which include the prevention of disease and promotion of health and family planning by teaching and counselling individuals and groups of persons; the facilitation of communication by and with a patient in the execution of the nursing regimen; the facilitation of the attainment of optimum health for the individual, the family, groups and the community in the execution of the nursing regimen; the establishment and maintenance, in the execution of the nursing regimen, of an environment in which the physical and mental health of a patient is promoted and the provision of effective patient advocacy to enable the patient to obtain the health care he needs (South African Nursing Council [SANC] n.d). Similarly, nurses in Nigeria take an oath to pledge their service at the end of their training. The nursing profession in Nigeria emphasises the health care of persons, families, and communities so they may achieve, maintain, or recover optimal health and get the best quality of life (TMLT Staff 2020).

It is therefore expected that the nurses will reach out to the community to strengthen communication, collaboration and partnership. McCollum *et al.* (2017) attest that it is the responsibility of nurses to engage with communities through health promotion or education activities and to initiate collaborations among health professionals and other relevant partners to address community needs.

Nurses gain knowledge of patients' and families' living situations by establishing long-lasting, collaborative relationships in which they understand the patients' and families' individual backgrounds, their everyday lifeworlds and their health needs and resources to address health problems (Heumann, Röhnsch and Hämel 2021). Nurses should strive to establish a shared understanding of health problems and needs of the Lemu rural community as this is the community that they serve. Several authors agree that a shared understanding of health problems and needs by patients, their families, communities and nurses is crucial as it allows

all parties to work together towards strategies that address health-related problems (Baratieri *et al.* 2012; Runciman 2014).

Heumann, Röhnsch and Hämel (2021) point out that a shared understanding should be supported by mutual trust which is achieved through discussions about the goals and responsibilities of patients and nurses and openness to the opinions and values of others. All this can be achieved through and during communication. Positive engagements will encourage all parties to have a shared understanding leading to solutions including allowing autonomy for MW.

8.4.2 Responsibilities of family and community members

Full involvement and cooperation of community members is critical for the framework to have an impact. Although most of the initiatives for implementation of the framework is on the shoulders of healthcare workers, the community also has an important role to play in all aspects as already alluded to in the previous section. A number of initiatives by the community can facilitate implementation and sustaining of the framework. Their willingness to cooperate and work with healthcare workers and other organisations is important. They also need to invite healthcare workers to their community activities to facilitate working together. Community members need to be open and willing to change for the benefit of the community.

8.4.3 Responsibilities of married women

The MW are the ones that the framework is aiming to assist. They also are the ones that have an opportunity to meet with both parties (the health care sector and the community sector) on a more regular basis than all the others. Therefore, they can play a role of establishing links between these two parties. They can strengthen links between the healthcare sector and their families and the community at large, and in this way facilitate collaboration and communication. While MW have dependency, love and respect for their family and community, they need to understand that respect does not equate to being submissive. They also need to stand up for their rights and work towards improvement of their health care status in a positive way. Thus, they also need to be part of the collaborations so that they can contribute and share in matters relating to their and their family's health.

8.5 CHAPTER SUMMARY

Chapter 8 presented the final reviewed version of the framework to facilitate healthcare decision-making and autonomy practices among MW in northern Nigeria. Components of MPMWAF and how it can be used were described. The roles and responsibilities of the healthcare workers, family and community members and the MM in implementing the framework were also describe. The next chapter will be the final chapter of this thesis and will present summary, limitations, recommendations and conclusions arising from the study.

CHAPTER 9: SUMMARY OF FINDINGS, CONCLUSION LIMITATIONS AND RECOMMENDATIONS

9.1 INTRODUCTION

The previous chapter presented a theoretical framework that was developed to meet one of the objectives of this study. The framework is setting specific in that it took consideration of the views of both MM and the MW. In this chapter, the researcher summarises the overview and the findings of the study and the conclusions reached. Furthermore, the study's limitations are highlighted and recommendations proposed.

9.2 OVERVIEW OF THE STUDY

The current study emanated from the the observed lack of autonomy in making health care seeking decisions by the MW in the Lemu rural district in Niger State, Nigeria. These observations were supported by research evidence that the lack of health-seeking decision making autonomy amongst MW is a major challenge in most developing countries, including Nigeria (National Population Commission (NPC) and ICF Macro 2009). According to these authors, cultural and religious beliefs affect the women from Nigeria, who are more likely to die due to reproductive-related complications and other disease conditions, such as, HIV/AIDS, hypertension, and many others due to lack of autonomy to seek healthcare early. The aim of the study was to develop a framework to promote healthcare decision-making autonomy among MW in northern Nigeria. Seven objectives to achieve this aim were set as follows:

- Explore the process of healthcare decision-making and autonomy practices among MW in northern Nigeria.
- Determine and describe the untoward outcomes experienced by MW due to the inability to make their own healthcare decisions.
- Explore the awareness of MM regarding the untoward outcomes experienced by MW due to the inability to make their own healthcare decisions.
- Determine the perspectives of MW regarding healthcare decision-making and autonomy practices among MW in northern Nigeria.

- Determine the perspectives of MW regarding healthcare decision-making and autonomy practices among MW in northern Nigeria.
- Explore possible strategies to promote healthcare decision-making autonomy among MW in northern Nigeria.
- Develop a framework to facilitate healthcare decision-making and autonomy practices among MW in northern Nigeria.

Data was collected from MM and MW.

9.3 SUMMARY OF FINDINGS

The themes and sub-themes that emerged from data analysis confirmed the lack of MW autonomy in the Lemu rural community.

Several reasons were highlighted by both participant groups as an explanation for the lack of MW autonomy for making health-seeking decisions. These were grouped into six themes with several sub-themes corresponding to each theme. The six themes that emerged from data analysis were: community awareness about autonomy of MW, traditional and cultural beliefs, financial issues, communication and transparency between the healthcare workers and the community, safety of mothers and children, and preservation of societal values, culture and traditions.

It was evident from the study that other factors over and above lack of MW autonomy were responsible for MW health seeking behaviours in the Lemu rural community. These included MM and MW level of education, financial status, employment status, living arrangement (whetherer living in extended families) and type of marriage (whether polygamous or monogomous). While these factors influenced health seeking decisions, they were also were contributing factors to the lack of MW autonomy not just for health seeking decisions, but in general. Lack of awareness on the part of MM was highlighted as the reason most MM insisted on either themselves or their elders being responsible for health seeking decisions for the MW. The majority of the MM regarded this as the responsible thing to do as heads of the houses to ensure protection and safety of women and children.

The positive findings from the study were that both MM and MW participants proposed similar strategies that could improve the situation in the Lemu rural district. The study participants

highlighted (1) awareness of MM and other community members regarding importance of autonomy of MW to make decisions to visit healthcare centres, and (2) collaboration and partnerships between health care workers and community as a means to create a platform where critical information regarding healthcare related issues could be discussed as the two critical strategies that could facilitate improved autonomy for MW.

9.4 THE FRAMEWORK TO FACILITATE HEALTHCARE DECISION-MAKING AND AUTONOMY PRACTICES AMONG MARRIED WOMEN IN NORTHERN NIGERIA

The framework is both a transformative process and an outcome, in which individuals can increase their capacity to make informed healthcare decisions, increase their ability to participate meaningfully in public and private discussions about healthcare seeking and autonomy, increase their ability to act on their preferences to achieve desired autonomy outcomes, and be free from a lack of autonomy to seek healthcare services and fear of making their own decisions. This framework's aim is to empower MW to exercise autonomy in accessing healthcare services in their communities.

9.5 LIMITATIONS

With this study being qualitative in nature, it was conducted in a tiny hamlet in Lemu, Gbako Local Government Area in Niger State, one of Nigeria's northern states, thus the study findings cannot be generalised to other parts of Nigeria. Nevertheless, they can be used as the basis for a much broader study.

A number of people that could have enriched the findings from the study were not included. These included the elders in the community, extended family members such as parents-in-law, traditional leaders and traditional healers and traditional birth attendants. The information gathered from the study participants revealed that all these people had some influence on the state of MW healthcare decision-making and autonomy practices in northern Nigeria.

The researcher did not sample the MM and MW participants as couples. Having these participants as couples could have allowed the researcher to verify data received by comparing information from the couple to see whether they complemented or contradicted each other.

9.6 RECOMMENDATIONS

Recommendations are made with special emphasis on policy development and implementation, institutional management and practice, nursing education, and further research.

Policy development and implementation

- Several participants' comments alluded to policies that did not take the needs of the community into account. Concerns included lack of awareness and value of autonomy, poor communication and transparency, traditional and cultural attitudes, and cost. When policies guiding services are developed or reviewed, it is suggested that the community needs be taken into account and that policies be subjected to public/community review before implementation, for their input and approval.
- Inter-sectoral collaboration and participation of all key stakeholders, such as traditional leaders and local village chiefs, should be included in policies to ensure that this process is formalised.

Institutional management and practice.

- The MW expressed their dissatisfaction with the lack of communication and awareness. As a result, it is advised that community healthcare workers pay more attention to the needs of MW and all community members, and that more home visits and trainings be conducted as envisaged.
- Regular house visits should be performed to get input from the community regarding the MM and MW focused services and to enhance their engagement.
- More health education programmes should be linked to community values, beliefs, and traditions to minimise community backlash from those who believe their traditions are being disrespected.
- It is suggested that traditional and cultural beliefs that prevent MW in the community from obtaining healthcare services be investigated, and that initiatives such as increased awareness be implemented through better health education.

Nursing education

- The MW expressed dissatisfaction with poor communication and a lack of understanding of the necessity of autonomy. Community issues such as autonomy and other traditional practice that hinder provision of health care services should be included in the nursing curriculum to prepare nurses to be able to deal with these when they are working after qualifying.
- Education and training should be tailored to the community's needs.
- In-service education programmes and workshops should be employed to ensure that healthcare personnel are kept efficient so that they may continue to deliver quality treatment.
- Formulating collaborations should form part of the nursing education curriculum.

Further research

- A broader study linking a greater area is required, not just in Lemu village, Niger State, but throughout Nigeria's northern region, and also involving more concerned stakeholders is recommended to acquire a larger perspective on health seeking practices and autonomy for all MW.

9.7 CONCLUSION

The findings from the current study confirm that collaboration, communication, and respect are essential elements required to resolve most societal problems. The participants highlighted that lack of information was responsible for the lack of MW autonomy for making health seeking decisions in their region of northern Nigeria. The researcher identified collaboration as a possible way to get through to the community to assist them to adopt practices that could assist in improving health outcomes such as MW autonomy. However for collaboration to work, respect was identified as the critical element that would promote trust and acceptance between the healthcare sector and the community. The researcher anticipates that the MPMWAFF framework developed will not only facilitate MW's autonomy in northern Nigeria, but will also assist in addressing other health-related community projects and that the framework, though developed from findings of a qualitative study that are not generalisable, could be adopted and utilised by other settings that are similar to that of northern Nigeria.

REFERENCES

- Abdulrahman, S. and Olaosebikan, M. 2017. An Assessment of the Level of Implementation and Impact of the National Health Insurance Scheme (NHIS) on the Health Care System in Yobe State, North-Eastern Nigeria. *IOSR Journal of Dental and Medical Sciences*. 16(5):60-67 <https://doi.org/10.9790/0853-1605116067>
- Abideen, A. A., Adewale, A. A. and Adeola, A. E. 2013. Analysis of rural literacy as a panacea for socio – economic development of Nigeria. *International Journal of Sociology and Anthropology*, 5(9): 381-390.
- Abor, P. A., Abekah-Nkrumah, G. and Sakyi, K. 2011. The socio-economic determinants of maternal health care utilization in Ghana. *International Journal of Social Economics*, 38(7): 628-648.
- Acharya, D. R., Bell, J. S., Simkhada, P., van Teijlingen, E. R. and Regmi, P. R. 2010. Women's autonomy in household decision-making: a demographic study in Nepal. *Reproductive Health*, 7(15). Available: <https://doi.org/10.1186/1742-4755-7-15>
- Adamu, Y. M. and Salihu, H. M. 2002. Barriers to the use of antenatal and obstetric care services in rural Kano, Nigeria. *Journal of Obstetrics and Gynaecology*, 22(6): 600-603.
- Adesoji, F.A. and Babatunde, M.A. 2018. Basic statistical techniques in research I in a book *Data collection, management and analysis in academic research: Proceedings of a Workshop* Available: https://www.researchgate.net/publication/324606840_BASIC_STATISTICAL_TECHNIQUES_IN_RESEARCH (Accessed 12 April 2022)
- Adhikari, R. 2016. Effect of Women's autonomy on maternal health service utilization Nepal: A cross sectional study. *BMC Women's Health* 16:26. Available: <https://doi.org/10.1186/s12905-016-0305-7>
- Adindu, A. 2010. Assessing and assuring quality of health care in Africa. *African Journal of Medical Sciences*, 3(1): 31-36.

Agha, N. and Tarar, M. D. 2018. Understanding the influence of women's education on their autonomy: evidence from a less developed area in Pakistan. *Pakistan Journal of Women's Studies: Alam-e-Niswan*, 25(1): 99-116.

Ahmadi-Javid, A., Seyedi, P. and Syam, S. 2017. A survey of healthcare facility location. *Computers and Operations Research*, 79: 223-263. Available: <https://doi.org/10.1016/j.cor.2016.05.018>

Akeju, D. O., Oladapo, O. T., Vidler, M., Akinmade, A. A., Sawchuck, D., Qureshi, R., Solarin, M., Adetoro, O. O., von Dadelszen, P. and the CLIP Nigeria Feasibility Working Group. 2016. Determinants of health care seeking behaviour during pregnancy in Ogun State, Nigeria. *Reproductive Health*. 13(Suppl 1): 32.

Albert, C. and Davia, M. A. 2011. Education is a key determinant of health in Europe: a comparative analysis of 11 countries. *Health promotion international*. 26(2):163-170.

Alemayehu, M. and Meskele, M. 2017. Health care decision making autonomy of women from rural districts of Southern Ethiopia: a community based cross-sectional study. *International Journal of Women's Health*, 9: 213-221. Available: <https://doi.org/10.2147/ijwh.s131139>

Alhojailan, M. I. 2012. Thematic analysis: a critical review of its process and evaluation. *West East Journal of Social Sciences*, 1(1): 39-47.

American Society for Reproductive Medicine. 2012. *Age and Fertility: A Guide for Patients*. Patient Information Series. Available: https://www.reproductivefacts.org/globalassets/rf/newsandpublications/bookletsfactsheets/english-fact-sheetsandinfobooklets/Age_and_Fertility.pdf (Accessed 13 March 2022).

Andersen, R. and Newman, J. F. 1973. Societal and individual determinants of medical care utilization in the United States. *The Milbank Memorial Fund Quarterly. Health and Society*, 51(1): 95-124. Available: <https://doi.org/10.2307/3349613>

Andersen, R. and Newman, J. F. 2005. Societal and individual determinants of medical care utilization in the United States. *Milbank Quarterly*, 83(4). Republication of 1973 article. Available: <https://dx.doi.org/10.1111/j.1468-0009.2005.00428.x>

Andersen, R. M. 1995. Revisiting the behavioral model and access to medical care: does it matter? *Journal of Health and Social Behavior*, 36(1): 1-10.

Andersen, R. M., Davidson, P. L. and Baumeister, S. E. 2014. Improving Access to Care. In: Kominski, G. F. (ed). *Changing the U.S. health care system: key issues in health services policy and management*. 4th ed. San Francisco, CA: Jossey-Bass, 33-69.

Anselmi, L., Lagarde, M. and Hanson, K. 2015. Health service availability and health seeking behaviour in resource poor settings: evidence from Mozambique. *Health Economics Review*, 5(1): 1-13.

Araromi, M. O. 2018. Language policy implementation in multilingual Nigeria: French and mother-tougue experience. *AFRREV LALIGENS: An International Journal of Language, Literature and Gender Studies*, 7(1). Available: <https://doi.org/10.4314/laligens.v7i1.10>

Aregbeshola, B. 2019. Health care in Nigeria: Challenges and recommendations. Available: https://www.wathi.org/debat_id/systemes-de-sante/wathinotes-systemes-de-sante/health-care-in-nigeria-challenges-and-recommendations/ (Accessed 10 July 2019).

Arthur, E. 2012. Wealth and antenatal care use: implications for maternal health care utilisation in Ghana. *Health Economics Review*, 2(1): 14.

Babalola, B. I. 2014. Determinants of urban-rural differentials in antenatal care utilization in Nigeria. *African Population Studies*, 28(3): 1263-1273.

Babalola, B. I., Adeyoju, T. O. and Makumi, A. 2013. Determinants of urban-rural differentials in antenatal care utilization in Nigeria. (online) Available: <http://paa2013.princeton.edu/papers/131127> (Accessed 20 September 2021).

Baker, D. P., Leon, J., Smith Greenaway, E. G., Collins, J. and Movit, M. 2011. The education effect on population health: a reassessment. *Population and Development Review*, 37(2): 307-332.

Balk, D. 1994. Individual and community aspects of women's status and fertility in rural Bangladesh. *Population Studies*, 48(1): 21-45.

- Baratieri, T., Mandu, E. N. T. and Marcon, S. S. 2012. Longitudinality nurses' work: a report of professional experiences. *Revista da Escola de Enfermagem da*, 46: 1260-1267.
- Barrett, D. and Twycross, A. 2018. Data collection in qualitative research. *Evidence Based Nursing*, 21(3): 63-64.
- Batool, S. A. and Batool, S. S. 2018. Impact of education on women's empowerment: mediational role of income and self-esteem. *Journal of Research & Reflections in Education*, 12(1): 11-23.
- Bazzano, A. N., Kirkwood, B., Tawiah-Agyemang, C., Owusu-Agyei, S. and Adongo, P. 2008. Social costs of skilled attendance at birth in rural Ghana. *International Journal of Gynecology and Obstetrics*, 102: 91-94.
- Beaujoin, C., Bila, A., Bicaba, F. Plouffe, V., Bicaba, A. and Druetz, T. 2021. Women's decision-making power in a context of free reproductive healthcare and family planning in rural Burkina Faso. *BMC Women's Health*, 21: 272. Available: <https://doi.org/10.1186/s12905-021-01411-4>
- Beel, J. and Langer, S. 2011. An exploratory analysis of mind maps. In: *Proceedings of the 11th ACM symposium on document engineering (DocEng '11)*. September 19-22, Mountain View, CA: ACM, 81-84.
- Bennett, N. J., Roth, R., Klain, S. C., Chan, K., Christie, P., Clark, D. A. and Wyborn, C. 2017. Conservation social science: understanding and integrating human dimensions to improve conservation. *Biological Conservation*, 205: 93-108.
- Beogo, I., Lui, C. Y., Chou, Y. J., Chen, C. Y., and Huang, N. 2014. Health-care-seeking patterns in the emerging private sector in Burkina Faso: a population-based study of urban adult residents in Ouagadougou. *PLOS ONE*, 9(5): e97521.
- Bergman, M. M. 2008. *Advances in mixed methods research: theories and applications*. London: Sage.

- Berry, D. M., Bass, C. P., Forawi, W., Neuman, M. and Abdallah, N. 2011. Measuring religiosity/spirituality in diverse religious groups: a consideration of methods. *Journal of Religion and Health*, 50(4): 841-851.
- Bhandari, T. R., Kutty, V. R. and Ravindran, T. K. S. 2016. Women's Autonomy and Its Correlates in Western Nepal: A Demographic Study. *PLoS ONE* 11(1): e0147473. Available: <https://doi.org/10.1371/journal.pone.0147473>
- Blank, M. J. and Langford, B. H. 2000. *Strengthening partnerships: community school assessment checklist*. Washington, DC: Coalition for Community Schools. Available: http://ca-sdfsc.org/docs/resources/SDFSC_SchoolAssessmentChecklist.pdf (Accessed: 13 April 2022).
- Bonono, R. C. and Ongolozogo, P. 2012. *Optimizing the use of antenatal care services in Cameroon*. Centre for Development of Best Practices in Health, Yaounde Central Hospital, Cameroon. Available: <http://www.who.int/evidence/sure/FRPBCPNEN.pdf> (Accessed 23 September 2021).
- Boskey, E. 2022. What is the health belief model? *Behavioural Psychology*. Available: <https://www.verywellmind.com/health-belief-model-3132721> (Accessed: 12 April 2022).
- Bour, D. and Bream, K. 2004. An analysis of the determinants of maternal mortality in sub-Saharan Africa. *Journal of Women's Health*, 13(8): 926-938.
- Brink, H., van der Walt, C. and van Rensburg, G. H. 2012. *Fundamentals of research methodology for health care professionals*. 3rd ed. Cape Town: Juta.
- Burkina Faso Amnesty international. 2010. Burkina Faso Briefing to the committee on the Elimination of Discrimination against women. *Amnesty International Publications* Available: <https://www.amnesty.org/en/wp-content/uploads/2021/07/afr600122010en.pdf> (Accessed 19 June 2020)
- Burns, N. and Grove, S. K. 2009. *The practice of nursing research: appraisal, synthesis and generation of evidence*. 6th ed. St Louis, MO: Saunders Elsevier.

Busija, L., Cinelli, R., Toombs, M., Easton, C., Hampton, R., Holdsworth, K. G., Macleod, A., Nicholson, G., Nasir, B., Sanders, K., McCabe, M. and Bowers, B. 2018. The role of elders in the wellbeing of a contemporary Australian indigenous community. *The Gerontologist*. 60(3): 513-524.

Bugajenko, O and Scalia, S. 2021. The Delphi Technique: Definition and example. Available: <https://study.com/academy/lesson/the-deiphi-technique-definition-example.html> Accessed: 19 May 2022

Butler, S. M. and Sheriff, N. 2021. How poor communication exacerbates health inequities- and what to do about it. Available: <https://www.bing.com/search?q=implications+of+poor+communication+between+health+care+ad+communit&qsn&form=QBRE&sp=1&pq=implications+of+poor+communication+between+health+car&sc=053&sk=&cvid=AE3A74E8542F48899BBE86A1608AEA5F&ntref=1#> (Accessed 27 June 2022).

Caldwell, B. K., Rashid, S. F. and Murthy, S. 2014. The informal health sector and health care-seeking behaviour of mothers in urban Dhaka slums. *Journal of Population Research*, 31(2): 111-129.

Cambridge Advanced Learners Dictionary and Thesaurus. 2018. Cambridge: Cambridge University Press.

Centers for Disease Control and Prevention (CDC). 2013. *Principles of community engagement. The value of community partnerships*. Issue Brief No. 3 Available: <https://www.cdc.gov/workplacehealthpromotion/tools-resources/pdfs/issue-brief-no-3community-partnerships-03062013.pdf> (Accessed 07 May 2022).

Chasowa, S., Kandodo, P.K., Jack R. M and Robert Kambalu, R. 2015. A study on factors hindering husbands from participating in maternal health care in Malawi. *African Journal of Nursing and Midwifery* 2 (1): 066-075. Available: www.internationalscholarsjournals.org (Accessed: 17 April 2022)

Cheraghi, M. A., Manookian, A. and Nasrabadi, A. N. 2014. Human dignity in religion-embedded cross-cultural nursing. *Nursing Ethics*, 21(8): 916-928.

- Chou, S. Y. Liu, J. T. Grossman, M. and Joyce, T. 2010. Parental education and child health: evidence from a natural experiment in Taiwan. *American Economic Journal: Applied Economics*, 2(1): 33-61.
- Chowdhury, S. 2015. Women's autonomy and its influences on utilization of maternal and child health care facilities in Bangladesh. *Journal of Business and Economics*, 8(1): 169-186.
- Cohen, L., Manion, L. and Morrison, K. 2011. *Research methods in education*. 7th ed. London: Routledge.
- Conley, M. W. 2016. Collaborating across educational divides: why it is important for literacy and what it takes. *Journal of Adolescent and Adult Literacy*, 59(5): 497-502. Available: <https://doi.org/10.1002/jaal.487>
- Corporate Finance Institute (CFI). 2020. Delhi Method: Overview, process and applications. Available: <https://corporatefinanceinstitute.com/resources/knowledge/other/delphi-method> (Accessed 19 May 2021).
- Creswell, J. W. 2014. *Research design: qualitative, quantitative, and mixed methods approaches*. 3rd ed. Thousand Oaks, CA: Sage.
- Currie, D. and Wiesenbergs, S. 2003. Promoting women's health-seeking behavior: research and the empowerment of women. *Health Care for Women International*, 24(10): 880-899.
- Daniyan-Bagudu, H., Khan, S. J. M. and Rosian, A. H. 2016. Household decision making of women in public service in Nigeria. *Gender Studies*, 16: 17.
- Das, A. 2017. The role of husbands in women's health-seeking behaviour. Doctoral thesis, University of New Brunswick, New Brunswick, Canada. Available: <https://alekhyadasblog.files.wordpress.com/2017/09/phd-summary.pdf> (Accessed 12 February 2022).
- Das, S., Bapart, U., More, N. S., Chordhekar, L., Joshi, W. and Osirin, D. 2010. Prospective study determinants and costs of home birth in Mumbai slums. *BMC Pregnancy and Childbirth*, 10, 38.

Datt, S. and Chetty, P. 2016. 8-step procedure to conduct qualitative content analysis in a research. [online] *Project Guru*. Available: <https://www.projectguru.in/qualitative-content-analysis-research/> (Accessed 04 February 2021).

Davenport, B. 2021. What is respect and why is it important? Available: <https://liveboldandbloom.com/02/self-improvement/what-is-resp>(Accessed 03 February 2022).

Deb, S. 2015. *Gender roles in family decision making: results from Indian states*. Paper for 18th Annual Conference on Global Economic Analysis, Organized by Centre for Global Trade Analysis (Perdue University) and Centre for Policy Studies (Victoria University, Melbourne) , Melbourne, 17-19 June. Available: <https://www.gtap.agecon.purdue.edu/resources/download/7401.pdf> (Accessed 6 February 2022).

Denscombe, M. 2010. *The good research guide: for small-scale social research projects*. New York, NY: McGraw-Hill.

Dibaba, Y. 2018. Women's autonomy and reproductive health-care-seeking behavior in Ethiopia. *Women and Health*, 58(7): 729-743. Available: <https://doi.org/1080/03630242.2017.1353573>

Dietrich, C. 2010. Decision making: factors that influence decision making, heuristics used, and decision outcomes. *Inquiries Journal/Student Pulse*, 2. Available: <http://www.inquiriesjournal.com/a?id=180> (Accessed 19 April 2021).

Divakaran, S. D. 2013. Women's autonomy: employment and education in india and their influence on facility delivery. Available: <https://core.ac.uk/download/210606741.pdf> (Accessed 11 March 2022).

Dyson, T. and Moore, M. 1983. On kinship structure, female autonomy, and demographic behavior in India. *Population Development Review*, 1: 35-60.

Dzino-Silajdzic, V. 2018. Practice guide: focus group discussions. *Catholic Relief Services*. Available: https://www.crs.org/sites/default/files/toolsresearch/fgds_april_24_final_lo_res_.pdf (Accessed 23 February 2021).

Edwards, T. 2016. Socio-demographic determinants of health-seeking behavior among the South African population: an analysis of NIDS. Masters's dissertation, University of KwaZulu-Natal, Durban, South Africa.

Eeuwijk, P. V. and Angehrn, Z. 2017. *How to conduct a focus group discussion: methodological manual*. Basel: University of Basel.

Ethiopian Society of Population Studies. 2005. *Maternal health care seeking behaviour in Ethiopia: findings from EDHS 2005*. Addis Ababa: Ethiopian Society of Population Studies.

Eze, T. C., Okpala, C. S. and Ogbodo, J. C. 2014. Patterns of inequality in human development across Nigeria's six geopolitical zones. *Development Studies Journal*, 4(8).

Falade-Fatila, O. and Adebayo, A. M. 2020. Male partners' involvement in pregnancy related care among married men in Ibadan, Nigeria. *Reproductive Health*, 17(14). Available: <https://doi.org/10.1186/s12978-020-0850-2>

Faneyé, B. 2011. Vers Une Ethique Biomédicale Africaine. *Ethique et Société*, 7(2-3). Available: <http://res.bi/fr/content/vers-une-%C3%A9thique-biom%C3%A9dicale-africaine> (Accessed 22 July 2016).

Fillipi, V., Ronsmans, C., Campbell, O. M. R., Graham, W. J., Mills, A., Koblinsky, J. B. M. and Osirin, D. 2006. Maternal health in poor countries: the broader context and a call for action Available: <http://www.thelancet.com> (Accessed 12 May 2019)

Flagg, L. A., Bisakha, S., Kilgore, M. L. and Locher, J. L. 2014. The influence of gender, age, education, and household size on meal preparation and food shopping responsibilities. *Public Health Nutrition*, 17(9): 2061-2070.

Fleming, E. 2020. How do perceptions influence individual behavior? Available: <https://www.sidmartinbio.org/how-do-perceptions-influence-individual-behavior/> (Accessed: 12 April 2022).

Floridi, L., Cowls, J., Beltrametti, M., Chatila, R., Chazerand, P., Dignum, V. and Schafer, B. 2018. AI4 People—an ethical framework for a good AI society: opportunities, risks, principles, and recommendations. *Minds and Machines*, 28(4): 689-707. Available: <https://doi.org/10.1007%252Fs11023-018-9482-5>

Fotso, J. C., Ezech, A., and Essendi, H. 2009. Maternal health in resource-poor urban settings: how does women's autonomy influence the utilisation of obstetric care services? *Reproductive Health*, 6:9. Available: <https://doi.org/10:1186/1742-4755-6-9>

Frie, K. G., Eikemo, T. A., and Von Dem Knesebeck, O. 2010. Education and self-reported health care seeking behaviour in European welfare regimes: results from the European Social Survey. *International Journal of Public Health*, 55(3): 217-220.

Gage, A. J. 2007. Barriers to the utilization of maternal health care in rural Mali. *Social Science and Medicine*, 65(8): 1666-1682.

Ganle, J. K. 2007. Ethnic disparities in utilisation of maternal health care services in Ghana: evidence from the 2007 Ghana Maternal Health Survey. *Ethnicity and Health*, 21(1). Available: <https://doi.org/10.1080/13557858.2015.1015499>

Ganle, J. K. 2014. Addressing socio-cultural barriers to maternal healthcare in Ghana: Perspectives of women and healthcare providers. *Journal of Womens Health, Issues and Care*. 3(6).

Ganle, J. K., Parker, M., Fitpatrick, R. and Otupiri, E. 2014. Free maternity care and equity of access to maternal health services in Ghana: a descriptive study. *Int J Equity Health*. 13: 89.

Gerrish, K. and Lacey, A. 2010. *The research process in nursing*. 6th ed. Oxford: Wiley.

Girls Not Brides. 2013. Because I am a girl. The state of the world's girls 2013. *In double jeopardy: adolescent girls and disasters*. Available: <https://www.girlsnotbrides.org/learning-resources/resource-centre/because-girl-2013-adolescent-girls-and-disasters/> (Accessed 05 June 2021).

Glanz, P. and Rimer, B. K. 2005. *Theory at a glance: a guide for health promotion practice*. 2nd ed. Waxhington DC: U.S. Dept. of Health and Human Services.

Graham, W. J., Ronsmans, C., Filippi, V., Campbell, O., Goodburn, E. A., Marshall, T., Shulman, C. and Davies, J. 1995. *Asking questions about women's reproductive health in community-based surveys: Guidelines on scope and content*. Maternal and Child Epidemiology Unit Publication No. 6. London: London School of Hygiene and Tropical Medicine.

Greco, M. 2021. Role-players: the importance of patients in co-designing Europe's future health system. *The European Files*. Available: <https://www.europeanfiles.eu/health/role-players-the-importance-of-patients-in-co-designing-europes-future-health-system> (Accessed: 13 April 2022).

Griffiths, P. and Stephenson, R. 2001. Understanding user's perspectives of barriers to maternal health care in Maharashtra, India. *Journal of Biosocial Science*, 33(3): 339-359.

Grove, S. K., Burns, N. and Gray, J. 2014. *Understanding nursing research: building an evidence-based practice*. St Louis, MO: Elsevier.

Grove, S. K., Burns, N. and Gray, J. R. 2013. *The practice of nursing research: appraisal, synthesis, and generation of evidence*. 7th ed. St Louis, MO: Elsevier.

Gulliford, M., Figueroa-Munoz, J., Morgan, M., Hughes, D., Gibson, B., Beech, R. and Hudson, M. 2002. What does 'access to health care' mean? *Journal of Health Services Research and Policy*, 7(3): 186-8. Available: <https://doi.org/10.1258/135581902760082517>

Gupta, L. M., Aborigo, A. R., Adongo, B. P., Rominski, S., Hodgson, A., Engmann, M. C. and Moyer, A. C. 2015. Grandmothers as gatekeepers? The role of grandmothers in influencing health-seeking for mothers and newborns in rural northern Ghana. *Global Public Health*. Available: <https://doi.org/1080/17441692.2014.1002413>

Haddon, B. 2013. Some lessons on health sector reform from DFID health programmes in Nigeria. *Abuja: Department for International Development*. Available: <http://www.prrinmnch.org/documents/lessonslearntonhealthsectorreform.pdf> (Accessed 08 July 2019).

Haque, S. E., Rahman, M., Mostofa, M. G., and Zahan, M. S. 2012. Reproductive health care utilization among young mothers in Bangladesh: does autonomy matter? *Women's Health Issues*, 22(2): e1 71-e180.

Hausmann, R., Tyson. L. D. and Zahidi. S. 2007. The global gender gap index. *The global gender gap report 2007*. Geneva: World Economic Forum.

Hausmann-Muela, S. and Muela, R. J. 2003. Recipe knowledge: a tool for understanding some apparently irrational behaviour. *Anthropology and Medicine*, 10(1): 87-105.

HelpAge International. 2009. Older people in community development: The role of older people's associations (OPAs) in enhancing local development. Available: <https://helpage.org/silo/files/older-people-in-community-development-the-role-of-olderpeoples-associations-opas-in-enhancing-local-development.pdf> (Accessed 17 May 2021).

Heumann, M., Röhnsch, G. and Hämel, K. 2021. Primary healthcare nurses' involvement in patient and community participation in the context of chronic diseases: an integrative review. *Journal of Advanced Nursing*, 78(1): 26-47. Available: <https://doi.org/10.1111/jan.14955>

Hochbaum, G. M. 1958. *Public participation in medical screening programs: a socio-psychological study*. Washington, DC: Department of Health Education and Welfare. Available: <https://doi.org/10.2105/AJPH.2009.189118>

Holland, K. and Rees, C. 2010. *Nursing evidence-based practice skills*. Oxford: Oxford University Press.

Hugé, J. and Mukherjee, N. 2018. The nominal group technique in ecology & conservation: application and challenges. *Methods in Ecology and Evolution*, 9(1): Available: <https://doi.org/10.1111/2041-210X.12831>

Ijadunola, K. T. 2013. Free health services in Nigeria: how beneficial to the poor. Available: <http://www.oauife.edu.ng/wp-content/uploads/2013/05/Dr.-K.-T.ijadunola> (Accessed July 8 2019).

Ikamari, L. D. E. 2004. Maternal health utilisation in Teso district. *African Journal of Health Sciences*, 11: 21-32.

Ilo, 2014. World Social Protection Report 2014/15: *Building economic recovery, inclusive development and social justice*, International Labor Office- Geneva.

International Association of National Public Health Institutes (IANPHI). 2013. National Primary Health Care Development Agency-Institute Profile. Available: <http://www.ianphi.org/membercountries/memberinformation/nigeria.html> (Accessed 22 April 2022).

International Conference on Population and Development (ICPD). 1994. International conference on population and development. Available: https://en.wikipedia.org/wiki/International_on_population_and_development (Accessed 12 March 2021).

Isiugo-Abanihe, U. and Obono, O. 2011. On male role and responsibility for reproductive health in Africa. *The Nigerian Journal of Sociology and Anthropology*, 9(1). Available: [https://doi.org/10.36108/NJSA/1102/90\(0101\)](https://doi.org/10.36108/NJSA/1102/90(0101))

Iyabo, L. J., Sina, J. O. and Ayodele, I. M. 2014. Socio-economic status and utilization of healthcare facilities in rural. *Standard Research Journal of Medicine and Medical Sciences*, 2(1), 1–43.

Jegade, S. 2009. African Ethic, Healthcare Research and community and individual participation. Available: <https://doi.org/10.1177/0021909608101412>

Jejeebhoy, S. .J. 1995. *Women's Education, Autonomy, and Reproductive Behavior: Experience from Developing Countries*. Oxford, the United Kingdom: Clarendon Press.

Kanthiti, M. and Njera, D. 2016. What factors influence community participation in afforestation activities? Case of Nathenje Area in Lilongwe District in Malawi. *International Journal of Research in Agriculture and Forestry*, 3(12): 22-28.

Karout, N., Abdelaziz, S. H., Goda, M., Altuwajri, S., Almostafa, N., Ashour, R. and Alradi, H. 2013. Cultural diversity: a qualitative study on Saudi Arabia women's experience and perception of maternal health services. *Journal of Nursing Education and Practice*, 3(11). Available: <http://dx.doi.org/10.5430/jnep.v3n11p172>

Keles, R. 2012 The Quality of Life and the Environment. *Social and Behavioral Sciences* 35: 23 – 32 Available: <https://doi.org/10.1016/j.sbspro.2012.02.059>

- Kennedy, B. M., Rehman, M., Johnson, W. D., Magee, M. B., Leonard, R. and Katzmarzyk, P. T. 2017. Healthcare providers versus patients' understanding of health beliefs and values. *Patient Experience Journal*, 4(3): 29-37.
- Khan, K. S., Wojdyla, D., Say, L., Gülmezoglu, A. M. and Van Look, P. F. 2006. WHO analysis of causes of maternal death: a systematic review. *The Lancet*, 367(9516): 1066-1074.
- Kilanowski, J. F. 2017. Breadth of the Socio-Ecological Model, *Journal of Agromedicine*, 22(4): 295-297. Available: <http://dx.doi.org/10.1080/1059924X.2017.1358971>
- Koenig, M., Jamil, K., Streatfield, P., Saha, T., Al-Sabir, A., Arifeen, S., Hill, K. and Haque, Y. 2007. Maternal Health and Care-Seeking Behavior In Bangladesh: Findings from a National Survey. *International family planning perspectives*. 33: 75-82. <http://dx.doi.org/10.1363/ifpp.33.075.07>
- Komen, S. G. 2020. Education toolkit: Applying culturally-responsive communication in black and African-American communities. Available: <https://komentoolkits.org/wp-content/uploads/2015/03/Applying-Culturally-Responsive-Communication-in-Black-and-African-American-Communities-B-AA-Comm.pdf> (Accessed 26 June 2019).
- LaMorte, W. W. 2019. Behavioural change models. *Boston University School of Public Health*. Available: <https://sphweb.bumc.bu.edu/otlt/mphmodules/sb/behavioralchangetheories/> (Accessed 26 June 2019).
- Lang, T. and Whittington, R. 2022. The best strategies don't just take a long view. They take a broad view. Available: https://hbsp.harvard.edu/product/H071U5-PDF-ENG_12 (Accessed 12 April 2022).
- Latunji, O. O. and Akinyemi, O. O. 2018. Factors influencing health seeking behavior among civil servant in Ibadan, Nigeria. *Annals of Ibadan Postgraduate Medicine*, 16(1): 52-60
- Lawson, G. W. and Keirse, M. J. N. C. 2013. Reflections on the maternal mortality millennium goal. *Birth*, 40(2): 96-102.
- Liamputtong, P. and Ezzy, D. 2005. *Qualitative research methods*. Oxford University Press, Oxford.

Levesque, J., Harris, M. F. and Russell, G. 2013. Patient-centred access to health care: conceptualizing access at the interface of health systems and populations. *International Journal for Equity in Health*, 12(18): 18-27.

Lincoln, Y.S. and Guba, E.G. 1985. *Naturalistic Inquiry*. Newbury Park, CA: Sage.

LoBiondo-Wood, G. and Haber, J. 2014. *Nursing research: methods and critical appraisal for evidence-based practice*. 8th ed. St Louis, MO: Elsevier.

Lomelin, N. J. 2013. Reproductive autonomy and choice: a reality for women in South Africa: Master's dissertation, University of Cape Town, Cape Town, South Africa.

Lutkevich, B. n.d. What is a Framework. Available:

<https://www.techtarget.com/whatis/definition/framework> (Accessed 13 March 2021)

Mainuddin, A. K. M., Bagum, H. A., Rawal, L. B., Islam, A. and Islam, S. M. S. 2015. Women's empowerment and its relationship with health seeking behavior in Bangladesh. *Journal of Family and Reproductive Health*, 9(2): 65–73.

Makinwa, P. and Jensen, A. (eds) 1995. *Women's position and demographic change in sub-Saharan Africa*. Liege, Belgique: IUSSP.

Maphumulo, W. T. and Bhengu, B. R. 2019. Challenges of quality improvement in the healthcare of South Africa post-apartheid: a critical review. *Curationis*, 42(1): e1-e9.

Marmot, M. 2010. *Fair society, health lives. The Marmot Review*. Strategic review of health in England post-2010. Available: <https://www.gov.uk/research-for-development-outputs/fair-society-healthy-lives-the-marmot-review-strategic-review-of-health-inequalities-in-england-post-2010> (Accessed 13 June 2021).

Mason, K. O. 1987. The impact of women's social position on fertility in developing countries. *Sociol Forum*, 2(4): 718-745.

Markani, A. Y., Yaghmaei, F. and Khodayar Fard, M. 2013. Spirituality as experienced by Muslim oncology nurses in Iran. *Br J Nurs*. 13(22) S22-4-S26-8. Available: <https://doi.org/10.12968/bjon.2013.22.sup2.s22.PMID:23448951>

Mattessich, P. W. and Rausch, E. J. 2013. Collaboration to build healthier communities: a report for the Robert Wood Johnson Foundation Commission to Build a Healthier America. Wilder Research/Federal Reserve Bank of Minneapolis. Available: <https://www.wilder.org/sites/default/files/imports/>..(Accessed 12 May 2021).

Mattessich, P. W. and Rausch, E. J. 2014. Cross-sector collaboration to improve community health: a view of the current landscape. *Health Affairs*, 33(11). Available: <https://doi.org/10.1377/hlthaff.2014.0645>

McCollum, M., Kovner, C. T., Ojemeni, M. T., Brewer, C. and Cohen, S. 2017. Nurses Improve their Communities' Health where they live, learn, work, and Play. *Policy, Politics, & Nursing Practice*. 18(1) Available: <http://dx.doi.org/10.1177/1527154417698142>

McKenzie, A., Sokpo, E. and Ager, A. 2014. The policy-implementation gap in federal health systems: Lessons from the Nigeria experience. *Journal of Public Health in Africa*, 5(38): 82-87.

McLemore, M. R., Altman, M. R., Cooper, N., Williams, S., Rand, L. and Franck, L. 2018. Health care experiences of pregnant, birthing and postnatal women of color at risk for preterm birth. *Social Science & Medicine*, 201: 127-135. Available: <https://doi.org/10.1016/j.socscimed.2018.02.013>

Merriam-Webster.com Dictionary. n.d. Definition of a Framework., Available: <https://www.merriam-webster.com/dictionary/framework> (Accessed 19 July 2022)

Miller, A. M. and Roseman, M. J. 2011. Sexual and reproductive rights at the United Nations: frustration or fulfilment?, *Reproductive Health Matters*, 19(38): 102-118, [https://doi.org/10.1016/S0968-8080\(11\)38585-](https://doi.org/10.1016/S0968-8080(11)38585-)

Mills, S. and Bertrand, J. T. 2005. Use of health professionals for obstetric care in northern Ghana. *Studies in Family Planning*, 36(2): 45-56.

Mistry, R., Galal, O. and Lu. M. 2009. Women's autonomy and pregnancy care in rural India: a contextual analysis. *Social Science & Medicine*, 69(6): 926-33. Available: DOI: 10.1016/j.socscimed.2009.07.008

- Mouton, J. 2011. *How to succeed in your master's and doctoral studies: A South African guide and resource book*. Pretoria: Van Schaik
- Moore, B. M., Alex-Hart, B. A. and George, I. O. 2011. Utilisation of health care services by pregnant mothers during delivery: a community based study in Nigeria. *Journal of Medicine and Medical Sciences*, 2(5): 864-867.
- Morley, L. and Cashell, A. 2017. Collaboration in health care. *Journal of Medical Imaging and Radiation Sciences*, 48(2): 207-216.
- Moyer, A. C., Adongo, B. P., Aborigo, A. R., Hodgson, A., Engmann, M. C. and DeVries, R. 2013. It's up to the women's people: how social factors influence facility-based delivery in rural northern Ghana. *Maternal and Child Health Journal*, 18: 109-119. Available: <https://doi.org/10.1007/s10995-013-1240-y>
- Mubita-Ngoma, C. 2016. Factors Influencing Women's Optimum Health in Zambia. *Journal of Healthcare Communication*. 1(30). Available: <https://doi.org/10.4172/2472-1654.100030>.
- Mumtaz, Z. and Salway, S. M. 2007. Gender, pregnancy and uptake of antenatal care services in Pakistan. *Sociology of Health & Illness*, 29(1): 1-26.
- Nabieva, J., Soares, A. 2019. Factors influencing decision to seek health care: a qualitative study among labour-migrants' wives in northern Tajikistan. *BMC Pregnancy Childbirth* **19**, 7 (2019). Available: <https://doi.org/10.1186/s12884-018-2166-6>
- Nahrgang, S. n.d. Husbands' and wives' reports of women's decision-making autonomy and their association with focused antenatal care utilization: empirical evidence from Cambodia. Available: https://paa.confex.com/paa/2016/mediafile/ExtendedAbstract/Paper1646/PAA2016_Submission%20Draft_Final.pdf (Accessed 13 April 2022)
- National Academy of Engineering and Institute of Medicine Committee on Engineering and the Health Care System. 2005. *Building a better delivery system: a new engineering/health care partnership*. Washington (DC): National Academies Press. Available: <https://www.ncbi.nlm.nih.gov/books/NBK22862/> (Accessed 14 April 2022).

National Health Insurance Scheme. 1999. *National health insurance scheme decree No 35 of 1999*. Available: <http://www.nigerialaw.org/National%20Health%20Insurance%20Scheme%20Decr> (Accessed July 8 2019).

National Population Commission (NPC) and ICF Macro. 2009. *Nigeria Demographic and Health Survey 2008: Key Findings*. Calverton, Maryland, USA: NPC and ICF Macro Available: <https://dhsprogram.com/pubs/pdf/sr173/sr173.pdf> (Accessed 19 April 2021)

Nayak, S. and Varambally, K. V. M. 2017. Impact of autonomy on health-seeking behavior: evidence from rural India. *Journal of Health Management*, 19(1): 109-120 Available: <https://doi.org/10.1177/0972063416682889>

Ndemanu, M. T. 2018. Traditional African religions and their influences on the worldviews of Bangwa people of Cameroon: expanding the cultural horizons of study abroad students and professionals. *Frontiers: The Interdisciplinary Journal of Study Abroad*, XXX(1): 70-84.

Neuber, K. 2020. Entry 3: Influences on perspective. Available: <https://ikan2.com/entry-3-influences-on-perspective> (Accessed 19 April 2022).

Nicholson, J. 2018. How a change of perspective can improve your decisions. Understanding reference dependence and loss aversion in everyday choices. *Psychology Today*. Available: <https://www.psychologytoday.com/us/blog/persuasion-bias-and-choice/201812/how-change-perspective-can-improve-your-decisions> (Accessed 19 April 2022).

Nigeria. Federal Ministry of Health. 2005. *Road map for accelerating the attainment of the millennium development goals related to maternal and newborn health in Nigeria*. Abuja: Federal Government of Nigeria.

Nigeria. Federal Ministry of Health. 2008. *Maternal health and obstetrics fistula; Nigeria demographic and health survey 2008*. Abuja: Federal Government of Nigeria.

Nigeria. National Population Commission Nigeria and International Calverton Funding. 2014. *Nigeria demographic and health survey 2013*. Abuja, Nigeria.

Nikbakht Nasrabadi, A., Sabzevari, S. and Negahban Bonabi, T. 2015. Women empowerment through health information seeking: a qualitative study. *International Journal of Community Based Nursing and Midwifery*, 3(2): 105-115.

Nikiema, B., Haddad, S. and Potvin, L. 2012. Measuring women's perceived ability to overcome barrier to healthcare seeking in Burkina Faso. *BMC Public Health*, 12-147. Available: <https://doi.org/10.1186/1471-2458-12-147>

Njuki, R., Kimani, J., Obare, F. and Warren, C. 2014. Using verbal and social autopsies to explore health-seeking behaviour among HIV-positive women in Kenya: a retrospective study. *BMC Women's Health*, 14(1): 1-11.

Nurses in Ghana. 2021. *The nurses' pledge and midwives' prayer*. Available: <https://nursesinghana.com/the-nurses-pledge-and-the-midwives-prayer/?share=tumblr> (Accessed 11 May 2022).

Offredy, M. and Vickers, P. 2013. *Developing a healthcare research proposal: an interactive student guide*. Oxford: Wiley.

Office of Disease Prevention and Health Promotion. 2020. Healthy People: Disparities. U.S. Department of Health and Human Services. Available: <https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities> (Accessed 13 April 2021)

Ojanuga, D. N. and Gilbert, C. 1992. Women's access to health care in developing countries. *Social Sciences and Medicine*, 35(4): 613-617.

Okechukwu, O. A. 2013. Perceived challenges of using maternal healthcare services in Nigeria. *Arts and Social Sciences Journal*, 2013(ASSJ-65) Available: <https://www.researchgate.net/publication/340376183>.(Accessed 11 March 2022)

Okemini, E. B. and Adekola, G. 2012. Violence against women in Ikwerre ethnic nationality of Nigeria: challenges for gender equity and development. 3(2): 6-12. Available: <http://dx.doi.org/10.3968/j.sss.1923018420120301.1445>

- Okonkwo, U. T. and Ezumah, N. N. 2017. Socio-cultural factors affecting the autonomy of reproductive decisions of married women in Nsukka L.G.A. of Enugu State, Nigeria *International Journal of Sociology and Anthropology Research*, 3(2): 1-12.
- Olonade, O., Olawande, T. I., Alabi, O. J. and Imhonopi, D. 2019. Maternal mortality and maternal health care in Nigeria: implications for socio-economic development. *Open Access Macedonian Journal of Medical Sciences*, 7(5): 849-855. Available: DOI: 10.3889/oamjms.2019.041
- Olonade, O., Olawande, T. I., Alabi, O. J. and Imhonopi, D. 2019. Maternal mortality and maternal health care in Nigeria: implications for socio-economic development. *Open Access Macedonian Journal of Medical Sciences*, 7(5): 849-855. Available: DOI: 10.3889/oamjms.2019.041
- Omu, O., Al-Obaidi, S. and Reynolds, F. 2014. Religious faith and psychosocial adaptation among stroke patients in Kuwait: a mixed method study. *Journal of Religion and Health*, 53(2): 538-551.
- Ononokpono, D. N. and Odimegwu, C. O. 2014. Determinants of maternal health care utilization in Nigeria: a multilevel approach. *The Pan African Medical Journal*, 17: 2.
- Onwujekwe, O., Onoka, C., Uzochukwu, B. and Hanson, K. 2011. Constraints to universal coverage: inequalities in health services use and expenditure for different health conditions and provides. *International Journal for Equity in Health*, 10.
- Orisaremi, T. C. and Alubo, O. 2012. Gender and reproductive rights of Tarok women in central Nigeria. *African Journal of Reproductive Health*, 16(1): 83-96.
- Orner, P. 2011. It hurt, but I don't have a choice, I am not working and I'm sick: decisions and experiences regarding abortion of women living with HIV in Cape Town, South Africa. *Culture, Health and Security*, 13(7): 781-795.
- Orodho, J. A. 2004. *Techniques of writing research proposal and reports in education and social science*. Nairobi: Masola.

- Osamor, P. and Grady, C. 2017. Factors associated with women's health care decision-making autonomy: empirical evidence from Nigeria. *Journal of Biosocial Science*, 50(1): 1-16. Available: <https://doi.org/10.1017/S0021932017000037>
- Osamor, P. E. and Grady, C. 2016. Women's autonomy in health care decision-making in developing countries: a synthesis of the literature. *International Journal of Women's Health*, 8. Available: <https://doi.org/10.2147/IJWH.S105483>
- Osamor, P. E. and Grady, C. 2018. Autonomy and couples' joint decision-making in healthcare. *BMC Medical Ethics*, 19. <https://doi.org/10.1186/s12910-017-0241-6>
- Pace, R. 2022. What is Marriage? Available: <https://www.marriage.com/advice/readiness/essence-of-marriage/> (Accessed 10 March 2022)
- Pascale, R. and Primavera, L. 2020. How do gender roles impact marriage? A look at traditional versus modern roles. *Psychology Today*, January 7. Available: <https://www.psychologytoday.com/us/blog/so-happy-together/202001/how-do-gender-roles-impact-marriage> (Accessed 18 April 2022).
- Patil, D. M. and Farooqui, M. 2016. Dimensions of women's autonomy and family influence: a statistical study. *International Journal of Science and Research*. Available: <https://www.ijsr.net/archive/v5i10/ART20162414.pdf> (Accessed 30 March 2022).
- Patton, M. Q. 2002. *Qualitative research and evaluation methods*. Thousand Oaks, CA: Sage.
- Paul, M. K. 2018. Factors influencing access and utilisation of antenatal care services by Lemu community in Niger State, Nigeria. Master's dissertation, Durban University of Technology, Durban, South Africa. Available: <https://hdl.handle.net/10321/3156> (Accessed 10 October 2020)
- Pender, N. J., Murdaugh, C. L. and Parsons, M. A. 2015. *Health promotion in nursing practice*. 7thed. Upper Saddle River, NJ: Prentice Hall.
- Polit, D. F. and Beck, C. T. 2021. *Nursing research: Generating and assessing evidence for nursing practice*. 11th ed. Philadelphia: Wolters Kluwer

Princewill, C. W., Jegede, A. S., Nordström, K., Lanre-Abass, B. and Elger, B. S. 2017a. Factors affecting women's autonomous decision making in research participation amongst Yoruba women of western Nigeria. *Developing World Bioethics*, 17(1): 40-49. Available: DOI: 10.1111/dewb.12112

Princewill, C. W., Wangmo, T., Jegede, A. and Riecher-Rössler, A. 2017b. Autonomy and reproductive right of married Ikwerre women in River State, Nigeria. *Journal of Bioethical Inquiry*, 14: 205-215. Available: DOI: 10.1007/s11673-017-9779-8: in

Purushothama, G. S. 2014. *Nursing research & statistics*. New Dehli: Jaypee Brothers Medical Publishers.

Quran Reading. 2018. The Culture of Islam: General Muslim Customs and Traditions Available: www.quranreading.com/blog/the-culture-of-islam (Accessed

Rivera-Franco, M. M. and Leon-Rodriguez, E. 2018. Delays in Breast Cancer Detection and Treatment in Developing Countries. *Breast Cancer (Auckl)*. 2018 Jan 8(2):1-5 <https://doi.org/10.1177/1178223417752677>

Robeyns, I. 2005. Selecting capabilities for quality of life measurement. *Social Indicators Research*, 74: 191-215. Available: <https://doi.org/10.1007/s11205-005-6524-1>

Runciman, P. 2014. The health promotion work of the district nurse: interpreting its embeddedness. *Primary Health Care Research & Development*, 15(1): 15-25.

Rustiana, R. and Handayani, D. 2018. *Does work influence women's autonomy or does autonomy deliberate women to work?* E3S Web of Conferences, Volume 74, id.10013. Available: <https://doi.org/10.1051/e3sconf/20187410013>

Sai, F. T. and Nassim, J. 1989. The need for a reproductive health approach. *Journal of Gynecology & Obstetrics*, 30: 103-113. Available: [https://doi.org/10.1016/0020-7292\(89\)90109-4](https://doi.org/10.1016/0020-7292(89)90109-4).

Salazar, A. 2019. *Respect: examples and how to learn or teach it*. Available: <https://blog.cognifit.com/respect/> (Accessed 12 June 2021).

Salkind, N. J. 2010. *Encyclopedia of research design* . Thousand Oaks, CA: Sage. Available: <https://doi.org/10.4135/9781412961288>

Schoevers, J. and Jenkins, L. 2015. Factors influencing specialist outreach and support services to rural populations in the Eden and Central Karoo districts of Western Cape. *African Journal of Primary Health Care and Family Medicine*, 7(1): 750-759.

Self, S. and Grabowski, R. 2012. Female autonomy and health care in developing countries. *Review of Development Economics*, 16(1): 185-198.

Senarath, U. and Gunawardena, N. S. 2009. Women autonomy in decision making for health care in South Asia. *Asia Pacific Journal of Public Health*, 21(2): 137-143.

Shaikh, B. T. and Hatcher, J. 2004. Health seeking behaviour and health service utilization in Pakistan: challenging the policy makers. *Journal of Public Health*, 27(1): 49-54.

Shaikh, B. T., Haran, D. and Hatcher, J. 2008. Women's social position and health seeking behaviors: is the health care system accessible and responsive in Pakistan? *Health Care for Women International*, 29(8): 945-959. Available: <https://doi.org/10.1080/07399330802380506>

Sheikh, S. A. and Paul, S. N. 2018. Factors affecting community participation in emergency humanitarian response projects in Galkacyo South, Central Somalia. *International Journal of Recent Research in Social Sciences and Humanities*, 5(4): 240-247.

Skinner, E. A. and Zimmer-Gembeck, M. J. 2007. The development of coping. *Annual Review of Psychology*, 58: 119-44. Available: <https://doi.org/10.1146/annurev.psych.58.110405.085705>.

Snow, J. 2012. Engaging your Community: A toolkit for partnership, collaboration and action. Available: https://publications.jsi.com/JSIInternet/Inc/Common/download_pub.cfm?id=14333&lid=3 (Accessed 2 December 2020)

Solnes Miltenburg, A., Lambermon, F., Hamelink, C. and Meguid, T. 2016. Maternity care and Human Rights: what do women think?. *BMC Int Health Hum Rights* 16:17 [https://doi-org.brum.beds.ac.uk/10.1186/s12914-016-0091-1](https://doi.org.brum.beds.ac.uk/10.1186/s12914-016-0091-1)

South Africa. Demographic and Health Survery (SADHS). 2016. Report, National Department of Health (NDoH), Statistics South Africa (Stats SA), South Africa Medical Research Council (SAMRC) and ICF. Available: <https://dhsprogram.com/pubs/pdf/FR337/FR337.pdf> (Accessed 17 April 2022).

South African Marketing Research Association (SAMRA). 2015. *Guideline for research with children in South Africa*. Available: https://www.samra.co.za/_files/ugd/1c6776_6bb0f281f74b40b4bd122b8f4602e637.pdf (Accessed 16 April 2022).

South African Nursing Council (SANC). n.d. Regulations Relating to the Scope of Practice of Persons Who are Registered or Enrolled under the Nursing Act, 1978. Government Notice No. R. 2598 of 30 November 1984 as amended by No. R. 260 of 15 February 1991. Available: <https://www.sanc.co.za/r-2598/> (Accessed 17 May 2022).

Story, W. T. and Burgard, S. A. 2012. Couples' reports of household decision-making and the utilization of maternal health services in Bangladesh. *Social Science and Medicine*, 75(12): 2403-2411. Available: <https://doi.org/10.1016/j.socscimed.2012.09.017>

Stretcher, V. and Rosenstock, I. M. 1997. The Health Belief Model. In K.Glanz, F. M. Lewis, and B. K. Rimer (Eds.), *Health Behavior and Health Education: Theory, Research and Practice* (2nd ed.). San Francisco: Jossey-Bass.

Streubert, H. J. and Carpenter, D. R. 2011. *Qualitative research in nursing: advancing the humanistic imperative*. 5th ed. Philadelphia, PA: Lippincott Williams & Wilkins.

Stritof, S. 2019. Definition of marriage Available: <https://www.brides.com/definition-of-marriage-2303011> (Accessed 19 April 2022)

Swierad, E. M., Vartanian, L. R. and King, M. 2017. The influence of ethnic and mainstream cultures on African Americans' health behaviors: a qualitative study. *Behavioral Sciences*, 7(3), 49. Available: <https://doi.org/10.3390/bs7030049>

Tangwa, G. B. 1996. Bioethics: an African perspective. *Bioethics*, 10(3): 183-200. Available: <https://doi.org/10.1111/j.1467-8519.1996.tb00118.x> 10(3)

Teddlie, C. and Tashakkori, A. 2009. Foundations of mixed methods research: integrating quantitative and qualitative approaches in the social and behavioral sciences. Thousand Oaks, CA: Sage.

Thaddeus, S. Maine, D. 1994. Too far to walk: maternal mortality in context. *Soc Sci Med* 38: 1091-1110 Available: [https://doi.org/10.1016/0277-9536\(94\)90226-7](https://doi.org/10.1016/0277-9536(94)90226-7)

Thapa, S., Sharma S. K. and Khatiwada, N. 2014. Women's knowledge of abortion law and availability of services in Nepal. *Journal of Biosocial Science*, 46(02): 266-77.

Tipping, G. and Segall, M. 1995. Health care seeking behaviour in developing countries: an annotated bibliography and literature review. *Development Bibliography*, 12.

Titaley, C. R., Hunter, C. L., Heywood, P. and Dibley, M. J. 2010. Why don't some women attend antenatal and postnatal care services? A qualitative study of community members' perspectives in Garut, Sukabumi and Ciamis districts of west Java province Indonesia. *BMC Pregnancy and Child Birth*, 10: 61.

Tiruneh, F. N., Chuang, K. Y. and Chuang, Y. C. 2017. Women's Autonomy and Maternal Healthcare Service Utilization in Ethiopia. *BMC Health Services Research*, 17: 718. Available: <https://doi.org/10.1186/s12913-017-2670-9>

Tiwary, A., Rimal, A., Paudyal, B., Sigdel, K. R. and Basnyat, B. 2019. Poor communication by health care professionals may lead to life-threatening complications: examples from two case reports. *Wellcome Open Research*, 4, 7. Available: <https://doi.org/10.12688/wellcomeopenres.15042.1>

TMLT Staff. 2020. *Relevant information about nurses in Nigeria*. Available: <https://www.currentschoolnews.com/articles/about-nurses-in-nigeria/> (Accessed 09 June 2022).

Trócaire. 2017. Understanding women's lives in polygamous marriages: Exploring community perspectives in Sierra Leone. Available: https://www.trocaire.org/sites/default/files/resources/policy/2-sierra-leone-polygamyreport_0.pdf (Accessed 21 June 2021).

Umar, A. S. 2017. Does female education explain the disparity in the use of antenatal and natal services in Nigeria? Evidence from demographic and health survey data. *African Health Sciences*, 17(2): 391-399.

Umar, A. S. and Bawa, S. B. 2015. Antenatal care services utilization in Yobe State, Nigeria: examining predictors and barriers. *International Journal of MCH and AIDS*, 4(1): 35.

Uneke, C. J., Ezeoha, A. E., Ndukwe, C. D., Oyibo, P. G. and Onwe, F. 2013. Promotion of health sector reforms for health systems strengthening in Nigeria: perceptions of policy makers versus the general public on the Nigeria health systems performance. *Social Work Public Health*, 28: 541-553.

United Nations Children's Fund (UNICEF) Nigeria. n.d. Situation of women and children in Nigeria Available: <https://www.unicef.org/nigeria/situation-women-and-children-nigeria> (Accessed 03 April 2021).

United Nations Fund for Population Activities (UNFPA). 2016. *Universal access to reproductive health. Progress and challenges*. Available: http://www.unfpa.org/sites/default/files/pubpdf/UNFPA_Reproductive_Paper_20160120_online.pdf. (Accessed 26 July 2019).

United Nations International Children's Fund. 2014. *Committing to child survival: a promise renewed*. Progress report. New York: UNICEF.

United Nations, Department of Economic and Social Affairs, Population Division. 2015. *World population prospects: the 2015 revision*. Working Paper No. ESA/P/WP.242. Available: https://esa.un.org/unpd/wpp/Publications/Files/WPP2015_Methodology.pdf (Accessed 5 June 2019).

United States Department of Agriculture. 2017. *Department of Agriculture interagency task force on agriculture and rural prosperity*. Available: <https://www.usda.gov/sites/default/files/documents/rural-prosperity-report.pdf> (Accessed 07 July 2022)

United States Department of Agriculture (USDA). 2021. Rural Education. Available: <https://www.ers.usda.gov/.../rural-education> (Accessed 7 June, 2021)

University of South Africa (UNISA), 2013. *Roles and responsibilities of role-players*. Available: https://www.dffe.gov.za/sites/default/files/docs/chapter7_rolesandresponsibilities_roleplayers.pdf (Accessed: 12 March 2022)

Uzochukwu, B. S. C., Ughasoro, M. D., Etiaba. E., Okwuosa, C., Envuladu, E. and Onwujekwe, O. E. 2015. Health care financing in Nigeria: implications for achieving universal health coverage, *Nigeria Journal of Clinical Practice*, 18(4). 437-444. Available: http://www.njcponline.com//temp/NigerJCIinpract184437-7438763_203947.pdf. (Accessed 8 May 2019).

Van der Hoeven, M., Kruger, A. and Greeff. M. 2012. Differences in health care seeking behavior between rural and urban communities in South Africa. *International Journal for Equity in Health*, 11: 31. Available: <https://doi.org/10.1186/1475-9276-11-31>

Varga, C. A. 2002. Pregnancy termination among South African Adolescent. *Studies in Family Planning*, 33(4): 283-298.

Vermeir, P., Vandijck, D., Degroote, S., Peleman, R., Verhaeghe, R., Mortier, E., Hallaert, G., Van Daele, S., Buylaert, W. and Vogelaers, D. 2015. Communication in healthcare: a narrative review of the literature and practical recommendations. *International Journal of Clinical Practice*, 69(11): 1257-1267. Available: <https://doi.org/10.1111/ijcp.12686>

Viner, R. M., Ozer, E. M., Denny, S., Marmot, M., Resnick, M., Fatusi, A. and Currie, C. 2012. Adolescence and the social determinants of health. *The Lancet*, 379(9826): 1641-1652.

Wagstaff, A., Claeson, M., Hecht, R. M., Gottret, P. and Fang, Q. 2006. Millennium Development Goals for health: what will it take to accelerate progress? In: Jamison, D. T. Breman, J. B. Measham, A. R. Alleyne, G. Claeson, M. Evans, D. B. Jha, P. Mills, A. and Musgrove, P. (eds). *Disease control priorities in developing countries*. 2nd ed. Washington (DC): The International Bank for Reconstruction and Development / The World Bank; 2006. Chapter 9.

Wado, Y. D. 2018. Women's autonomy and reproductive health-care-seeking behavior in Ethiopia, *Women and Health*. 58(7): 729-743

Weiss-Gal, I. 2008. The Person-in-Environment Approach: Professional Ideology and Practice of Social Workers. Israel. *Social work*. 53. 65-75. <https://doi.org/101093/sw/53.1.65>

Welcome, M. O. 2011. The Nigerian health care system: need for integrating adequate medical intelligence and surveillance system. *Journal of Pharmacy and Bioallied Sciences*, 3(4): 470-478.

Wiredu, K. 1980. *Philosophy and an African Culture the case of the Akan*. Cambridge: Cambridge University Press.

Witter, S., Arhinful K. D., Kusi, A. and Zakariah-Akoto, S. 2007. The experiences of Ghana in implementing a user fee exemption policy to provide free delivery care. *Reproductive Health Matters*,15(30): 61-71.

World Health Organization (WHO). 2010. A conceptual framework for action on the social determinants of health: discussion paper 2. Geneva, Switzerland. Available: http://www.who.int/social_determinants/publications/9789241500852/en/ (Accessed 19 July2020)

World Health Organization (WHO). 2012. Health Systems in Africa: Community Perceptions and Perspectives. The Report of a Multi-Country Study The World Health Organization Regional Office for Africa. Brazzaville. (online) Available: https://www.afro.who.int/sites/default/files/2017-06/englishhealth_systems_in_africa---2012.pdf (Accessed 14 April 2022)

World Health Organization (WHO). 2013. *World health statistics 2013*. Available: http://www.who.int/gho/publications/world_health_statistics/2013/en/ (Accessed 10 May, 2021).

World Health Organization (WHO). 2014. 1990-2013. Trends in maternal mortality, estimates developed by WHO, UNICEF, UNFPA and the World Bank. Geneva: World Health Organization.

World Health Organization (WHO). 2015a. *Causes of maternal mortality*. Available: www.who.int/mediacentre/factsheets/Fs348/en/ (Accessed 5 July, 2020).

World Health Organization (WHO). 2015b. *Trends in maternal mortality 1990-2015*. Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva: World Health Organization. Available: http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf?ua=1. (Accessed 26 July 2019).

World Health Organization (WHO). 2019. Maternal mortality. Available: <https://www.who.int/news-room/fact-sheets/detail/maternal-mortality> (Accessed 23 June, 2021)

Yahaya, A. 2019. List of Six Geopolitical Zones in Nigeria And Their States Available: <https://nigerianinfopedia.com.ng/six-geopolitical>. (Accessed 23 June 2022)

Yusuf, E. H. 2014. Purdah: a religious practice or an instrument of exclusion, seclusion and isolation of women in a typical Islamic setting of northern Nigeria. *American International Journal of Contemporary Research*, 4(1): 238-245.

Zakuan, U. A. A. and Hassan, K. 2019. Women's Economic Empowerment in the Developing Countries: Reengineering Patriarchy? In book: *Socio-Economic Development*. 155-170 Available <https://doi.org/10.4018/978-1-5225-7311-1.ch009>

Zimmerman, E. B., Woolf, S. H. and Haley, A. 2015. Understanding the relationship between education and health: a review of the evidence and an examination of community perspectives. In: Kaplan, R., Spittel, M. and David, D. (eds). *Population health: behavioral and social science insights*. 347-384. Available: <https://www.ahrq.gov/sites/default/files/publications/files/population-health.pdf> (Accessed 15 February 2022).

Zyaambo, C., Siziya, S. and Fylkesnes, K. 2012. Health status and socio-economic factors associated with health facility utilization in rural and urban areas in Zambia. *BMC health Services Research*, 12(1): 1-8.

APPENDICES

Appendix 1a: DUT ethics clearance: full approval (IREC 181/21)



16 November 2021

Ms M K Paul
Corlo Court Residence
18 Heswall Road
Durban
4001

Dear Ms Paul

Health Seeking Behaviours among Married Women in Northern Nigeria: A framework to promote autonomy
Ethical Clearance number 181/21

The Institutional Research Ethics Committee acknowledges receipt of your gatekeeper permission letter.

Please note that **FULL APPROVAL** is granted to your research proposal. You may proceed with data collection.

Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the IREC according to the IREC Standard Operating Procedures (SOPs).

Please note that any deviations from the approved proposal require the approval of the IREC as outlined in the IREC SOPs.

Yours Sincerely,

Prof J K Adam
Chairperson: IREC

Appendix 1b: DUT ethics clearance: provisional approval (IREC 181/21)



23 September 2021

Ms M K Paul
Corlo Court Residence
18 Heswall Road
Durban
4001

Dear Ms Paul

Health Seeking Behaviours among Married Women in Northern Nigeria: A framework to promote autonomy

I am pleased to inform you that **PROVISIONAL APPROVAL** has been granted to your proposal subject to:

- Obtaining and submitting the necessary gatekeeper permission/s to Institutional Research Ethics Committee (IREC).

PLEASE NOTE THAT THIS IS NOT A FINAL APPROVAL LETTER. KINDLY SUBMIT THE ABOVE MENTIONED DOCUMENTS WITHIN THREE MONTHS TO THE IREC OFFICE. DATA COLLECTION CAN ONLY COMMENCE WHEN IREC ISSUES FULL APPROVAL.

The Proposal has been allocated the following Ethical Clearance number **IREC 181/21**. Please use this number in all communication with this office.

Approval has been granted for a period of **ONE YEAR**, before the expiry of which you are required to apply for safety monitoring and annual recertification. Please use the Safety Monitoring and Annual Recertification Report form which can be found in the Standard Operating Procedures [SOP's] of the IREC. This form must be submitted to the IREC at least 3 months before the ethics approval for the study expires.

Yours Sincerely

Dr K Padayachy
Deputy Chairperson: IREC

Appendix 2a: Permission letter to the chairman local government Lemu

G R A,
Pichi road Bida
Niger State, Nigeria.

1st May 2021

The Chairman
Gbako Local Government Area Lemu,
Niger State, Nigeria.

Request for Permission to Conduct Research

Dear Sir

My name is Mary k Paul, a PhD student at the Durban University of Technology. The research I wish to conduct for my Doctoral thesis involves Health seeking behaviors of married women in Northern Nigeria: A framework to promote autonomy.

I am hereby seeking your consent to conduct the study at Lemu, Gbako local government area, Niger state Nigeria. The study participants who will be married men and women will be all of whom will be recruited from the rural community gathering places, (community hall), where major functions, like celebration and festivities (multipurpose hall), take places with special permission from the chair of the meeting. Data will be collected from the married women using focus group discussions and from married males using one on one interviews.

I have provided you with a copy of my proposal which includes copies of the data collection tools and consent and/ or assent forms to be used in the research process, as well as a copy of the approval letter which I received from the Institutional Research Ethics Committee (IREC).


If you require any further information, please do not hesitate to contact me +2348065367395. Thank you for your time and consideration in this matter.

Yours sincerely,

Mary k Paul

Durban University of Technology

Appendix 2b: Approval letter from the Chairman


Office of the Chairman
GBAKO LOCAL GOVERNMENT COUNCIL
Local Government Secretariat, P.M.B 37 Lemu, Niger State.


Our Ref. _____ *Your Ref.* _____ *Date:* 8th Nov., 2021

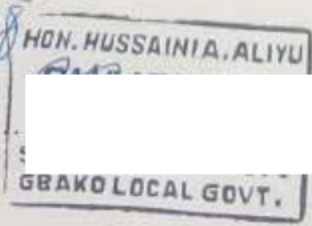
Mrs. Mary K. Paul
Nursing Department,
Durban University of Technology,
Durban 4001.

Dear Madam,

REF: Permission to Conduct Research at Lemu Community

I have the pleasure of informing you that permission has been granted to you by the Acting Chairman Gbako Local Government to conduct research in Lemu Community on: Health Seeking behavior among married women in Northern Nigeria. A framework to promote Autonomy.

Signature... 


HON. HUSSAINIA, ALIYU
GBAKO LOCAL GOVT.

Appendix 3a: Permission letter to the in charge Lemu community hall

1st May 2021
G. R .A,
Pichi road Bida
Niger State, Nigeria.

The Head In charge,
Community Hall
Gbako Local Government Area Lemu,
Niger State, Nigeria.

Request for Permission to recruit the participants during the community meeting and to use the community hall for data collection

Dear Sir/Ma,

My name is Mary k Paul, a PhD student at the Durban University of Technology. The research I wish to conduct for my Doctoral thesis involves Health seeking behavior of married women in Nigeria: A framework to promote autonomy.

I am hereby seeking your consent to recruit the participants for my research project during the rural community gathering that will be taking place in the community hall on 20/5/2021. I need to recruit married men and women to take part in the study .

I also request your permission to use the community hall to collect data from the recruited participant who will agree to take part in the study. Data will be collected from the married women using focus group discussions and from their male counterparts using one on one interviews.

There will be 6-8 women in one focus group discussion session and only one session will be conducted per day lasting for one to two hours.

The interview with the married men will be either at their places of residence or in the hall depending on the choice of each individual participants. Maximum two interviews will be conducted per day each lasting for maximum 45 minutes Details regarding the number of interview sessions for each day, the date and times of data collection will be communicated to you well in advance to ensure that these do not coincide with other functions in the hall.

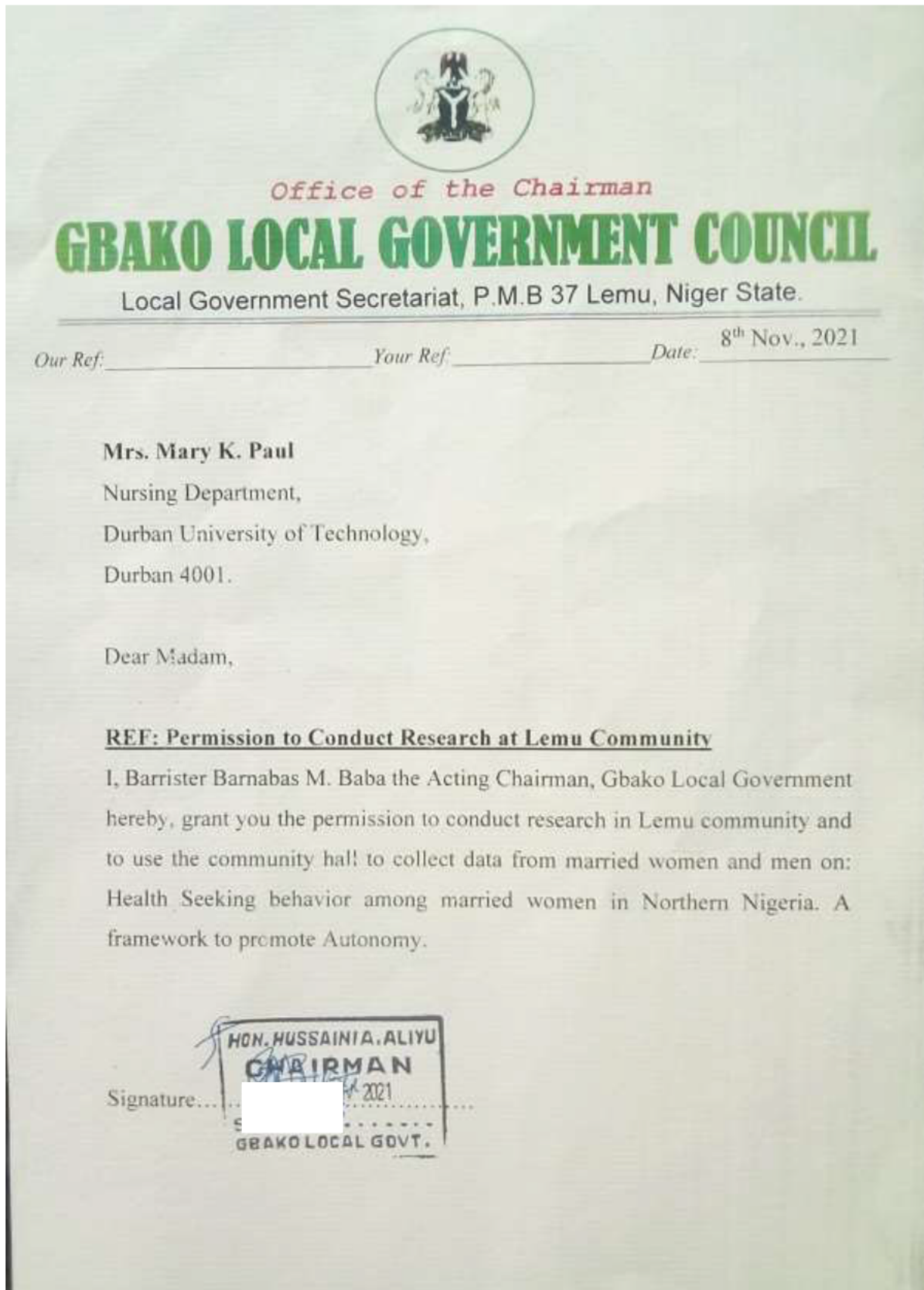
I have provided you with a copy of my proposal which includes copies of the data collection tools and consent and/ or assent forms to be used in the research process, as well as a copy of the approval letter which I received from the Institutional Research Ethics Committee (IREC).

If you require any further information, please do not hesitate to contact me +2348065367395. Thank you for your time and consideration in this matter.

Yours sincerely,

Mary k Paul
Durban University of Technology

Appendix 3b: Approval letter from the in-charge community hall



Appendix 4: Preselection form

PRE-SELECTION FORM

Participant No: **Date:**

Venue:

DEMOGRAPHIC CHARACTERISTICS

Gender

Male	
Female	

Age in years

<25 years	
25-35years	
>35years	

Religion

None	
Christian	
Other	

Level of Education

Never went to school	
Below Matric	
Matric	
Tertiary	

Marital status

Single	
Married	
Widowed	
Divorced	
Separated	

Number of years married

<5 years	
5-10 years	
>10years	

Living arrangements

Permanently living in one home with spouse	
Spouse Working/living away from home	

Number of children

0-1	
2-5	
5+	

Employment status

Unemployed	
Employed	
Self Employed	

Family Type/size

Nuclear family	
Extended family	

Home language

Nupe	
Hausi	

FOR OFFICE USE

1. Prospective Participant:

YES	NO
------------	-----------

2. Gender:

MALE	FEMALE
-------------	---------------

3. Meets Inclusion criteria

YES	NO
------------	-----------

4. Decision about Participation:

INTERESTED	STILL TO DECIDE	NOT INTERESTED
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Contact details:Alternate number:

Suitable time to call:

--	--	--	--

Appendix 5a: Letter of information and consent for Married women in English



LETTER OF INFORMATION

Dear Participant,

Thank you for voluntarily agreeing to participate in this study.

Title of the Research Study: Health seeking behaviors among married women in Northern Nigeria: A framework to promote autonomy.

Principal Investigator/s/researcher: Mary K Paul, Master in Nursing.

Co-Investigator/s/supervisor/s: Professor Ngxongo Thembelihle (Doctor in Nursing),

Dr. Naidoo Vasanthrie (Doctor in Nursing)

Brief Introduction and Purpose of the Study: Health seeking behaviour is defined as any action or inaction undertaken by individuals who perceive they have a health problem or to be ill to find an appropriate remedy, autonomy could be independent decision-making, having the freedom to do something or the right to choose to do something in a certain way without someone else deciding what should be done. Social and cultural discrimination experience of girls and women in developing countries like Nigeria, is a result of the belief that men are superior to women, thereby denying women their autonomy, which in turn affects their healthcare choices. The study aims to develop a framework to promote health Care Decision autonomy among married women in Northern Nigeria. I would like to invite you to participate in the research.

Outline of the Procedures: The researcher will obtain permission from the Durban University of Technology to recruit you as a participant. In addition, permission will be obtained from the chairman Lemu, Gbako Local Government to recruit you as a participant. If you agree to take part in the study, please complete the consent form attached to this document to consent to partaking in this study. Data collection method will depend on gender where for all married males participants one on one interviews will be done and for married women focus group discussions will be done. Due to the nature of the study, it is not easy to say in advance how many participants will be included, that will depend on the information provided where I will stop recruiting more participants when there is no longer any new information coming in. However, a minimum of 55 participants for each gender will be recruited (30 Males and 25 women). Thus a minimum total of 24 participants. You will have choice to have the

interview/focus discussion group either in English or Nupe. The venue, the date and time for the interview/focus discussion session will be negotiated with you

Risks or Discomforts to the Participant: There are no potential risks associated with this study.

Explain to the participant the reasons he/she may be withdraw from the Study: Participation is voluntary, and you may choose to withdraw from the study at any point. There will be no consequences to you should you wish to withdraw.

Benefits: The outcome of the study will have potentials, as the researcher will make recommendations based on the factors that prevent married women from having autonomy to seek healthcare and how they can be allowed to have autonomy to seek healthcare.

Remuneration: There will be no remuneration to you for partaking in the study.

Costs of the Study: There will be no monetary cost to you for partaking in the study.

Confidentiality: Confidentiality will be assured throughout the study and distribution of results. Code numbers instead of name will be used for the questionnaires. The consent forms with participant details will be kept in a locked cabinet only accessible to the researcher.

Results: Publication in accredited journals and Conference presentations.

Research-related Injury: The nature of the study does not pose any potential risk of injury to you as the participants.

Storage of all electronic and hard copies including tape recordings: The consent forms with participant details and the recording tapes will be kept in a locked cabinet for 5 years, only accessible to the researcher.

Persons to contact in the Event of Any Problems or Queries:

Researcher: Mary k Paul Tel: +2348065367395/0718225493

Supervisor: Prof TSP. Ngxongo Tel: 0313732609

Co-Supervisor: Dr. V. Naidoo Tel: +27825191550

Institutional Research Ethics administrator Tel: 0313732375

Complaints can be reported to: the Director: Research and Postgraduate Support Dr L Linganiso on 031 373 2577 or researchdirector@dut.ac.za.



CONSENT

Full Title of the Study: Health seeking behaviors among married women in Northern Nigeria: A framework to promote autonomy.

Names of Researcher/s:

Principal Investigator/s/researcher: Mary K Paul, Master in Nursing.

Co-Investigator/s/supervisor/s: Professor Ngxongo Thembelihle (Doctor in Nursing),
Dr. Naidoo Vasanthrie (Doctor in Nursing)

Statement of Agreement to Participate in the Research Study:

I hereby confirm that I have been informed by the researcher, Mary k Paul,

about the nature, conduct, benefits and risks of this study - Research Ethics Clearance

Number: _____,

I have also received, read and understood the above written information (Participant Letter of

Information) regarding the study.

I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.

In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.

I may, at any stage, without prejudice, withdraw my consent and participation in the study.

I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.

I understand that significant new findings developed during the course of this research which may

relate to my participation will be made available to me.

Full Name of Participant **Date** **Time** **Signature** / **Right**
Thumbprint

I, _____ (name of researcher) herewith confirm that the above participant has been fully

informed about the nature, conduct and risks of the above study.

Full Name of Researcher **Date** **Signature**

Full Name of Witness (If applicable) **Date** **Signature**

Full Name of Legal Guardian (If applicable) **Date** **Signature**

Appendix 5b: Letter of information and consent for Married women in Nupe...



Wosika nya Egwadin lo ba etun nana, to Yedajin

WOSIKA NYA EGWADIN LO BA ETUN NANA

Lo ba nya Eza na a de ‘gwa dan jinjin nana o na,

Yi dajin na be bamba we nyi wo a yedajin gan we a de ‘gwa dan dudugi wa nana o na.

Egan ‘ti nya dudugiwa nana: Halibozhi eti lafiya wa o tacin nyizagi nazhi da yawo ani na nya kin Arewa: shirijin na a ku jinkana fi kinnigi nya etitacin nya atso eshin o na.

Eza na e wa dudugu nana za na: Mary K. Paul, Kpikpe wa legenlege eti lafiya tswa o

Eza baci na e wa dudugi nana za na/Eyeladanci nya dudugi wa za nana: Profeso Ngxongo Thembelihle (Likita nya kpikpe nya eyeladan nya lafiya tswa), to Dr. Naidoo Vasanthrie (Likita nya kpikpe nya lafiya tswa)

Etan tetengi eti wujia nya dudugiwa nana o: Halibo eti lafiya wa o yi jinjin ko cinbo nya jinjinzhi na eza na kpe gan wun de ezo nya lafiya ko ma na e tan batan na e jin na ebo wun wa yeko nya egwagan na. Kinnigi nya eti tacin yi: jinjin na eza jin be eti tacin nya eza e na, ko ma fifo na eza ajin enya na eza kpaye gan u yi gboro na bambe na eza ndoci a gan ya u gan u jin na ma nyi. Enya nazhi egi nyizagizgi to nyizagi nazhi da yawo ani na e da taru nimi kin nazhi ede yegboro lo ke kin Naijeriya na a yi ebo yiyakpe na a de ke gan bagizhi de cinwon gan nyizagizhi na. Nana ma a kinnigi nya etitacin nya nyizagizhi la kan a, nana ma kezhe a egwa la to tsitsa nya lafiya nya a. Dudugi wa nana wa na a la shirijin tin ya na a ku jikanna fi kinnigi nya nyizagizhi shin o ya tsitsa nya lafiya wa ya nyizagizhi nya Arewa nya Naijeriya na. Mi e nya we ‘ka na we a de ‘gwa dan dudugi wa nana o na.

Jinjinzhi nazhi yi a jin nimi etun nana o na. Dudugi waci nana a wa yeda be Makanta nya legenlege nya Etungwazhi nya Durban nyi, na wun a go we dan etun nya dudugi wa nana o na. Kanga wun a kezhe wa yeda be Nda ‘sako nya eka muliki tetengi nya Gbako e, na wun a jin yeda na u ga ye go dan etun dudugi wa nana o na. Wo ga a yeda jin, jin hankuri a fomu na a jin shiri ebo wuncin o na she ke eri nya yedajin nya we na. Ezhe nazhi a ku dan dozhin na a de a jin be eza yiri nazhi a ga yi na. Nya bagizhi, eye be eye nyi ga a gbin a gan o, nya nyizagizhi a yi ezaba keba nya za eni be ena enazhi ga a jin anfani be nyi o. Yi gan wo nya eza sunsun gunkin na a de ‘gwa dan dudugi wa nana o na a, ama yi de a fe go ezazhi hari be kami na yi de labari woro ndondo na e tin ya be be a na nyi. Ama de bagizhi eza guwo be guba nyi, to nyizagizhi eza guwo be guba nyi ga a yi eza kundo na gbagba gan na a de ‘gwa dan dudugi wa nana o na. We a de kafa na we a gbin egazhi nya dudugi wa nana nimi Nasara o ko nimi Nupe o na. Yi a be jin shiawura eti nya dana, etswafo to kami nya egangbin nanazhi o be we nyi.



YEDAJIN

Egan ‘ti shisheci nya dudugi waza nana: Halibozhi eti lafiya wa o tacin nyizagi nazhi da yawo ani na nya kin Arewa: shirijin na a ku jinkana fi kinnigi nya etitacin nya atso eshin o na.

Eza na e wa dudugu nana za na: Mary K. Paul, Kpikpe wa legenlege eti lafiya tswa o

Eza baci na e wa dudugi nana za na/Eyeladanci nya dudugi wa za nana: Profeso Ngxongo Thembelihle (Likita nya kpikpe nya eyeladan nya lafiya tswa), Dr. Naidoo Vasanthrie (Likita nya kpikpe nya lafi ya tswa)

Egan misun nya yedajin ke we a de egwa dan dudugi waza nana o na:

- **Mi** gan aninga ke Dudugiwazaci nana, Mary K Paul ta ya mi eti nya sifa,jinjinzhi, anfani to masibazhi nazhi dan dudugi waza nana o na – Nomba nya jinjingboro nya dudugi waza nana yi
- Mi ma de wosika nya eza na a de ‘gwa dan dudugi waza nana o na go, ci gba, u ma a ye mi.
- Wun a ye mi ke ezhe nya dudugi waza nana, keba be enya nazhi de a jin be mi nyi kebagi ko nyizagi mi yi o na, eya mi, efo na a ma mi na, to enya na aga be kpe ke wun e tan mi na a gau fe enya susoci na a jn anfani ya dudugi waza kawonyi na e.
- Ebo enya na a e waza be dudugi wa nana e na, mi a yeda jin ke a jin anfani wo nimi yeko nya kpikpe nya zaman bo be ezhe nazhi a ga be de go eba mi bo ya dudugi wa na nyi.
- Mi ya nimi mi tinya wo nimi dudugi waza nana o kami ndondo bambe manafiki nyi.
- Mi de kafa wangi ya egangbinzhi (be bamba mi nyi) jin yeda ke mi a jin shiri na mi a de ‘gwa dan dudugi waza nana o na.
- Mi kpe gan enya woro nazhi ga be tinya na yi yi dan nimi dudugi waza nana o na,na de a jin be didejin nya mi na o, a a ta ya mi.

Sunna nya Eza na de ‘gwa Etswa fo Efin Egwadan/ Egwa Tintiko

dan dudugi waza nana o na

Mi, Mary k Paul _____ (sunna nya dudugi wazaci) ye ke gan eza na sunna dan efinti o ke wun a de ‘gwa dan dudugi wa za nana o na de kpikpe shisheci eti nya sifa,jinjinzhi, anfani to masibazhi nazhi dan dudugi waza nana o na

Sunna shisheci nya dudugi wazaci Etswafo Egwadan

**Sunna nya erijinci (U ga dan bo na)
Egwadan**

Etswafo

Appendix 6a: Letter of information and consent for Married men in English



LETTER OF INFORMATION

Dear Participant,

Thank you for voluntarily agreeing to participate in this study.

Title of the Research Study: Health seeking behaviors among married women in Northern Nigeria: A framework to promote autonomy.

Principal Investigator/s/researcher: Mary K Paul, Master in Nursing.

Co-Investigator/s/supervisor/s: Professor Ngxongo Thembelihle (Doctor in Nursing),

Dr. Naidoo Vasanthrie (Doctor in Nursing)

Brief Introduction and Purpose of the Study: Health seeking behaviour is defined as any action or inaction undertaken by individuals who perceive they have a health problem or to be ill to find an appropriate remedy, autonomy could be independent decision-making, having the freedom to do something or the right to choose to do something in a certain way without someone else deciding what should be done. Social and cultural discrimination experience of girls and women in developing countries like Nigeria, is a result of the belief that men are superior to women, thereby denying women their autonomy, which in turn affects their healthcare choices. The study aims to develop a framework to promote health Care Decision autonomy among married women in Northern Nigeria. I would like to invite you to participate in the research.

Outline of the Procedures: The researcher will obtain permission from the Durban University of Technology to recruit you as a participant. In addition, permission will be obtained from the chairman Lemu, Gbako Local Government to recruit you as a participant. If you agree to take part in the study, please complete the consent form attached to this document to consent to partaking in this study. Data collection method will depend on gender where for all married males participants one on one interviews will be done and for married women focus group discussions will be done. Due to the nature of the study, it is not easy to say in advance how many participants will be included, that will depend on the information provided where I will stop recruiting more participants when there is no longer any new information coming in. However, a minimum of 55 participants for each gender will be recruited (30 Males and 25 women). Thus a minimum total of 24 participants. You will have choice to have the interview/focus discussion group either in English or Nupe. The venue, the date and time for the interview/focus discussion session will be negotiated with you

Risks or Discomforts to the Participant: There are no potential risks associated with this study.

Explain to the participant the reasons he/she may be withdraw from the Study: Participation is voluntary, and you may choose to withdraw from the study at any point. There will be no consequences to you should you wish to withdraw.

Benefits: The outcome of the study will have potentials, as the researcher will make recommendations based on the factors that prevent married women from having autonomy to seek healthcare and how they can be allowed to have autonomy to seek healthcare.

Remuneration: There will be no remuneration to you for partaking in the study.

Costs of the Study: There will be no monetary cost to you for partaking in the study.

Confidentiality: Confidentiality will be assured throughout the study and distribution of results. Code numbers instead of name will be used for the questionnaires. The consent forms with participant details will be kept in a locked cabinet only accessible to the researcher.

Results: Publication in accredited journals and Conference presentations.

Research-related Injury: The nature of the study does not pose any potential risk of injury to you as the participants.

Storage of all electronic and hard copies including tape recordings: The consent forms with participant details and the recording tapes will be kept in a locked cabinet for 5 years, only accessible to the researcher.

Persons to contact in the Event of Any Problems or Queries:

Researcher: Mary k Paul Tel: +2348065367395/0718225493

Supervisor: Prof TSP. Ngxongo Tel: 0313732609

Co-Supervisor: Dr. V. Naidoo Tel: +27825191550

Institutional Research Ethics administrator Tel: 0313732375

Complaints can be reported to: the Director: Research and Postgraduate Support Dr L Linganiso on 031 373 2577 or researchdirector@dut.ac.za.



CONSENT

Full Title of the Study: Health seeking behaviors among married women in Northern Nigeria: A framework to promote autonomy.

Names of Researcher/s:

Principal Investigator/s/researcher: Mary K Paul, Master in Nursing.

Co-Investigator/s/supervisor/s: Professor Ngxongo Thembelihle (Doctor in Nursing),
Dr. Naidoo Vasanthrie (Doctor in Nursing)

Statement of Agreement to Participate in the Research Study:

I hereby confirm that I have been informed by the researcher, Mary k Paul,

about the nature, conduct, benefits and risks of this study - Research Ethics Clearance

Number: _____,

I have also received, read and understood the above written information (Participant Letter of

Information) regarding the study.

I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.

In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.

I may, at any stage, without prejudice, withdraw my consent and participation in the study.

I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.

I understand that significant new findings developed during the course of this research which may

relate to my participation will be made available to me.

Full Name of Participant **Date** **Time** **Signature** / **Right**
Thumbprint

I, _____(name of researcher) herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

Full Name of Researcher **Date** **Signature**

Full Name of Witness (If applicable) **Date** **Signature**

Full Name of Legal Guardian (If applicable) **Date** **Signature**

Appendix 6b: Letter of information and consent for Married men in Nupe



Wosi

WOSIKA NYA EGWADIN LO BA ETUN NANA

Lo ba nya Eza na a de ‘gwa dan jinjin nana o na,

Yi dajin na be bamba we nyi wo a yedajin gan we a de ‘gwa dan dudugi wa nana o na.

Egan ‘ti nya dudugiwa nana: Halibozhi eti lafiya wa o tacin nyizagi nazhi da yawo ani na nya kin Arewa: shirijin na a ku jinkana fi kinnigi nya etitacin nya atso eshin o na.

Eza na e wa dudugu nana za na: Mary K. Paul, Kpikpe wa legenlege eti lafiya tswa o

Eza baci na e wa dudugi nana za na/Eyeladanci nya dudugi wa za nana: Profeso Ngxongo Thembelihle (Likita nya kpikpe nya eyeladan nya lafiya tswa), to Dr. Naidoo Vasanthrie (Likita nya kpikpe nya lafiya tswa)

Etan tetengi eti wujia nya dudugiwa nana o: Halibo eti lafiya wa o yi jinjin ko cinbo nya jinjinzhi na eza na kpe gan wun de ezo nya lafiya ko ma na e tan batan na e jin na ebo wun wa yeko nya egwagan na. Kinnigi nya eti tacin yi: jinjin na eza jin be eti tacin nya eza e na, ko ma fifo na eza ajin enya na eza kpaye gan u yi gboro na bambe na eza ndoci a gan ya u gan u jin na ma nyi. Enya nazhi egi nyizagizgi to nyizagi nazhi da yawo ani na e da taru nimi kin nazhi ede yegboro lo ke kin Najeriya na a yi ebo yiyakpe na a de ke gan bagizhi de cinwon gan nyizagizhi na. Nana ma a kinnigi nya etitacin nya nyizagizhi la kan a, nana ma kezhe a egwa la to tsitsa nya lafiya nya a. Dudugi wa nana wa na a la shirijin tin ya na a ku jikanna fi kinnigi nya nyizagizhi shin o ya tsitsa nya lafiya wa ya nyizagizhi nya Arewa nya Najeriya na. Mi e nya we ‘ka na we a de ‘gwa dan dudugi wa nana o na.

Jinjinzhi nazhi yi a jin nimi etun nana o na. Dudugi waci nana a wa yeda be Makanta nya legenlege nya Etungwazhi nya Durban nyi, na wun a go we dan etun nya dudugi wa nana o na. Kanga wun a kezhe wa yeda be Nda ‘sako nya eka muliki tetengi nya Gbako e, na wun a jin yeda na u ga ye go dan etun dudugi wa nana o na. Wo ga a yeda jin, jin hankuri a fomu na a jin shiri ebo wuncin o na she ke eri nya yedajin nya we na. Ezhe nazhi a ku dan dozhin na a de a jin be eza yiri nazhi a ga yi na. Nya bagizhi, eye be eye nyi ga a gbin a gan o, nya nyizagizhi a yi ezaba keba nya za eni be ena enazhi ga a jin anfani be nyi o. Yi gan wo nya eza sunsun gunkin na a de ‘gwa dan dudugi wa nana o na a, ama yi de a fe go ezazhi hari be kami na yi de labari woro ndondo na e tin ya be be a na nyi. Ama de bagizhi eza guwo be guba nyi, to nyizagizhi eza guwo be guba nyi ga a yi eza kundo na gbagba gan na a de ‘gwa dan dudugi wa nana o na. We a de kafa na we a gbin egazhi nya dudugi wa nana nimi Nasara o ko nimi Nupe o na. Yi a be jin shiawura eti nya dana, etswafo to kami nya egangbin nanazhi o be we nyi.



YEDAJIN

Egan ‘ti shisheci nya dudugi waza nana: Halibozhi eti lafiya wa o tacin nyizagi nazhi da yawo ani na nya kin Arewa: shirijin na a ku jinkana fi kinnigi nya etitacin nya atso eshin o na.

Eza na e wa dudugu nana za na: Mary K. Paul, Kpikpe wa legenlege eti lafiya tswa o

Eza baci na e wa dudugi nana za na/Eyeladanci nya dudugi wa za nana: Profeso Ngxongo Thembelihle (Likita nya kpikpe nya eyeladan nya lafiya tswa), Dr. Naidoo Vasanthrie (Likita nya kpikpe nya lafi ya tswa)

Egan misun nya yedajin ke we a de egwa dan dudugi waza nana o na:

- **Mi** gan aninga ke Dudugiwazaci nana, Mary K Paul ta ya mi eti nya sifa,jinjinzhi, anfani to masibazhi nazhi dan dudugi waza nana o na – Nomba nya jinjingboro nya dudugi waza nana yi
- Mi ma de wosika nya eza na a de ‘gwa dan dudugi waza nana o na go, ci gba, u ma a ye mi.
- Wun a ye mi ke ezhe nya dudugi waza nana, keba be enya nazhi de a jin be mi nyi kebagi ko nyizagi mi yi o na, eya mi, efo na a ma mi na, to enya na aga be kpe ke wun e tan mi na a gau fe enya susoci na a jn anfani ya dudugi waza kawonyi na e.
- Ebo enya na a e waza be dudugi wa nana e na, mi a yeda jin ke a jin anfani wo nimi yeko nya kpikpe nya zaman bo be ezhe nazhi a ga be de go eba mi bo ya dudugi wa na nyi.
- Mi ya nimi mi tinya wo nimi dudugi waza nana o kami ndondo bambe manafiki nyi.
- Mi de kafa wangi ya egangbinzhi (be bamba mi nyi) jin yeda ke mi a jin shiri na mi a de ‘gwa dan dudugi waza nana o na.
- Mi kpe gan enya woro nazhi ga be tinya na yi yi dan nimi dudugi waza nana o na,na de a jin be didejin nya mi na o, a a ta ya mi.

Sunna nya Eza na de ‘gwa

Etswa fo

Efin

Egwadan/ Egwa Tintiko dan dudugi waza nana o na

Mi, Mary k Paul _____ (sunna nya dudugi wazaci) ye ke gan eza na sunna dan efinti o ke wun a de ‘gwa dan dudugi wa za nana o na de kpikpe shisheci eti nya sifa,jinjinzhi, anfani to masibazhi nazhi dan dudugi waza nana o na

**Sunna shisheci nya dudugi wazaci
Egwadan**

Etswafo

Sunna nya erijinci (U ga dan bo na)

Etswafo

Egwadan

Appendix 7a: Focus group discussion with Married women in English

GUIDE FOR FOCUS GROUP DISCUSSION WITH MARRIED WOMEN

Group code:**Date:** **Number of Participants:**

Venue:

.....

Time: From**to**..... **Duration:**

Present: 1 Interviewer: **(Researcher)**

2. Research assistant:

Title of the study: Health Seeking Behaviours among Married Women in Northern Nigeria: A framework to promote autonomy

PRE-CHECKING INFORMATION

Information	Yes	No	Comments
Preselection form completed for all participants			
All participant meet inclusion criteria			
Consent forms signed by all participants			
All participants gave verbal consent for recording the group discussion			

GRAND TOUR STATEMENT

1. Please share with me the current practice regarding the process of healthcare seeking decision-making and autonomy practices amongst married women in Nigeria.

FOLLOW UP QUESTIONS

1. What are the current practices regarding healthcare decision-making and autonomy practices amongst married women in Northern Nigeria?
2. What are your perceptions regarding married women having autonomy to make own health care seeking decisions?
3. In your opinion what are the challenges experienced by married women in Nigeria due to inability to make own healthcare decisions?
4. Which untoward outcomes are you aware of that have been experienced by the married women due inability to make own healthcare decision?
5. How would you describe the awareness of men in Nigeria about the untoward outcomes experienced by married women in Nigeria due to inability to make own healthcare decision?
6. In your opinion, what strategies could promote healthcare decision autonomy among married women in Nigeria?
7. In your opinion how would the men in Nigeria react to a framework to facilitate women autonomy in health seeking behaviours?

NB: a) *Further probing*

Appendix 7b: Focus group discussion with Married women in Nupe

Cintaragi 6b: ENYATUN NA A KU EGANGBINZHI DAN DOZHI NA

EBAWUZHI YA EZABA KEBA BE ENA NYA NYIZAGI NAZHI DA YAWO A NI NA

Nomba kanyi nya Ena nana: Etswafo: Eza sunsun nazhi dan bo na:

Dana nay gungunkeba:

Wokati: DagaDa Ekpawun nya lokaci

Eza nazhi zhi bo na: 1 Eza na e gbin ‘gazhi na: (Dudugi wazaci)

2. Eza na e ba u jin re na:

Eganti nya dudugi waza nana: Halibozhi eti lafiya wa o tacin nyizagi nazhi da yawo ani na nya kin Arewa: shirijin na a ku jinkana fi kinnigi nya etitacin nya atso eshin o na.

ENYA NAZHI A LA HANKALI TU BEDZO NA

Enya nazhi a wa dede u na	Eba (Acinga)	Ah Ah (U yi acinga a)	Ke we de a gan eti u bo o
Shishe nya Fomu nya eza li nya eza ndondo			
Za ndondo a she kporo na a a lotun nana won a?			
Eza ndondo a fomu nya yedajin ya etun lo nana she?			
Eza ndondo a yeda jin na a ga eganzhi na a ga la jin ezaba na ku fi kaseti o?			

EGA KPOKI ETI DUDUGI WAZA NANA O

1. Jin hankuri ta ya mi jinjin nazhi e lo ye gbani eti nya halibozhi nya lafiya wa be eti tacin atso nyi tacin nyizagi nazhi da yawo ani na nya kin Najeriya o na.

EGANGBIN NAZHI LAMITU NYA MAFARI NA

1. Ke yi yekpa nya we eti nyizagi nazhi da yawo a ni na o, na a tso a gikinni wo ci la bicikinkpe eti lafiya tswa wa nya a tso o na o?

2. Enya bibici kicizhi wo kpe ye na e be tsun nyizagi nazhi da yawo a ni na ebona a tso de kafa na a la bici kinkpe nya lafiya wa na a nyi o?

3. Nimi yekpa wo bo, ke wo kpaye gan a jin wo na a ba nyizagi nazhi da yawo a ni na jin re Najeriya o eba bici kinkpe nya lafiya wa nya a tso o na o?

La hankali tu nana: a) Wo kezhe gbin egan ndocizhi wo be kendona u ga a la u la tin ye na.

Appendix 8a: Interview guide with Married men in English.....

DATA COLLECTION INSTRUMENT

INTERVIEW GUIDE FOR MARRIED MEN

Participant code: **Date:**

Venue:

.....

Time: From**to**..... **Duration:**

Present: 1 Interviewer: **(Researcher)**

2. Research assistant:

Title of the study: Health Seeking Behaviours among Married Women in Northern Nigeria: A framework to promote autonomy

PRE-CHECKING INFORMATION

Information	Yes	No	Date	Comments
Preselection form completed				
Participant meets inclusion criteria				
Consent form signed				
Verbal consent given for recording				

INTERVIEW GUIDE

GRAND TOUR QUESTION

2. What is the current practice regarding the process of healthcare seeking decision-making and autonomy practices amongst married women in Nigeria?

FOLLOW UP QUESTIONS

8. Does your wife have autonomy to make own healthcare seeking decision?
9. What led to the current practice of your wife regarding health care seeking behaviour?
10. What is your opinion regarding married women having autonomy to make own health care seeking decisions?
11. In your opinion what are the challenges experienced by married women in Nigeria due to inability to make own healthcare decisions?
12. Are you aware of any untoward outcomes that your wife or any other married women have experienced due inability to make own healthcare decision? If yes, please share these with me.
13. In your opinion, which strategies could possible promote healthcare decision autonomy among married women in Nigeria
14. In your opinion how would the men in Nigeria react to a framework to facilitate women autonomy in health seeking behaviours?

NB: a) *Further probing for each response will be done as required*

Cintaragi 8b: ENYATUN NA A KU EGANGBINZHI DAN DOZHI NA

EBAWUZHI YA EGANGBINZHI BE BAGI NAZHI A YAWO JIN A NI NA NYI

Nomba kanyi nya Bagi nana: Etswafo:

Dana:

Wokati: DagaDa Ekpawun nya lokaci

Eza nazhi zhi bo na: 1 Eza na e gbin ‘gazhi na: (Dudugi wazaci)

2. Eza na e ba u jin re na:

Eganti nya dudugi waza nana: Halibozhi eti lafiya wa o tacin nyizagi nazhi da yawo ani na nya kin Arewa nya Naijeriya o: shirijin na a ku jinkana fi kinnigi nya etitacin nya atso eshin o na.

ENYA NAZHI A LA HANKALI TU BEDZO NA

Enya nazhi a wa dede u na	Eba (Acinga)	Ah Ah Etswafo (U yi acinga a)	Ke we de a gan eti u bo o
Shishe nya Fomu nya eza li nya eza ndondo			
Za ndondo a she kporo na a a lotun nana won a?			
Eza ndondo a fomu nya yedajin ya etun lo nana she?			
Eza ndondo a yeda jin be misun a nyi na a ga eganzhi na a ga gbin a na ku fi kaseti o na?			

EGA KPOKI ETI DUDUGI WAZA NANA O

1. Kezhi yi jinjin nazhi e lo ye gbani eti nya halibozhi nya lafiya wa o tacin nyizagi nazhi da yawo ani na nya kin Najeriya na o.

EGANGBIN NAZHI LAMITU NYA MAFARI NA

1. Mgba nyimi nya we de kafa na wun a la bicikinkpe nya eti tacin wuntso eti lafiya tswa wa nya nya wuntso o na o? Kagan u yi acin a ta ya mi enya na la na.

2. Ke yi yekpa nya we eti nyizagi nazhi da yawo a ni na a tso a gikinni wo ci la bicikinkpe eti lafiya tswa wa nya a tso o na o?

3. Wo kpe enya bibici na be tsun nyimi we ko nyizagi ndocizhi nazhi da yawo a ni na ebo na a tso de kafa na a la bici kinkpe nya lafiya wa na a na o? Wun a yi acinga o, jin hankuri ta ya mi kemina u be fe fen a.

4. Nimi yekpa wobo, ke wo kpaye gan a jin wo na a ba nyizagi nazhi da yawo a ni na jin re Najeriya o eba bici kinkpe nya lafiya wa bo na o?

La hankali tu nana: a) Wo kezhe gbin egan ndocizhi wo be kendona wo gal eye gan u gonyi na.

Appendix 9: Contract with research assistant



AGREEMENT BETWEEN THE RESEARCHER AND RESEARCH ASSISTANT

Title of the study: Health Seeking Behaviour among Married Women in Northern Nigeria: A framework to promote autonomy

Study Setting: Lemu, Gbako Local Government of Niger State

Principal Researcher: Ms Mary K. Paul

Details of the study: The study is a qualitative study that will be conducted with the aim of developing a framework to promote healthcare decision autonomy among married women in Nigeria. A series of information giving sessions will be conducted in local community halls to inform the community about the study and to recruit qualifying participants to take part in the study. All participants who are willing to take part in the study will be required to complete the preselection questionnaire in order to establish eligibility and also to sign an informed consent form. Data will be collected from married men and women using one on one semi-structured interviews and focus group discussions. The focus group discussion sessions will take place in the community halls. The one on one semi-structured interviews with married men will depend on the choice of each individual participant which could be their place of residence or the community hall.

Duties of the research assistant:

1. Distribution of information letters, preselection questionnaires and consent forms
2. Assist the researcher in completing the preselection questionnaire during information giving sessions
3. Assist the researcher with recording the interview and Focus group discussion sessions

Instructions to the research assistant

- 1 The research assistant will be expected to accompany the researcher to all the information giving and data collection sessions.
- 2 Transport will be provided for the assistant to travel to and from all data collection sites
The assistant will be paid a once payment of R3000. 00 at the end of data collection (74,392,94 Naira).
- 3 The research assistant will assist with the duties as detailed in '**Duties of the research assistant**' section above.
- 4 The research will provide orientation and guidance to the research assistant regarding role expectation
- 5 The research assistant will not be allowed to transport any research documents from the data collection site.

- 6 The researcher will provide the research assistant with all the necessary tools such as voice recorder, stationary etc.
- 7 The research assistant will notify the researcher well in advance if she/he is unable to make it for the planned session and if she wishes to terminate this contract before completion of data collection.
- 8 The research assistant will notify the researcher regarding any untoward situations in the data collection sites.

A total of R100 (2,481,04 Naira) will be deducted from the final pay for the number of days that the research assistant was absent.

A total of R100 (2,481,04 Naira) will be paid per day for the total number of days that the research assistant will have worked at the time of terminating the contract



Agreement

This is to certify that I ...Mr Timothy Eze.....
ID. No:NIL.....have agreed to assist the researcher Mrs Mary K. Paul in
the process of recruiting participants and collecting data in Lemu, Gbako Local Government of Niger State
. I have read and fully understood all the written instructions as stated in this agreement letter. I voluntary
agree to assist the researcher on the agreement that the researcher will pay me R3000.00 (74,392,94 Naira)
in cash on completion of data collection.

Signed _____ Date _____
Research assistant

Signed _____ Mpaul _____ Date 30th/06/2022 _____
Researcher

Signed _____ Date _____
Witness



Acknowledgement of payment

I.....MrTimothyEze.....
..... ID. No.....Nil..... acknowledge that on the
30/11/2021..... a total amount of R3000.00 (74,392,94 Naira).was paid to me in
cash by Mrs Mary K. Paul for having assisted her with recruitment and data collection for her study
titled: Health Seeking Behaviour among Married Woman in Nigeria: A framework to promote autonomy
Signed_____ Date_____

Research assistant

Signed_____Mpaul_____ Date_30/06/2022_____

Researcher

Signed_____ Date_____

Witness

Appendix 10A: Transcription of focus group discussion with married women English

SSTUSStudy siteST	Participant number	Age	Year in marriage	Marital status	Home language	Employment status	Source of income	Recorded information	Themes and sub-themes
LCH	FGDI	35	8	M	N	Unemployed	HW	<p>Main research question:</p> <p>Please share with me the current practice regarding the process of healthcare seeking decision-making and autonomy practices among married women in Northern Nigeria.</p> <p>As a married woman you can't seek for healthcare on your own, on-less your husband gives you permission to do so.</p>	<p>Traditional and cultural believes</p> <p>Awareness of married men men regarding importance of autonomy</p>

								<p>What are the current practice regarding healthcare decision-making and autonomy practices amongst married women in Northern Nigerians?</p> <p>Currently as married women under the authority of a man, we cannot take any serious decision about our healthcare</p> <p>What are your perception regarding married women having autonomy to make own healthcare seeking decisions</p> <p>It will improve our health and that of our children</p> <p>In your opinion what are the challenges experience by married women in Nigeria due</p>	<p>of married visit women to visit health</p> <p>Care centres</p> <p>Awareness of married men men regarding importance of autonomy of married visit women's to visit health</p> <p>Care centers</p> <p>Information consigning the right of married women to access or to take decision on their own to seek healthcare services</p> <p>Communication and transparency</p>
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							<p>to inability to make healthcare decision</p> <p>Fear of men, fear of divorce, pain and suffering in silence, lack of finances, dead, and lack of awareness</p> <p>Which untoward outcome are you aware of that have been experienced by the married women due inability to make own healthcare decision</p> <p>Sudden death, high maternal and child mortality rate, and fear of been rejected by men</p> <p>How would you describe the awareness of men in Nigeria about the untoward outcomes experience by married women in Nigeria due inability to make own healthcare decision</p>	<p>Package of services</p> <p>Community awareness of autonomy among married women and married men</p> <p>Community awareness of autonomy among married women and married men</p> <p>Traditional and cultural beliefs</p>
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							<p>It will promote the health of married women</p> <p>Death rate of married women and children will be reduced</p> <p>Bring peace and happiness</p> <p>In your opinion, what strategies could promote healthcare decision autonomy among married women in Northern Nigeria</p> <p>Men should be health educated about what autonomy is all about</p> <p>There should be general orientation and awareness of married men, that could change their behavior towards their wives</p> <p>Married men should be convinced that women are part of their riches and wealth</p>	<p>Financial issues</p> <p>Communication and transparency</p> <p>Information regarding of importance of autonomy</p>
--	--	--	--	--	--	--	---	---

								<p>In your own opinion how would the men in Nigeria react to a framework to facilitate women autonomy in healthcare seeking behavior</p> <p>Some can divorce their wife</p> <p>Some can fight and beat their wife's</p> <p>Some will be unhappy and feels the wife has not giving him respect due to him</p> <p>Some could accept</p>	<p>Communication and transparency</p> <p>Communication and transparency</p>
--	--	--	--	--	--	--	--	--	---

										<p>Financial issues</p> <p>Information consigning the ht of right of married women to or to access or take decision on</p> <p>Their own to seek healthcare</p>
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Appendix 10b: Transcription of focus group discussion with married women Nupe

Study site	Nomba	Egi Nya Eya Na wo	Eya We	Eza Yiri Kici Wo yi Yawojin	Ezhi Misun We	Ekpo Nya Etunlo	Yeko na we e la de aziki na	Labarizhi Na A ka Na	Ega 'ti to Egan Gwalagizhi
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LCH	FG D1	35	8	Mi a yawo jin a ni	Nu pe	Mi De etun a	Nyimi Nimi 'Mbo	<p>Egangbin kpataki nya dudugiwa nana:</p> <p>Baza be mi nyi eti jinjin nazhi e lo ye gbani na eti nya yeko nya shiawurajin eti lafiya wa o to jinjinzhi nya etitacin nya nyizagizhi nazhi da yawo a ni na nimi Kin nya Arewa nya Najeriya o na o.</p> <p>Ke nyizagi na da yawo ani na, wo de kafa na we a da wa lafiya tswa nya eti we na a, sayi be yeda nya eba we nyi.</p> <p>Ke yi jinjinzhi na e lo ye gbani eti nya yeko nya shiawurajin eti lafiya wa o to jinjinzhi nya etitacin nya nyizagizhi nazhi da yawo a ni na nimi Kin nya Arewa nya Najeriya bo o?</p> <p>Gbani, ke nyizagi na da yawo a ni, ci dan tako nya yikunci nya eba u bo na, yi la bicikinkpe kpataki ndondo wo eti lafiyatswa nya yi bo a.</p>	<p>Alada to zhizhizhi nazhi a</p> <p>yakpe na</p> <p>Eyekepe wa ya bagi nazhi a yawo jin a ni na o eti kpatakibo nya kafa na nyizagi nazhi da yawo a ni na a de ci la bicikinkpe ko wa lafiya tswa be etitacin nya atso nyi lo dana lafiya tswa na.</p> <p>Eyekepe wa ya bagi nazhi a</p>
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							<p>Ke yi yekpa we eti nyizagi nazhi da yawo a ni na, na a de kafa ci la bicikinkpe be nimi a tso nyi eti lafiya tswa o na o?</p> <p>Wun a ba lafiya yi to nya egi yizhi jinre.</p> <p>Yekpa nya we bo, ke yi ekopawuzhi na nyizagi nazhi da yawo ani na e de Najeriya ebo na a de kafa na a la bicikinkpe eti lafiya tswa nya etitacin a tso bo a na o?</p> <p>‘Dasun nya bagizhi, edasun nya yawola, etan to walajin susoci, cincinbo nya ewo, tsutsu to cincinbo nya eyekpe ko kpikpe.</p> <p>Kezhi yi enya bibici ndoci nazhi wo kpeye ga e be tsun nyizagi nazhi da yawo a ni na o, ebo na a de kafa na a la bicikinkpe eti lafiya tswa nya etitacin a tso bo a na o?</p>	<p>yawo jin a ni na o eti kpatakibo nya kafa na nyizagi nazhi da yawo a ni na a de ci la bicikinkpe ko wa lafiya tswa be etitacin nya atso nyi lo dana lafiya tswa na.</p> <p>Eyekpe ya Ezazhi eti kafa la ya nyizagi nazhi da yawo a ni na o</p> <p>na a la bicikinkpe nya be nimi</p> <p>atso nyi na a da wa lafiyatswa</p> <p>nya eti atso na</p> <p>Ezaba keba be dozhi to</p>
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							<p>Tsutsu giriku, ekundo nya tsutsu nya Nnazhi to Egizhi, to edasun nya ninavo na ezazhi a be na a von a.</p> <p>Ke wo gan wo eti dedede nya bagizhi nya naijeriya eti enya bibici ndoci nazhi e be tsun nyizagi nya Naijeriya nazhi da yawo a ni na o, ebo na a de kafa na a la bicikinkpe eti lafiya tswa nya etitacin a tso bo a na o?</p> <p>Wun a ba lafiya nya nyizagi nazhi da yawo a ni na jinre.</p> <p>Tsutsu nya nnazhi to egi a zhi ga a de egwakan.</p> <p>Wun a la lafiya to ninma be.</p> <p>Eba wo bo, yeko kici bo yi ku jinkana fi egan nya bicikinkpe la nya nyizagi na da yawo ani na eshin o ya lafiya wa be etitacin nya atso nyi o nimi kin nya arewa nya naijeriya bo o?</p>	<p>Gaskiya ta ya dozhi</p> <p>Etun lafiyatswa nazhi a ba nyizagizhi jinre wo na</p> <p>Eyekpe ya Ezazhi nya ezhizhi</p>
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								<p>Bagizhi a de kpikpe nya lafiya tswa to enya na kafa nya bicikinkpe la nya etitacin nya eza yi na.</p> <p>U gonyi bagi nazhi a yawo jin a ni na a de wuwu nazhi a la ebanzhe be ya a eti jinjin a zhi o lo 'ba nya nyimi a zhi na. Bagi nazhi a yawo jin a ni na gonyi a kpe gan nyimi a zhi yi dukiya to aziki nya a zhi.</p> <p>Eba yekpa wo bo, ke bagizhi nya Najeriya a jin wun ayike a ga de shirijin na a ba nyizagizhi jin re ci la bicikinkpe nya lafiyatswa wa na o?</p> <p>Bagi ndocizhi ga yawo la be nyimi a nyi, ndocizhi ma a sunwun ko wu nyimi a zhi. Sashizhi a de ninma a, ama few o san ke nyimi azhi a a la cinwon na go a nyi na ya a ya a na.</p> <p>Eza ndocizhi ma go u wo.</p>	<p>eti kafa la ya nyizagi to bagi</p> <p>nazhi da yawo a ni ko a yawojin</p> <p>a ni na o.</p> <p>Eyekepe ya Ezazhi nya ezhizhi</p> <p>eti kafa la ya nyizagi to bagi</p> <p>nazhi da yawo a ni ko a yawojin</p> <p>a ni na o</p> <p>Alada to zhizhizhi nazhi a</p> <p>yakpe na</p> <p>Wuzurizhi nazhi de a jin be aziki</p> <p>nyi na</p>
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									<p>Alada to zhizhizhi nazhi a</p> <p>yakpe na</p> <p>Kpikpe ya Ezazhi eti kafa la ya nyizagi nazhi da yawo</p> <p>a ni na o eti kafa na a a de eti</p> <p>bicikinkpe la eti lafiyatswa nya</p> <p>a bo na o.</p> <p>Ezaba keba be dozhi to</p> <p>Gaskiya ta ya dozhi</p>
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										<p>Ezaba keba be dozhi to</p> <p>Gaskiya ta ya dozhi</p> <p>Wuzurizhi nazhi de a jin be aziki</p> <p>nyi na</p> <p>Kpikpe ya ezazhi eti kafa la ya nyizagi nazhi da yawo</p> <p>a ni na o eti kafa na a a de eti</p> <p>bicikinkpe la ebo lafiyatswa nya</p> <p>a bo na o.</p>
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Appendix 11A: Transcription of interview with the married men English

Study site	Participant number	Age	Year in marriage	Marital status	Home language	Employment status	Source of income	Recorded information	Themes and sub-themes
LCH	MM	37	8	M	N	Unemployed	Farmer	<p>What is the current practice regarding the process of healthcare seeking decision-making and autonomy practices among MW in Nigeria?</p> <p>Married women have no right to take decision to seek healthcare without the husband permission, our religious and traditional beliefs don't permit us MM to permit them MW to seek for healthcare services.</p> <p>Does your wife have autonomy to make own healthcare seeking decision?</p>	<p>Communication and transparency</p> <p>Traditional and cultural belief</p>

								<p>NO</p> <p>What led to the current practice of your wife regarding healthcare seeking behaviour?</p> <p>Traditional and cultural beliefs</p> <p>What is your opinion regarding MW having autonomy to make own health care seeking behaviour?</p> <p>In my own opinion, it will make women feel they have freedom to do anything they like, without the consent of the husband, which is against our culture</p> <p>In your opinion what are the challenges experienced by MW in Nigeria due to inability to make own healthcare decision.</p> <p>Suffering, pain, lack of money, poor transportation system to visit clinic and dead</p>	<p>Community awareness about autonomy of MW</p> <p>Community awareness about autonomy of MW</p> <p>Traditional beliefs, norms and values</p>
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							<p>Are you aware of any untoward outcome that your wife or any other MW have experience due inability to make own decision if yes please share these with me</p> <p>YES</p> <p>Premature death, stillbirth, poor health status and some time it can be inform of pain and suffering</p> <p>In your opinion which strategies could possible promote healthcare decision autonomy among MW in Nigeria</p> <p>Adult education, improvement on education of the young ones, freedom from husband, in-laws and the elderly for MW to seek healthcare freely.</p> <p>In your opinion how would the men in Nigeria react to a framework to facilitate women autonomy in health seeking behaviour</p> <p>Some men may accept it and some may not accept, it can lead some</p>	<p>Communication and transparency</p> <p>Information regarding relevant health issues</p> <p>Financial issues</p>
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								<p>husband to separate or divorced their wife because of their traditional beliefs. Generally, in Northern Nigeria Islamic religion affects the way of life of MW in their marital homes, they are limited in power and in decision making at any level.</p>	<p>Awareness of MM regarding importance of autonomy of MW to visit health center</p> <p>Traditional and cultural beliefs</p> <p>Information concerning the right of MW to access or take decision on their own t seek healthcare services</p>
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									Employment status Information regarding importance of autonomy Communication and transparency Information concerning the right of MW to access or seek healthcare services
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Appendix 11B: Transcription of interview with the married men Nupe.

Dana nya Dudugi wa	Nomba nya Ezazhi Nazhi jin dudugu wa nana na	Egi Nya Eya Na wo Yi Na	Eya We Nimi Yawojin o	Eza Yiri Kici Wo yi Yawojin Bo o?	Ezhi Misun We	Ekpo Nya Etunlo	Yeko na we e la de aziki na	Labarizhi Na A ka Na	Ega 'ti to Egan Gwalagizhi
LCH	Bagi na a yawojin a ni na.	37	8	Mi a yawo jin a ni	Nupe	Mi De etun a	Enunu	Ke yi jinjinzhi na e lo ye gbani eti nya yeko nya shiwurajin eti lafiya wa o to jinjinzhi nya etitacin nya nyizagizhi nazhi da yawo a ni na nimi Kin nya Najeriya o na o? Nyizagi nazhi da yawo a ni na de kafa na a a jin shiwura be etitacin nya a tso nyi na a wa lafiya tswa bambe yedajin nya eba a nyi a na a, adinni yi, to alada yi jin yeda na bagi nazhi a yawojin na, a lu nyizagi	Ezaba keba be dozhi to Gaskiya ta ya dozhi

							<p>nazhi da yawo ani na ‘gwa na a da wa lafiya tswa be nimi a tso nyi na a.</p> <p>Mgba nyimi we de kafa na wun tso a tsa enya na yi gboro eye u bo eti lafiya tswa o na?</p> <p>Ah ah.</p> <p>Ke la nyimi we be dan ekpo nya shiawurajin nya etitacin nya u eti lafiya wa ya etitacin wuntso o</p>	<p>Alada to Zhizhizhi</p> <p>Eyekpe ya Ezazhi nya ezhizhi eti kafa la ya nyizagi nazhi da yawo a ni na o</p>
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								<p>Alada to zhizhizhi to enya nazhi a yakpe na</p> <p>Eyepke ya Ezazhi nya ezhizhi eti kafa la ya nyizagi nazhi da yawo a ni na o</p> <p>Ke yi yekpa we eti nyizagi nazhi da yawo a ni na, na a la bicikinkpe be nimi a tso nyi eti lafiya tswa o na o?</p> <p>Eba mi bo, wun a la nyizagizhi kpaya gan a de kafa na a jin enya ndondo na ga ba a na bambe yeda wa daga eba nya eba a bo, nana ma jin gangani be alada yi nyi a.</p> <p>Alada to zhizhizhi nazhi a yakpe na</p>
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							<p>Yekpa nya we bo, ke yi ekopawuzhi na nyizagi nazhi da yawo ani na e de Najeriya ebo na a de kafa na a la bicikinkpe eti lafiya tswa nya etitacin a tso bo a na o?</p> <p>Wala, etan, cincinbo nya ewo, egwagba nya enya ‘zanda lo dana lafiya wa, to tsutsu</p> <p>Mgba wo kpe enya bibici ndoci na be tsun nyimi we, ko nyizagi na da yawo a ni na ebo na a de kafa na a la bicikinkpe be eti tacin a tso nyi eti lafiya o na. Wun a yi acinga o, baza eti u bo ya mi.</p> <p>Acinga o</p>	<p>Eyekpe ya Ezazhi nya ezhizhi eti kafa la ya nyizagi nazhi da yawo a ni na o</p> <p>Kpikpe de eti enya nazhi de a jin be lafiya tswa e na.</p> <p>Wuzurizhi nya aziki</p> <p>Eyekpe ya bagi nazhi a yawojin a ni na, eti kpatakibo nya kafa nya bicikinkpe la nya nyizagi na da yawo a ni na</p>
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							<p>Tsutsu Giriku, Egima na tinya be rayi nyi a na, ekpo nya lafiya tswa na ge a na to kami ndocizhi u yi be etan to walazhi nyi.</p> <p>Eba yekpa nya wo bo, yeko kiczhi bo yi ku jinkana fi zunmatu ya bicikinkpe la nya nyizagi nazhi da yawo a ni na eti lafiya tswa wa o nimi Najeriya bo o?</p> <p>Kpikpe wa nya eza nusazhi, Yiyejin nya kpikpe nya eza egiabodongizhi, kafa wa ya nyizagi nazhi da yawo a ni na daga 'ba nya eba a zhi o, to yelezhi, to nusazhi o eti wuwa nya lafiya o bambe ekan ndondo nyi.</p> <p>Eba yekpa wo bo, ke bagizhi nya Najeriya a jin o wun ayike a ga de shirijin na a ba nyizagizhi jin re ci la</p>	<p>a lo dana lafiya tswa be eti a tso nyi na.</p> <p>Alada to zhizhizhi to enya nazhi a yakpe na</p> <p>Kpikpe de eti kafa na nyizagi nazhi da yawo a ni na a de ci la bicikinkpe ko wa lafiya tswa be etitacin nya atso nyi na.</p> <p>Ekpo nya etunlo nya we</p>
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							<p>bicikinkpe nya lafiyatswa wa na o?</p> <p>Bagi ndocizhi ga yeda jin be u nyi, ndocizhi ma a a jin a, u la bagi ndocizhi kegan wo ko la yawo wo be nyimi a nyi ebo alada to adinni a zhi o. Nimi kin nya arewa nya Najeriya o, adinni nya Musulumi e la ‘gwa to yizhele to edunfe nimi yawojin o nya nyizagi nazhi da yawo a ni na. A de kafa, eba bicikinkpe la o yeko ndondo bo a.</p>	<p>Kpikpe de eti kpatakibo nya bicikinkpe la o.</p> <p>Ezabakeba be dozhi to Gaskiya ta ya dozhi</p> <p>Kpikpe de eti kafa na nyizagi nazhi da yawo a ni na a de ci la bicikinkpe ko wa lafiya tswa</p>
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									be etitacin nya atso nyi na.
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Appendix 12A: Letter to request expert participation in review process

G R A,
Pichi road Bida
Niger State, Nigeria.

1st May 2021

To:
Address:

Request for participation in review process

Dear Sir/Madam

My name is Mary k Paul, a Doctoral student at the Durban University of Technology. I have just completed a research project towards my Doctoral qualification. I have as part of this project, develop a framework toto facilitate healthcare decision-making and autonomy practices amongst married women in Northern Nigeria.

I am hereby seeking your assistance based on your experties to kindly review the provisional framework that I have just developed and provide input that will assist improve the framework and make it more userfriendly for the intended purpose
I have provided you with a template to capture your comments.

The review process will continue till all experts invited to review the framework have reached consensus.All review rounds except the final one will be online via email communication.The final round will be to present the final approved framework to all the experts and for this you will be invited to a zoom meeting.

If you require any further information, please do not hesitate to contact me +2348065367395.
Thank you for your time and consideration in this matter.

Yours sincerely,
Mary k Paul
Durban University of Technology

Appendix 12b: Sample of acceptance letter from one of the experts

Makafu Area
Gbako Local Government
Lemu

Mrs Mary .k Paul
Nursing Department
Durban University of Technology
Durban
4001

Dear Madam

REF: PERMISSION TO PARTICIPATE IN THE REVIEW PROCESS OF THE
FRAMEWORK

It is my pleasure (mw no15) to inform you that permission has been granted to you by the mw and mm (experts) to review the provision framework that was developed by you during data collection in Lemu community Gbako Local Government of Niger state Nigeria

Yours Sincerely

Appendix 13A: Template for reviewers' comments.

Review No:

Reviewers expertise : Please tick appropriate box:

Midwifery Expert	Community Member
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Review round: Please tick appropriate box:

1	2	3	4
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Title of the study: Health Seeking Behaviours among Married Women in Northern Nigeria: A framework to promote autonomy

PRE-CHECKING INFORMATION

Information	Appropriate	Ammendments required	Comments/ Suggestions
Name of the Framework			
Relevant of structure for end user			
Language clarity			
Relevance of content to address problem			

Adittional coments :

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.....

Signatures: **Date:**

Appendix 13B: Sample of completed reviewers' comments.

Review No: 3

Reviewers expertise: Please tick appropriate box:

Midwifery Expert: X	Community Member
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Review round: Please tick appropriate box:

1: X	2	3	4
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Title of the study: Health Seeking Behaviours among Married Women in Northern Nigeria: A framework to promote autonomy

PRE-CHECKING INFORMATION

Information	Appropriate	Ammendments required	Comments/ Suggestions
Name of the Framework	X	Have suggestion to improve the framework	Do not restrict name to Lemu but rather Nigeria so as to increase area where the framework could be used
Relevant of structure for end user	X	No	It is appreciated that instruction on implementation is included, this will make implementation much easier
Language clarity	X	Have suggestion to improve the framework	I propose that the ffinal framework and the instruction for implementation be made available in a local langusge to facilitate understanding and implementation by the local people
Relevance of content to address problem	X	No	

Additional comments:

The researcher is recommended for this valuable contribution .It is hoped that this will benefit health services and the women in Nigeria.

Signature

Date: 17 January 2022

Appendix 14: Framework translated to Nupe

SHIRIJIN NYA MARY PAUL YA NYIZAGI NAZHI DA YAWO A NI NA YA BICIKINKPE LA YA LAFIYA WA NYA ETI A TSO (MPMWAFF)

MPMWAFF yishirijinna a jinebo u banyizaginazhi da yawo a ninanya kin nyaarewanyaNajeriya a be jinanfani be nyiebobicikinkpe la etilafiyatswawa o nyaetitacin a tso o na. Nana ga ma yianinyagutswanyici to zunmagocinya katun dudugiwa nana o. Shirijin nana yietunnayitsojinjinna u ma de kinshinya u dagadudugiwanayijin be baginazhi a yawojin ani na to nyizaginazhi da yawo a ninanimi kin yaLemu o na dan kin nyaarewanyaNajeriya o na.Dudugiwa nana u fedagaebanyaerindocizhinazhidudugiwazaci nana la go wo a na o to na de zunmatunyadudugiwazacindocizhi o na ga kegancinbonyabicikinkpe la nyanyizaginazhidayawo a ninaafeekopawunimiezhi nana o, to ezhindocizhi o nimi kin nyaarewanyaNajeriya o. Shirijin nana de tsuwondandagaebaegbanyakpikpezhi o, ezaguwokendonayigannimikasan 7.5 nyaetun nana, nayi ma la sunnanyadudugiwazaci nana (Mary K. Paul) tu u na.Ebonawun ga kushirijinwuncin da dozhi o na.

BagunbagunzhinyaShirijinnyabicikinkpe la nyaetitacinnyaNyizaginazhi da yawo a ninanya Mary Paul (MPMWAFF)

Shirijinnya MPMWAFF a tu ta etinyaekpogutananazhi o; etunlobanyalafiyatswa, ezhinyadudugiwaza nana o, to a tsonyizaginazhi da yawo a nina o, ebonaekpogutananazhi a de keminaela ‘gwa la to bicikinkpe la nyanyizaginazhi da yawo a ninaetilafiyatswanyaeti a tso o. Ezandocina a yi Lifestyle (n.d.) nag an kegan dana to enyanazhi go ezabana to yekpa, halibo to tsitsazhi a yienyakpatakizhinazhi e de egwa la to rayinyaezana. A ci kezhegan be gan, najinkpatakigan a kpata ci e la ‘gwa to halibonyaeczawanginayienyanazhi go u banaebonawun e la gwa to enyanazhieazhi e tsana to bicikinkpenazhiwun e la na. Enya nashirijinnya MPMWAFF la wuna u yi ga, nyizaginazhi da yawo a nina dan tatacinnyaenyananazhi o, etunyalafiyatswa ma dan kasannini o, be ezhi ma dan kasanbaci o. To na de nyizagina da yawo a nina ga e tsaenyanazhi de a jin be rayi u nyinya ‘fondondo o na, enyagubanazhike de kemina a e de dejin be lafiyatswa to wuwazhinyayializhinyanyizagina da yawo a ninanyi. Enyazhinimiyali to ezhizhi o, to enyazhinimi dana etunlobanyalafiyatswa o de kemina a e la ‘gwa la to

halibonyalafiyatswanyanyizagizhina. Kendo na Lifestyle (n.d.) ganna, elirayishishecinyaezandondoyikukukebanyaelirayi u keba be keminaezandondo ga jinjin be enyanazhi e de jin be yizhele u nyina. A ma kezhegan be gan, halibo to jinjinyizhi lo baenyazhinyarayi nana, tsitsazhinyaenyazhinyarayi, to haliboyizhi to enyanazhi go yibana, kpata a de ejin be yirikeminayizheleyi a yiyina.

Dudugiwaci nana nimi MPMWAFF o, tun enyagutanazhi la ‘gwa fin dozhinna ye, a yiezabakeba, egwafinkeba to cinwon la yadozhi. Nanazhi a yienyakpatakinazhi e banyizaginazhi da yawo a ninajinreebaticinkpe la nyaeti a tso, nama a zhin ‘gwakpenyaebalafiyatswawa o na ma. Dudugiwaci nana nimi MPMWAFF o yakpekeganyadajintsakaninya dana etunlafiyatswa be jinjinzhinimiyali o yikpataki, nana ma ye de wo be egwanyaegwafinkeba, ezabakeba to cinwon la yadozhinyi o. Mattessich to Rausch (2014) jinerikeganegwafinkebatsakaninyaetunlobanyalafiyatswa o be kpangwanyayegborolonyaezhizhi be a de hankali la tukeyekonyaninsa de yalafiyatswa way a kin ko ezhizhina. Kemi natakadakacinanazhigandagaebadudugiwanya kin gangarina a jinna o na, wun a tulakegan, egwafinkebanyakasanniniobekasanndocinyi la wukeegwafinkebaeboyegboro lo lafiyatswanyaezhizhi o dan eka ndondonya kin nyaamerika o. Egwafinkebawuncinzhi ma, kami dokunbajinreebanasarana a de ebayegboro lo na a de ci ye leye wo na o. Tun acin de, Mattessich to Rausch (2014) wanayiyejinnyaegwafinkeba to enyanazhi e bajinreebaezabakeba o ci a lugwayi de dedewanginyinyakeminaenyananazhi e lagwa la to lafiyanyaezazhina to kemina a a de zunmatuyaetunnyaegwafinnyakasankanzhinyalafiyatswanimiezhizhi o eboyegboro lo woro o na. Na Mattessich to Rausch (2014) jinyedaganegwafinkebatsakani dana lafiyatswa o be kasanndocizhinyi la kafaworondocizhina a la yegboro lo be yaetunyalafiyatswa wo na, tun acinde awana a kpeiyakanyabanaegwafinkebawuncin ga a ye jink an na. Wunayike u ga la ezhewangi tin yana, kezhiyenyanazhijin u ci la ezhewuncinzhi tin yana o?

Tacinnyashirijin nana o yinyizaginazhi da yawo a nina. Egwagannya a tin halibozhietitsitsanyalafiyanya a bo to kemina a ga le etunnya a ye le nimiyizhe le nya a bona o. Kemi naezazhi ga le dana nya a ye rayi a bona, kpatakizhinebanyaaladazhi, to enyanazhi a la cinwonyabana a e le yizhenakeaninya a zhi, enyanazhi a e tuyena, emazhi to enyanazhi a e kpayeeti a bonayienyanazhi e la ‘gwa to rayinyaezana (Keles 2012.). Eboegwakannyagwandako to

enyabibicinazhi a be gbazunma u na o, u gonyi a tso a la bicikinkpe a wo etiwuwa to dana lafiyatswa lo o. Lulo dan wokati o, to nimi kami gungunci o a ya a kafana a dada le enyanazhi e la tsutsunyanna to egizhi be na ye.

Dana lafiyatswawa to ezhilecizhi a dan kasanndondonyanyizagina da yawo a nina. Ama de kemina e la 'gwa la to nyizagina da yawo a nina. Enya nanazhi ma e la gwa to ka yiriyizhelewanginaezaa lena. Wunayikeenyananazhi ga e lotun a kperekperenyina, wun e be la ezo be yanyizagina da yawo a nina. Nyizagizhi ga jin e be de ezonyanawun a tsa ko yakpenimi a bona. Kami na u ga e jinanfani be nyanininyina, anfanijin be nyabacitso e e be la de zhinkiri, kpatakiwunayike a za gubabajinyeda ko ma tuetunnyadozhizunma a na. Kicitsowun a tsa o, de a jin be enyazhidokunnyi, keenyana u da taru le nanyi, kafa de yaanfanijin be enyawuncinnyi to enyandocizhi. Na kpan u ye bi na u yigannimiezhizhi o, u jin u wo a de enyandocizhinazhi dan bokperekperenyina e, keetunlafiyatswanyaaladana, ko nyaadinnizhina to ndocizhi.

Shirijin nana e tuesdaywafinkeba to ezabakebatsakanienaenanazhi de a jin be etunlafiyatswa o to ezhizhi o nazunma. Etasamafari u yidededenyaetunnyadozhi. Etunlocizhinyalafiyatswazhigonyi a kpeezanazhi de egwa dan etunlafiyatswa o nimiezhizhiwuncinzi o na a kpedozhi ye na, acinga ma za nazhikena ma a kpe a tso ye ma o. U gonyi a kpeetunnyadozhi ye to kendo naetun a zhiyiyina to kagbo, egwagbanya a to banaetun a zhi e be gifidozhina, bana e be guke fi dozhina to bana a de egwafinkeba be dozhinnyi wo na. Eboegwafin nana u de ba u ye u jin, u gonyi a de dana bana a fe gun yekankebaeboshiawurajin, to shirijinetikemina a a la guncinazhi ga a chekagbonyaetunnya 'za enina lo baetunlobanyaehandocina. a ma a kezhe a de ba a bazaetiekopawuzhinya a bo ma, to didekpin be dozhinyiyekogborozhinyaetun lo to cigbekonyaezonazhi a ga de na.

Be 'gwanyaegwafinkeba nana nyinyizagizhi a de anfaninya a, gamashi a ajin a tile na a tsatsakaninyaezagubazhi o na a, koma la enyazhi so dozhi a. Be egwanya ezabakebakandondonyi, a be de egwafinkeba to didejinkeba to anuriyirininiyabicikinkpe la yanyizaginazhi da yawo ani na, to yawuwandocizhinyaezhizhi.

Bambewuncinnyishirijin nana de cinwon la yadozhi dan nimi u bo. Nana ma yienyawacina a la kpangwanyalafiyatswa to enanazhikenaanazhi fi ezhizhi o na a jin u wo na a de egwafin ci de ezabakeba be dozhinyiwanginyina. Mattessich to Rausch (2014) yashiaurake ga, enyagutanazhijinkpatakigankpataebaegwafinkebatsakanietunlobanyalafiyatswa o be

ezhiezhizhinyina a yi 1) edzoshiwangi, 2) cinwon la yadozhi to yekpenyadozhitsakanienaenazhi o, to 3) aninyanini to guriyirinini. Acinga be ma, duduguwazaci nana tun cinwon la yadozhi ye keninimishirijin nana o na to cinwon la yadozhitsakanienaenazhi dan etun nana o na. U ma yakpekeganwun a la ezanazhidanetunnanazhi o na de anuri to aninyayirinini. Nimiezhizhi o yializhi fi bo (eba ko nyimi to nyamanciyizhi), nusazhi, to edzoshicizhinyaezhizhi, edzoshicizhinyaadinni, nyaalada, cigbejincizhinyaalada to nyizaginazhi a sun ewondecizhi ‘gwayaegimana.Kpata a a de ‘gwa dan bicikinkpe la nyaetitacinyanyizagina da yawo a nina o yekondoci o. Ebogabo, u gonyi a feemapacizhinimiegwafinkeba nana o ebo u fan u yanyizagizhinazhi da yawo a ninana a de kafana a a la bicikinkpenyaetiatsobalafiyatswawa o na. Ka to nadudugiwa nana yiebobicikinkpe la nyaetitacinyanyizaginazhi da yawo a nina, dudugiwazaci nana a yedajinkeganezaezhizhi a wa kami na a ga a zhebandagakemina a e kpayekpaetikannyanyizaginazhi da yawo ani naebabicikinkpezhi la o na.Ebogabo u yikpatakiyaezanazhi de ‘gwa dan shiawurajin o na, ko nyizaginazhi da yawo a nina, ko eba a zhi, ko nyamancizhina a a de kpe be ‘me gaskiyanyinyaenyanashiawurajinnya a la be tsunnyizagina da yawo a nina. Nana a ye jinwunayike a ga de katambakobanaetunlocizhinyalafiyatswa a fe gun yekan a ci febazakebabezaezhizhinyina. Be egwanyaetunladandozhi to egwafinkebanyi, baginazhi a yawojin a nina to nyizagizhi a be kpeetunlocizhinyalafiya ye to yirietunnazhi a e lo na. A ma a be kpekpatakibo to anfaninyalafiyatswawadaganlazin ‘fo e to asibito lo dan kami gungunci o ye. Ama a kezhe be de nyagban la yaetunzhinaetunlocinyalafiyatswananazhi e lo na. Nana a bajinreeba kike nyakinkannyanyizaginazhi da yawo a nina o ebabicikinkpe la yalafiyatswawanyaetitacin a tso. Enya ndocizhidokundanbonazhi e la ‘gwa to bicikinkpe la na, sashi a zhiyi, didejinnyapani, nyagbanbodi de etinyandocizhi o etunkama de dan ‘gwa o to elegideginyaetunwuncinzi, erikpenya ‘za eni ‘za eni, eyanyaeforayinyaeza, ekponyaazikinyaeza, to keminaeza ga e kpayekpaetiwuntso o na (Dietrich 2010). Acinga ga be, Dietrich (2010) jinerikeganbambenanazhinyenyandocina de a jin be bicikinkpenyi la nanyi u yiyiyakpenaeza de keshiawuranyawuyikpatakina.Wunayikeeza ga yakpekebicikinkpenawun ga la nayikpatakina, a afewagan a la bicikinkpewuncin.

Foto 1: la shirijinzunmagoci nana tu la na a bajinreebaticikinke la ebolafitswawa o nyanyizaginazhi da yawo a nana o. Zasangi nana dan nimiNasara to Nupe o. NyaNupe dan nimitakadakperecintaragigwuegi be ninici o 16.

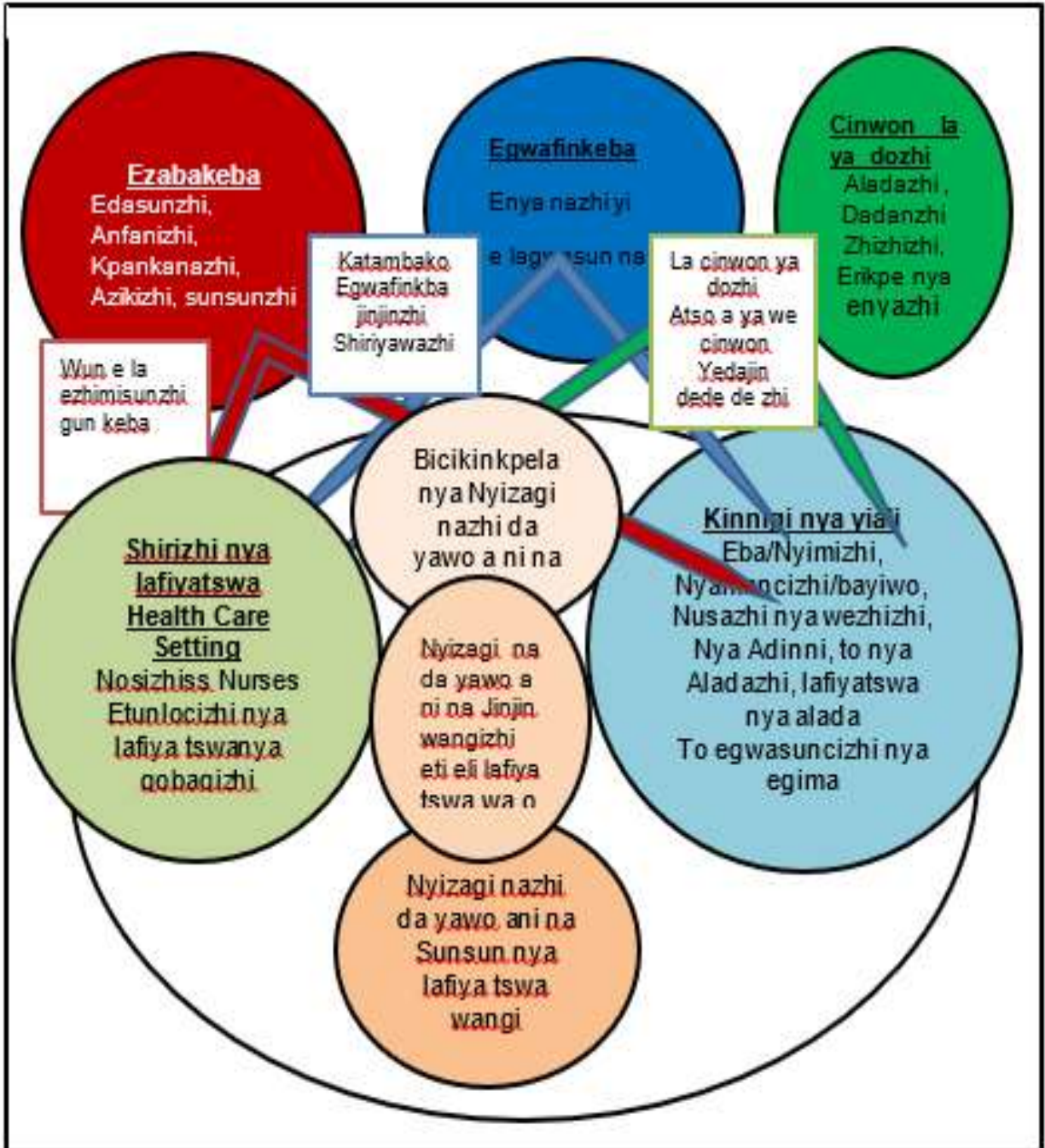


Figure 1: Mary Paul's Married Women Autonomy Facilitation Framework (MPMWAFF)

Liladanjinjin o nyaShirijinyabicikinkpe la nyaetitacinnyaNyizaginazhi da yawo a ninanya Mary Paul (MPMWAFF).

Enya ndocizhigonyi a la a jinbedzoshirijin nana ci a ye jin.

Egwafinkeba

U yikpatakinaenyagunninanazhi a dan bona, didenyaemapacizhi, dana nyaegwafinkeba, enya/jinjinnazhi a fin ‘gwakeba be nyina, to yekozhinyaegwa fin keba.

Nya mafariyididennaemapacizhinazhi a fin egwakeba be dozhinyina. Nana ye de wo dagaebanyaetunlocizhinyalafiyatswa o to ezanyaezhizhi o. Egwafinkebacizhidagakasan ta nyaetunbanyalafiyatswa o e kalona a yinosizhina a, ama to ezanazhi e lotunnazhi de e jin be ezawangizhinyina e, shiawurayacizhi, to kpikpedecizhietihalibozhinyaezawangizhi o to ezandocizhi. **Egwafinkebacizhinyaezhizhi a yiezanazhi e gikinniyaekpoekpozhinyaezhina**.aa de ezazhinazhi e gikinniyaEba to nyimazhina, nyamancizhinusazhinyaezhi, nusazhinyaadinnizhi, to nyaaladazhi, cigbejincizhinyaalada to zezhi e baewondecizhijinre be egimanyina.**Egakpatakinazhi a fin ‘gwakebaeti a bonana** a de jin be enyanazhi de a jin be ezhizhinyina.**Dana bana a de egwafinkebanaa** yiezhininbokoma dana etunlobanyalafiyatswanyaezhi o. Enya najinkpatakiganna u yigan dana wuncin u yi dana wanginageyagungunkebana.

Yekonazhi a jinenyazhijinna la wun a wa. Nana de a jin be kikannyaKomitizhi, to nkobana a fe be jinshiawurakebana.Dagaebakinnigicizhinyaegwafinkeba nana o, komitinyaetungbaro – gbaro ye kan wo eboetunkenyaefogungunkebayaegangbinzhi o naetunlocizhinyalafiya a shitina.Bambenanazhinyi, ena – enazhinyaenandocizhi eka wo be gungunkebanya a zhiebo a de dedenyadozhi ama a de sanwoke a yininina.

Ezabakeba

Ezabakebagboro to kpikpeciyyekoninina a banyizaginazhi da yawo a ninajinre ci la bicikinkpenyaeti a tsoebalafiyatswawanya a tso o na.Ezandondo a kujinkana fi ezababere – berenyi shin o kandondo. Enya gutanazhi e bajinreebaezabakebagboro o na a yi; esatayaezabakeba,

ezhimisun to enyana a bazaeti u bona. Yekokama dan bona a ga a bazakebana, eye be eye nyi, ko rediyi to emirediyofoto(Tv), takadalabarizhi, to takadakperegizhinyalabarizhi. U gonyiezhimisunna a jinanfani be nyina u yinaezazhi a de dede u na. Eboanfanyaezakpata o, a ajinanfani be ezhimisunnyaezaezhiwuncin.

Egan ‘tina a ga a jinezabakebana u de u jin be enyawuwacizhinazhi ga jinkpatakiganyaezazhiwuncinzhina.

Cinwon la ya

Wun a yike etun nana ga ga a da gborona, cinwon la yadozhiyikpatakiyaezandondobambeerikpenyaepanakannyi, ekponyapkikpe, eza kin to adinni. Cinwon la yadozhi e fin ‘gwa fin be enyaya to dede de nyadozhi. Eri nyacinwon la ya ‘za yina wo ga a cinzhinekponyaezawuncinna, kanga a tso ma a go weciya we cinwon ma. Ebo nana o, u gonyietunlocizhinya dana lafiyatswawa a lotun be nana nyi, a ci a kpeyiriekponanyizaginazhi da yawo ani na dana, to enyaaladanazhi a yakpena. Nana a la yedajin to gugonyaetun nana be a de ‘ti ama a shitukpaya a. Ezazhizhi to ena – enanazhiyi tun ye le na, a tso a la cinwon a yaetunlocilafiyatswawananzhi a ma a go eganazhi a ga la be yaaetilafiyatswa o na.

Enya nazhitinyaebadudugiwa nana o na la wukeenyagutadabonayietunnyaeza de a jin be etunlafiyatswa nana nyina ci a banyizaginazhi da yawo a nijinreebaticinkpenyaetitacin a tso la lo balafiyatswawa o na, ezanazhi dan yiali o na, ezaezhizhi to nyizaginazhi da yawo a nina.

Etunzhinyaetunlocizhinya dana lafiyatswawa

Etunlocizhinyalafiyatswawa a ga yiezamafarizhinyashirijin nana o. Ebaalikawolinyaetun a bo, nugunnyaetun a, to nyana a tuye be a nyina a ajinna, a yikinnigiciyaguncizhi to etunlocinyalafiyatswayaezazhizhikpata. Shirijin nana de a jinbe etunlocizhinyalafiyatswawazhinyi, atoto ‘zezhi e la ’ye dan guncizhina. Tun acin de naezandocizhinazhi e lotunasibiti o najinanfani wo be u nyina. Eye ladancizhinyaguncizhinimi kin ndondo o de kutinyaetunna a e la dagaeciabanyaetun a bona. Eyeladancizhinyaguncizhinya kin takonya Afrika e la kutinyaetunwunwunyaewangizhikpata, to nalafiyashishecinyaguncizhi ga a feenyakpatakimafarina a awana (EtunlobanyaetunlociNosizhinya kin Afrika Tako). Nimi kin nya

Ghana o, a zhibake a a de ‘gwa dan etun o keba be ezandocizhinyetilafiyatswawaya ‘za kpata o (EtunlociNosizhinya kin Ghana 2021). Bambenanazhinyi, Gominantinya kin Afrika Tako, kezhe a tsuwonndocizhi la zhizhiyaezanazhi ga a lotunnyaeyeladanguncizhina (Nosizhi) na a jinna, sashinyatsuwonwuncinzhiiyi, egwakannyabatan to jinkanaku fi lafiyatswawa to naruladantsakaniegima ko ewonde o be egwanya katun wu to shiawurayaya ‘za eni ‘za eni o to ezakamazhi o; bibajinreetiezabakeba o be guncinyietietunnyanosizhi o; to guritsonyalafiyashishecinya ‘za eni ‘za eni o, to nyayiali, ko nyaena – enazhi to nya kin gangari o ebaetunnyaNosizhi o. egwa de dan ciccia to eyeladanetunzhinyaNosizhi o yaebodannyaguncinniminakancigban to hankali o nimiyekona a kujinkana fi lafiya u shin o na to bibajinreebaegbandinyaguncizhi o ebo a de lafiyashishecina a wana(EmiyanyaGominanti No. R. 2598 nya 30 Novemba 1984 na a ye jinna No. R. 260 nya 15 Februari 1991 na). Acingama Nosizhinimi Kin nyaNajeriya o, e zhibaetietunwunwun a bozunmana a ga a sajinmakanta o na. Ena nyaetunlociNosizhinyaNajeriya e yalafiyatswanya ‘za eni – ‘za eni to yializhi to ezaezhizhikagbo, ebo a de baa de ci la ‘yedanlafiyashishecina a ga wana(TMLT Staff 2020).

U yienyakpatakinaetunlocizhinyalafiyatswa a ta ‘gwa lo baezaezhizhinaebokagbobenyaezabakeba, egwafinkeba to emapa o. McCollum to ‘zabaci u zhi (2017) jinerikegaetunnyaNosizhi u yi o na a akuezhizhi ta be ‘gwanyaruwokpoyalafiyatswa o, to jinjinzhietilafiyatswa o, to na a kuegwafinkeba ta tacinnyagandzozhi to emapacizhi o ebowuwazhinyaezhizhi o naebobibajinre o to sisaloyena a jinwo na o nyaegwafinkeba to emapa o.

Etunlocizhinazhi e la eye dan guncizhina e be de kpikpeetiguncizhi to yizhelenya ‘yiali a zhi o be ‘gwatanyadidejinkeba a be dozhinyi, be nana nya e be de dedenyaenyanazhi go ezawuncinzhii to ‘yiali a zhibana a toto wuwa a zhinyalafiyawa, to aziki a zhinazhi a ga a wo bukatawuncinzhina. (Neumann, Röhnschto Hämel 2021). Etunlocieyeladancizhinyaguncizhi a jinkokarina a la kpikpenyaetiezozhietilafiyatswa o to wuwazhinyaezhiLemu tin ya dan fili o naezanazhigonyi a kkpena a a de a kpena. Takadakacizhidokun a jinyedake ga, li la jinyedayadozhinyakpikpeetiezozhi to wuwazhinyaguncizhi, ‘yialiazhi, ezhizhi to etunlocinazhi e la eye dan guncizhinayienyakpataki,

ebonawun e lugwaezakpatanazhi de ‘gwa dan egwafinkeba nana o nalotunkebaebobicikinkpe la na a ga a ko cigbenyaezonalafiyatswawawuncinzhina o (Baratieri to ‘zabaci u zhi, 2012; Purkis, 2001; Runciman, 2014).

Neumann, Röhnsch to Hämel (2021) yashiawurakegan, lilajinyedayadozhinyakpikpe u de tutu ta etinyagaskiya la yadozhina e be la fe be ‘gwatanyaezabakebaetianinyazhi to etunzhikakanyinyaguncizhi, to etunlocizhinyaasibiti to nyagbankpeyashiawurazhinyadozhina. Nanazhikpata a be a ye de be ‘gwatanyaezabakebanyi. Didejingboro nana a lugwaezakpatanazhi de ‘gwa dan shirijin nana o na a jinanfani wo be kpikpe nana e yacigbekonyaezonanazhi, kpataki, yedajinyanyizaginazhi da yawo ani naebo a la bicikinkpenyaeti a tsoetilafiyatswa o na.

Etunzhinya ‘yializhi to ezazhinyaezhizhi

Bedzoshirijin nana ci u be u de ‘ti, wun a tin egwa de dan boshisheci, to egwafinkebanyaezazhinyaezhizhi. Ka to na de bicikinkpe la nyaetu nana yinyaetunlocizhinyalafiyatswana, tun a cinezanyaezhizhi de etunkpatakina a lo nakendonayi tun a ye le a nina. Bicikinkpe la nyaezazhizhibajinre wo yekonajinjin to shirijin nana ci ga a de etina. WuwanaetunlociNosiyaegwa fin keba be etunloci to etunbanazhikenanyinayikpataki. Ezaezhizhigonyi a fe a nyaetunlocizhinyalafiyatswa ‘ka be ebajinjinhinyaezhi a zhieboetunlokeba o. A tso ma a de nyagbankpikpeciyaezazhizhinazhi ga a la anfani be yaezhi a zhina.

Etunzhinyanyizaginazhi da yawo a nina

Nyizaginazhi da yawo a nina ga shirijin nana e wa a bajinrenyisaranyi o. A ga ma de kafana a de jinkeba be ekpo – ekponazhi dan egwafinkeba nana o na o (etunlobanyalafiyatswawa, to ezaezhizhi) kamizhidokun o ganezanazhikena o. U yikpatakinaatso ma a lotunnayikasannya a tsowanginyinatsakaniekpogubanazhikena o na. A yienaninina la kagbo be yaetunnyalafiyatswaya be yialinyina, to ezazhinyaezhinyina, nana ma a yaegwafinkeba to ezabakebakagbobe. Ka to nanyizaginazhi da yawo a nina de kpikpetso, e la cincin to cinwonya ‘yiali a zhi to ezaezhi a zhina,

u gonyi a kpe keg a, cinwon la yaezajinyedajin a. U gonyi a tso a ku a ta gikinniyaenyanayi alali nya a na, a ci a lotun a yagigeloyenyaekponyalafiyanya a nimiyekogboro o. Ebogabo, a tsogonyi a de 'gwa a dan egwafinkebananazhi o ebo a tso a de ninya a ta fi enyanazhi de a jin be lafiyanya a tso to nya 'yiali a zhinyina.

Appendix 15: Letter from the Language translator and Confidential declaration

SUPPORT LETTER FROM THE LANGUAGE TRANSLATOR

St. Matthew's Anglican,
Church, G.R.A. Bida,
Niger State.
Nigeria.

To whom it may concern,

This is to confirm that I Theophilus S. Audu, Bsc. Mathematics, assisted Mrs Mary Kakamission Paul in translating the consent, information letter and interview guide for participants from English to Nupe and back to English.

My assistance included verifying that no messages were lost or altered during the translation and back translation.

Regards,

Theophilus S. Audu
Audutheophilus@gmail.com
+2348060196637

Confidential declaration by the interpreter

Confidential declaration by interpreter (only completed applicable)

I THEOPHILUS S. AUNU declare that I assisted the investigator MARY K
PAUL to interpret the questioner to (name of participant)

Using the language medium of Nupe

I covered a factually corrected version of what was related to me.

I am satisfied that the participant fully understood the interview questions and has had all her questions satisfactorily answered

The information I have received from the participant will be kept confidential

Signed at place BIDA, NIGER STATE on the date 14TH OCTOBER 2021

Signature

Appendix 16: Editing Certificate

DR RICHARD STEELE

BA HDE MTech(Hom)

HOMEOPATH

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EDITING CERTIFICATE

Re: **Mary Kakamission Paul**

Durban University of Technology doctoral thesis: **HEALTH SEEKING
BEHAVIOUR AMONG MARRIED WOMEN IN NORTHERN NIGERIA: A
FRAMEWORK TO PROMOTE AUTONOMY**

I confirm that I have edited this thesis and the references for clarity and language. I returned the document to the author with track changes so correct implementation of the changes and clarifications requested in the text and references is the responsibility of the author. I am a freelance editor specialising in proofreading and editing academic documents. My original tertiary degree which I obtained at the University of Cape Town was a B.A. with English as a major and I went on to complete an H.D.E. (P.G.) Sec. with English as my teaching subject. I obtained a distinction for my M.Tech. dissertation in the Department of Homoeopathy at Technikon Natal in 1999 (now the Durban University of Technology). I was a part-time lecturer in the Department of Homoeopathy at the Durban University of Technology for 13 years and supervised many master's degree dissertations during that period.

Dr Richard Steele

16 July 2022

per email