ISSN: 2582 – 3647(Online)
International Journal of Arts, Humanities and Social Studies (IJAHSS)
(Multidisciplinary Open Access Refereed e-Journal)

RESEARCH METHODOLOGY ON SOCIOECONOMIC DETERMINANTS OF ACCESS AND UTILIZATION OF ANTENATAL CARE SERVICES AMONG WOMEN OF REPRODUCTIVE AGE IN EDO SOUTH, NIGERIA.

Dawodu, Oluwatosin Abigail*[1] Nwankwo, Ignatius Uche[2]
[1]Department of Sociology and Anthropology,University of Benin, Benin City, Nigeria
[2]Department of Sociology and Anthropology, Nnamdi Azikiwe University, Awka, Nigeria

ABSTRACT

This paper elucidate an empirical research methodology and data gathering experience among primigravida and multigravida women of reproductive age in Edo South, Nigeria. The study adopted a mixed research method comprising of both quantitative and qualitative research methods. The questionnaire served as the quantitative instrument while focused group discussion and in-depth interview were used as qualitative instruments of data collection. The sample size of 1108 respondents was statistically derived using the Taro Yamane statistical formula. The fieldwork experience and data gathering were encircled with lots of challenges ranging from language barrier to request for compensation and negative perception on the essence of the study. Despite these challenges, the lesson learned during the course of the fieldwork has been expository and have further strengthened the researchers skills and knowledge. Hence, scholars are encouraged to document their fieldwork experience in other to enlighten the populace on sociological research practices.

Keywords: *Antenatal Care, Access, Utilization, Fieldwork, Edo South, Nigeria*

Introduction

Antenatal care is an essential care designed to ensure the best care and health outcomes for women and children. To achieve expected antenatal care, WHO (2017) recommends that all pregnant women should have eight contacts with a healthcare provider throughout pregnancy. This should be initiated with a first contact at less than 12 weeks gestational age. The antenatal care service is expected to provide pregnant women with respectful, individualized and person-centered care at every contact with implementation of effective clinical practices and provision of timely information. Quality antenatal care will encourage women to seek skilled care at childbirth, reduce stillbirths, childbirth complications and newborn deaths [1]. Globally, more than half of all women receive early antenatal care, but too many women are still left behind posing a challenge to their health and that of the baby. However, it must be stated that the greater percentage of women that receive antenatal care are mostly in developed nations, while most women in developing nations still lack access to antenatal care and do not utilize the services [1].

According to a paper presented at the 6th African population conference in Burkina Faso, access and utilization of maternal health facilities decrease as the distance increases. This could translate to the fact that distance from health facilities are linked with utilization of maternal health services [2;3] hence, the extent to which modern maternal healthcare has been to the door step of rural people in Nigeria is low [4]. In addition, the rural nature of the people is also a challenge to access and utilization of modern antenatal care as most of the people culturally prefer to use traditional birth attendants (TBAs). The dire situation arises because modern maternal healthcare mostly provided seem not to be in tune with the culture of the people. Evidence shows that modern maternal healthcare is not so much in parallel with socio-cultural reality of pregnant women in Nigeria as this is evident in the fact that traditional birth attendants (TBAs) are part and parcel of rural areas of Nigeria [5;6]. Over a long period of time, it has been shown that Nigerian women had to rely on TBAs for assistance and advice during pregnancy because their services are seen to be culturally acceptable [7;8].

In a developing nation like Nigeria, many of the poorest women still do not have equal access to high-quality early antenatal care that can help ensure their health and wellbeing [1]. Nigeria [9] revealed that only about 59% of women receive antenatal care from skilled healthcare professional and not all of them attend the antenatal clinic regularly. The period of pregnancy has become a dangerous time for women and girls who become pregnant in Nigeria each year; pregnant women face a lifetime risk of maternal death of 1 in 13 compared to 1 in 31 for sub-Saharan Africa as a whole [10]. The global report on maternal mortality ratio also revealed that Nigeria and India accounted for over one-third of the global maternal deaths in 2015; Nigeria had approximately 58,000 maternal deaths, accounting for 19% globally, this therefore suggests that 830 women die in every 100,000 live births [1]. These issues are not far-fetched in Edo South senatorial district where several women died as a result of pregnancy related complications and childbirth annually [11].

Socioeconomic and cultural factors had been documented to influence maternal mortality. This is dependent on the ability of the woman to command resources and make independent decision about her fertility [3]. [12]argued that

women are accorded a low status in the society which translates to the fact that their health needs are neglected and existing health facilities not accessed when in need. Illiteracy, social cultural barriers, inability to seek care at the time of emergency, acceptance of death as wish of God and concern that only female healthcare providers should attend to women's reproductive health had been linked to maternal death. [13] also asserted that increasing problems of maternal death are even more prevalent in developing countries, due to debilitating current socioeconomic conditions leading to inaccessibility of health facilities. Low level of education hinders pregnant women access to health related information as some of this information are not delivered in their local languages. [14] the adult literacy rate in Nigeria was at the level of 59.6% in 2015; hence, the high level of illiteracy especially in rural areas contributes to low life expectancy because the pregnant woman usually don't recognize early symptoms of pregnancy related illness nor seek prompt medical advice. Illiteracy therefore leads to low appreciation of the benefits of use of health care services. Also, Alder and Estrove (2006) posited that the more socio-economically advantaged individuals are, the better their health. Perhaps, pregnant women with low financial capability have limited access to antenatal care services. Similarly, [15] stated that in Edo South, for instance, ability to meet basic healthcare needs as well as antenatal care services has remained a major challenge, especially for those within rural areas.

Over the years, Edo state healthcare facilities have not achieved all its objectives of ensuring inclusive access to adequate health care services. Regardless of the scientific evidences of ANC as a useful tool in improving maternal health, some pregnant women do not utilize it. [16] indicates that utilization of antenatal care is determined by some socioeconomic factors such as age, marital status, education, location of health facilities and income; hence, the consequences of limited access to antenatal care as a result of these factors are dreadful. The non-availability of health centers in rural areas has exposed pregnant women to adverse outcomes such as miscarriages; some pregnant women in the rural area cannot gain quick or easy access to health facilities. Some women have miscarriages during long distance journey to antenatal care centers while in some cases; the women might even die [17]. It is against this backdrop that this study seeks to investigate the socioeconomic determinants of access and utilization of antenatal care services among women of reproductive age with particular reference to primigravida and multigravida women in Edo South, Nigeria.

Research Questions

The following research questions are put forward to guide the study:

1. What is the level of access to antenatal care services among primigravida and multigravida women of reproductive age in Edo South, Nigeria?
2. What is the level of utilization of antenatal care services among primigravida and multigravida women of reproductive age in Edo South, Nigeria?
3. What are the factors affecting access to antenatal care services among primigravida and multigravida women of reproductive age in Edo South, Nigeria?
4. How does the level of education affect utilization of antenatal care services among primigravida and multigravida women of reproductive age in Edo South, Nigeria?
5. How does the level of income affect utilization of antenatal care services among primigravida and multigravida women of reproductive age in Edo South, Nigeria?

Study Hypotheses

The following hypotheses put are forward to guide this study:

1. There is a significant difference in the level of access to antenatal care services between primigravida and multigravida women of reproductive age in Edo South, Nigeria.
2. There is a significant relationship between accessibility and utilization of antenatal care services among primigravida and multigravida women of reproductive age in Edo South, Nigeria.
3. Respondents with higher level of education are more likely to utilize antenatal care services than those with low level of education in Edo South, Nigeria.
4. There is a significant relationship between respondent's level of income and their utilization of antenatal care services among primigravida and multigravida women of reproductive age in Edo South, Nigeria.

Methodology

Research Design: This study adopts the mixed research design. This method involved the combination of quantitative and qualitative approach to data collection and presentation. The mixed research design involves integrating quantitative and qualitative approaches to generate new knowledge and can involve either concurrent or sequential use of these two methods to follow a line of inquiry [18]. The choice of this research design was considered because of its flexibility in generating reliable data from the two approaches that complement each other. This research design was also considered appropriate for this study because it has the capacity to use a sample to study the characteristics of a larger population at a given point in time and at a relatively lower cost, in order to generalize the findings to the entire study population.

Area of the Study

The study is conducted in Edo South Senatorial District which is one of the three senatorial districts in Edo State, Nigeria. Geographically, Edo South is located approximately between latitude 05°44N and 06° 87'N and longitudes 05° 00'E and 06°' 43E of the equator [19]. Politically, Edo South is divided into seven local government areas namely: Oredo, Orhionwon, Egor, Ovia North-East, Ikpoba-Okha, Ovia South-West and Uhunmwode respectively. Edo South Senatorial District constitutes 57.1 percent of the population in Edo State and virtually, all the groups traced their origin to Benin City; hence the dialects of the groups vary with their distance from Benin City. It is bounded in the North by Ondo State, North-East by three local government areas (Owan West, Esan West and Igueben) and the South by Delta State. Benin City which is the capital of Edo State encompasses three of these Local Government Areas. The total land area of the senatorial district is 10,835.37 km [20]. The inhabitants of Edo South have two major occupations (agricultural production and large/medium scale trading). They are mostly traders, civil servants, farmers and business men/women. The district has 553 health facilities which is made up of both public and private hospitals and further grouped into primary, secondary and tertiary health facilities. Oredo LGA has the highest number of health facilities with 31%, Ikpoba-Okha has 22% while Egor equally shares 19% of health facilities in the study area. Coincidentally, these local government areas also have the highest rate of maternal mortality in Edo South [11]. The following areas Orhionmwo, Ovia North-East, Ovia South-West and Uhunmwode has a total share of 28% of health facilities [21; 22]. However, the major target area for this study is three (3) Local Government areas in Edo South namely Egor Local Government Area, Oredo Local Government Area and Ikpoba-Okha Local Government Area.

Population of the Study

The population for this study comprised women within the reproductive age of 15-49 years. The Nigeria 2006 Census figures put the total population of women of reproductive age in Edo South at 451,710 [20]. However, the target population for this study consisted of primigravida and multigravida women within the reproductive age of 15-49 years in the three local government areas within Edo South (Oredo LGA, Egor LGA and Ikpoba-Okha LGA). Using the current national growth rate of 3.2%, the projected population of women of reproductive age of the three LGAs for 2019 stood at 457, 211 (*See table 1 and 2*). Also, for the purpose of this study, primigravida and multigravida women receiving antenatal care services, nursing mothers seeking maternal care services from hospitals and traditional birth attendants (antenatal, delivery and postnatal care) and non-clinic female attendees who have pregnancy experiences were part of the research population; while women who are within the child bearing age but have not received antenatal care services were excluded from the target population for this study. The rationale behind adopting only primigravida and multigravida women was based on the fact that they possess more knowledge and experience about ANCs and provided relevant information useful for this study. Also, it is believed that as direct recipients of ANCs, they are familiar with the socioeconomic determinants affecting accessibility and utilization of antenatal care services.

Table 1: Population Distribution of Women of Reproductive Age by LGA's in Edo South

Local Government Area	2006 Population of Women of Reproductive Age
Oredo	104, 954
Ikpoba-Okha	101, 220
Egor	94, 623
Orhionmwon	46, 532
Ovia North East	41, 461
Ovia South West	34, 129
Uhunmwonde	28, 791
Total	**451, 710**

Source: [21] and [20]

Table 2: Target Population Projection of Women of Reproductive Age by Local Government Area

L.G.A	No. of Women of Reproductive Age (2006)	Projected Population of Women of Reproductive Age (2019)	Population Proportion in Percentage
Oredo	104,954	159,530	35%
Ikpoba-okha	101,220	153,854	34%
Egor	94,623	143,827	31%
Total	**300, 797**	**457,211**	**100.0%**

Source: Author's Estimation from National Population Commission (2006); Fieldwork, (2019)

Scope of the Study

This study is limited to investigating the socioeconomic determinants of access and utilization of antenatal care services among women of reproductive age in Edo South, Nigeria. Specifically, the target group for this study is limited to primigravida and multigravida women of reproductive age. Geographically, this study was conducted in three L.G.As namely: Egor Local Government Area, Ikpoba-Okha Local Government Area and Oredo Local Government Area of Edo South senatorial district.

Sample Size

The sample size of 1,108 was used to generate quantitative data in this study. This was determined using [23] statistical formula for sample size determination. The formula provided a simplified method to calculate sample size for finite (known) population, with a 95% confidence level assumption and 5% margin of error. However, in order to have a larger sample size needed for a more reliable and accurate result, the margin of error was reduced to 3%. This sample size was considered adequate to represent the entire population of the study in view of the statistical requirements, time frame and available resources at the disposal of the researcher. Also, considering the funds available to the researcher, there was need to work with a number that could be effectively managed. However, this sample size was exclusively for the quantitative aspect of the study. The sample size for the qualitative aspect comprised 24 participants for the focus group discussions and 18 participants for the in-depth interview – giving a total of 42 samples.

Sampling Technique

The multi – stage sampling procedure was employed for this study. This involves the application of different sampling techniques including simple random sampling and proportionate sampling techniques, in the sampling process. In the first stage, the purposive sampling technique was used to select three local government areas from the seven L.G.A in Edo South senatorial district that have highest number of maternal mortality. The selected LGAs include: Oredo, Egor and Ikpoba-Okha Local Government Area. This was done by relying on the data of [11] on maternal mortality in Edo South. In the second stage, the simple random sampling technique was used in selecting enumeration areas in each of the three selected local government areas. This was done by first numbering all the elements in the sampling frame out of which two enumeration areas were selected from each selected LGA through the lottery method. In the third stage, the selected enumeration areas were clustered into two broad strata based on their urban and rural characteristics. Then through simple random sampling technique, one urban, and one rural enumeration area were selected in each of the local government areas. These clustered areas include Ugbowo, and Evabareke in Egor LGA; St Saviour, and Ologbo in Ikpoba Okha LGA; and Newbenin and Ogbelelaka/Nekpenekpen in Oredo LGA respectively. The use of enumeration areas was considered appropriate for this study because they are made up of compounds from which the households for the study were selected. Finally, due to the nature of this study and the target group involved, the selection of households for the study was done randomly; and the selection of a household was based on the presence or availability of a primigravida or multigravida woman in such household. In each selected household, a woman of reproductive age was selected in each house. This was done until the desired number of respondents was achieved.

Furthermore, the proportionate sampling technique was used in distributing the questionnaire to the respondents in each local government areas in view of the fact that the population categories do not have equal sizes. Based on the proportional population distribution of women in the selected L.G.As (***see Table 3***), 387 respondents representing 35% of the total sample were selected from Oredo L.G.A. Also, 372 respondents representing 34% of the total samples were selected from Ikpoba-Okha L.G.A; while 349 respondents representing 31% of the total samples were selected from Egor L.G.A – making a total of 1,108 samples. The questionnaire was shared proportionately to the women of reproductive age in the selected local government areas as shown in table 3. These techniques were chosen because it gives each element of the population an equal chance of being selected in the sample and also helps the researcher to make empirical generalization.

Table 3: Distribution of Participants By the Local Government Areas Sampled

S/N	Study Areas	Proportional Sampling of Women of Reproductive Age in the LGA	Questionnaire Distribution	Focus Groups Discussion Distribution	In-depth Interview Distribution (ANC providers)	In-depth Interview Distribution (Spouse)
1	Oredo	$\frac{159530}{457211} \times \frac{1108}{1} = 387$	387	8	3	3
2	Ikpoba-Okha	$\frac{153854}{457211} \times \frac{1108}{1} = 372$	372	8	3	3

3	Egor	143827 x 1108 457211 1 = 349	349	8	3	3
*	**Total**		**1,108**	**24**	**9**	**9**

Source: Field survey, 2019

For the qualitative aspect of this study, three FGD sessions were conducted in three LGA; eight participants were drawn from each selected L.G.As which brings the total FGD participants to 24 samples. Participants were purposively selected from the women of reproductive ages. Specifically women who are pregnant for the first time and women who have been pregnant more than one time were selected. For the In-depth interview (IDI), three interviewees who are heads of household was purposively selected from each of the local government area (3 samples per LGA) making a total of nine (9) IDI participants. These participants were married men whose wives are of child bearing age (and are pregnant or have borne children). These individuals were chosen as interviewees because of the position they occupy in the households; it is believed that they have vital information pertaining to the subject under investigation that can provide relevant data for the study. Another IDI was conducted for traditional caregivers and modern health caregivers; four persons with relevant experience and knowledge were purposively selected from the three local government areas making a total of twelve IDI participants. They include professional healthcare providers (doctors, nurses, midwives) and traditional birth attendants in the area of study. Purposive sampling technique was considered most suitable in the selection of participants for qualitative aspect of this study because, it affords the researcher the opportunity to use her judgment to choose the study participants who are considered knowledgeable on the key themes of this study.

Instruments for Data Collection

The study adopted the mixed methods for data collection. This involved the combination of quantitative instruments and qualitative instruments in the collection of data for the study. The major instruments for collecting data for this study were questionnaire, focus group discussions and in-depth interviews. The questionnaire was the quantitative instrument while focus group discussions and in-depth interview served as the instruments for qualitative data collection. The choice of questionnaire was informed by the relative ease of generating data on the research objectives and also because it is amenable to different forms of statistical analysis which facilitate deeper understanding of the issues under investigation. The questionnaire was designed in a concise and simple English language to avoid ambiguity in understanding its contents. On the other hand, the focused group discussions (FGD) and In-depth interview was used as instruments for collecting qualitative data. The questions for the FGD and IDI guide were structured in open-ended format.

Administration of Instruments

The questionnaire was self-administered and other administered. The questionnaire was self-administered by respondents who were literate and was also administered on a face-to-face (other administered) basis by the researcher and six research assistants to the illiterate respondents within the study area. The research assistants specifically helped in the distribution of the questionnaires to selected respondents as well as explaining the content of the instrument to those who may not read and write effectively. The research assistants were graduates from the Department of Sociology and Anthropology, Faculty of Social Sciences, University of Benin, who are residents in the study area at the time of the study and are conversant with Benin language. This was to ensure ease of interaction with respondents who may not understand English language. The research assistants were selected based on their prior knowledge of scientific research process; they were trained by the researcher for three days on the objectives of the study and well as modus operandi of the research, in other to ensure efficiency, flexibility and accuracy in the data collection process. Due to the consideration of the characteristics of the study population in terms of literacy level, the questionnaire were administered using both English and local dialect (Bini dialect). Each of the six research assistants were allocated to enumeration areas in the study area for the questionnaire administration. The researcher was also aided by a communicator that understands Benin language and terrain of the study area which facilitated the ease of communication, movement and acquaintance with the study terrain.

The focused group discussions and In-depth interviews (IDI) schedules were also conducted by the researcher with the help of two research assistants at a venue and time suggested by the selected participants. The researcher informed the selected participants about the research with the introduction letter from the Department of Sociology/Anthropology, Nnamdi Azikiwe University Awka. English or Vernacular (Pidgin or Bini dialect) was used to conduct the interview sessions depending on preference of the selected respondents. Also, the research assistants were informed on the nitty-gritty for qualitative data collection by the researcher so as to ensure that they worked together as a team. Permission was sought from the interviewees to allow the use of a recorder in recording the responses, so as to avoid losing any important information in the interview process. In addition to the tape recorder, field note book was used to record proceedings of the interview. The researcher moderated all the FGD/interview sessions; one research

assistant took notes while the interview was going on; while the other research assistant operated and monitored the recorder during the discussion/interview sessions.

Methods of Data Analysis

Managing the quantitative data start by scrutinizing the completed questionnaires in other to identify and minimize errors, incompleteness and gaps. After these have been done, the data was be entered into the Statistical Package for Social Sciences (SPSS) statistical software. This software used because it has the capacity to process relevant statistical data in a very flexible and accurate way. However, data analysis in this study involved both descriptive and inferential statistics. The descriptive statistics involves simple statistics such as mode, mean, cross-tabulations, frequencies, simple percentages and charts. It will be used to describe data on most items on the questionnaire such as questions on demographic characteristics of respondents and other variables involved. On the other hand, the inferential statistics will involve the test of study hypotheses to make inferences about the samples in relation to the entire population characteristics. The hypotheses in this study will be tested at 0.05 significant levels. It will also involve both parametric statistics and non-parametric statistics. In this study, the binary logistic regression will be used for the parametric test, while Mann-Whitney U test and Chi-Square will be used for the non-parametric test. These tests will be conducted to investigate the relationship between the independent and dependent variables in this study. The test of hypotheses will follow the pattern shown in table 4.

Table 4: Measurements of Independent and Dependent Variables

	Independent Variable (IV)	Dependent Variable (DV)	DV's Level of Measurement	Test Statistics
$H_1$1	Women of Reproductive Age	Level of Access	Nominal (Yes, No & Don't Know)	Mann-Whitney Test
$H_1$2	Level of Access	Utilization of ANC	Nominal (Yes, or No)	Binary logistic Regression
$H_1$3	Level of Education	Utilization of ANC	Nominal (Yes, or No)	Binary logistic regression
$H_1$4	Level of Income	Utilization of ANC	Nominal (Yes, or No)	Chi-square

Source: Field Survey, 2019

The qualitative data collected through FGD and IDI were analyzed using the content analysis. This was done by careful transcription, translating, sorting, and editing/cleaning of the data, followed by examination and isolation of various responses according to the objectives of the study (i.e. the categorization of responses into the objectives of the study where they match). The process begin with proper transcription. The data was sorted, edited and cleaned; thereafter, data was arranged in line with study objectives. Extracts of verbatim quotes was also be used to complement the data analysis. The qualitative and quantitative data generated were presented sequentially and interpreted thematically. This is to enable appreciation of areas of convergence and divergence. The findings will thereafter be related to literature and theories to support or disapprove the assumptions of the study.

Field Work Experience/Challenges Encountered During the Collection of Research Data

Questionnaire Administration

The following challenges were encountered during the administration of the questionnaire:

I. Finance

The fieldwork was immensely costly.

II. Reluctance by Respondents to Partake in the Research Exercise

Another notable constraint encountered during the administration of the questionnaire was the reluctance and in some cases, refusal of some women to participate in the exercise. The women complained about not having time to fill the questionnaire; while some of them out-rightly refused to grant the researcher and the research assistants' audience. The literate respondents claimed that they were busy and would need time before they can fill the questionnaire.

However, this challenge was overcome through dialogue, repeated appealing to the respondents; and by the researcher and research assistants to dropping the copy of the questionnaire with them, then checking back after some days to collect the questionnaire. It took the researcher and the research assistants' time and efforts to also convince those that out rightly refused to collect the questionnaire, the researcher assured them that the study was not peculiar to anybody and that it was for academic purpose and not to indict them in any way. The researcher and her assistants convinced the respondents by constantly stating that their name and their identities were not required on the questionnaire and no one would know what they have responded to. Eventually, majority of them later agreed to partake in the study. This challenge was not peculiar to the respondents alone but to the interviewees also in the course of conducting IDI with traditional birth attendants. To overcome this challenge, the researcher presented the letter of introduction from the Department and University Identity Card to convince them to co-operate.

III. Illiteracy

Another major challenge was that some of the respondents were illiterates and could not write nor speak English fluently. To overcome this constraint, the researcher and the research assistants had to adopt a technique of reading out the questions and options to the illiterate respondents and ticking their preferred options. Some of the technical words in the questionnaire such as access, utilization, traditional antenatal care, modern antenatal care etc, also warranted the use of the pidgin or native languages to make the respondents comprehend what the question was all about before either writing for them and choosing the option that best explain their thought. Even some of the literate women at some point even had to request that the researcher and her assistants read out the questions and corresponding options to them before selecting the best option that suits them. They claimed that they were too tired to read. This challenge was duly overcome by perseverance on the part of the researcher and research assistants to continue the administration of the questionnaire with more vigor so as to achieve the expected outcome without undermining the research process.

IV. Request for Compensation by Respondents

Another challenge the researcher faced was request for financial demands or one form of compensation or the other by some participants before responding to the instruments. Some respondents requested for what they would get in return for their participation and compensation for their time. This problem was solved through dialogue and presentation of the introduction letter from the department to them. The researcher had to intimate them that the research work was self-sponsored and also went further to explain to them that it was unethical for the researcher to give them money for the exercise. Convincing compensation-demanding women to respond to the questionnaire without giving them anything was a herculean task that the researcher and the research assistants overcame. The researcher had to implore their support and apply diplomacy in order to seek the cooperation of the participants.

V. Poor Road Networks and Flooded Areas

Another major challenge encountered during the course of the questionnaire administration was the poor road network and flooding in some areas. The rural areas where some of the respondents resided were quite difficult to access as a result of the poor road networks and floods on the road paths. Accessing areas such as Upper Sakponba areas, Ugbekun community in Ikpoba-Okha local government area, Sapele road, Ugbor community and Ekae community in Oredo local government area respectively was a serious challenge. The study was conducted during rainy season, as a result, the topography of some areas was flooded and accessibility to these areas become difficult and posed a serious challenge. In some areas, people lived together while in some other areas, houses were far from one another, and this made access to some the enumeration areas very stressful. To address this challenge, the researcher and research assistants had to navigate the route and trek very long distances while distributing the questionnaires to the households.

Administration of In-depth Interview (IDI) Guide and Focused Group Discussion

The following incidents and challenges were encountered during the administration of IDI guide and Focus Group Discussions:

VI. Language Barrier for Some Participants for the Focus Group Discussions and IDI

Some of the participants selected for the Focus Group Discussion had challenge in understanding and speaking English. Some of them could not even express themselves freely in English Language while some felt timid to talk in the midst of other fellow women. To address this challenge, the researcher had to adopt a method that suit the exigency by speaking Pidgin English and also got an interpreter to translate the FGD guide and IDI guide in the native dialect in order to continue the FGD discussions and interviews. Some of the interviewees when asked a question in English language responded in Pidgin English and in some cases the researcher had to start asking and explaining the questions with Pidgin English and Bini dialect where necessary during the FGD sessions.

VII. Accessing Research Participants for the Interview Sessions

Some of the interviewees especially the health care providers found it difficult to keep to appointment because of their busy schedules in the hospital. They kept on postponing the dates for the interview; it was observed that most of

the management staff that was given an introduction letter for an in-depth interview tactically avoided being interviewed, their actions could possibly be linked to the nature of the position they occupied in the management or possibly because of their tight schedule or fear of victimization. Even at a time, some of the health care providers when approached to grant an interview out rightly refused; claiming that they were too tired to talk. This posed a great challenge and at a time got the researcher frustrated. However, the researcher and her assistants had to endure all these frustrating challenges by constant perseverance and by exercising patience and to plead when it became necessary so that the expected outcome was achieved. More so, the researcher had to keep attending the hospitals' antenatal care sessions so as to conduct the interviews very early before their routine checkup commenced. In some instances, the researcher and the research assistants had to wait for several hours before conducting an interview.

VIII. Negative Misconception about the Researcher and her Assistants that they were Government Officials

Another major challenge encountered was misconceptions by traditional birth attendants (TBAs) that the researcher and her assistants were government officials sent to elicit information that will indict them and as such withdrew their cooperation. This is because the government frowns at some of the unprofessional activities of TBAs. For example, a traditional birth attendant (TBA) at Egor Local Government Area refused to grant the researcher audience due to her skepticism. The researcher got to know later that she had once being arrested by the police after a gruesome incident. The problem was addressed with the assistance of a research assistant who understood Bini language and took some time to convince her that the purpose of research was not for indictment but for academic purpose. In addition, the researcher also had to present the letter of introduction and University Identity Card to convince her to co-operate. Similarly, the researcher was faced with another difficulty during her visit to one of the public hospital in Egor Local Government Area, where some doctors also resisted participation for the interview; with the suspicion that the researcher wanted to implicate their hospital. The doctors and nurses within a government owned hospital to be specific were uncooperative and feigned busy schedules while some other health care providers initially refused to grant the interview. This problem was solved through dialogue and constant reminder to the participants that the research was for academic purpose and not to indict them in anyway. The researcher prevailed over this challenge by presenting the department's introduction letter to the participants which influenced their cooperation.

Conclusion

The field-work research experience was an interesting exercise that exposed the researcher and her research assistants to field experiences that cannot be gotten from the four-walls of a classroom. It was also full of challenges as already highlighted. The research as earlier stated was strenuous especially where the researcher and her assistants got less cooperation and were asked for gratifications. These challenges were however surmounted by the researcher through the help of encouraging, humorous and resourceful research assistants and also through the application of the skills acquired during the coursework and participation in departmental seminars and defenses. Fieldwork research should be encouraged in other to enlighten other scholars and researchers on the essence of scientific research knowledge in general as well as sociological research practices.

References

1. WHO (2017). Nigeria fights high maternal mortality through improved quality of care. Retrieved From https://www.afro.who.int/news/nigeria-fights-high-maternal-mortality-through-improved-quality care
2. Omotor, D. G. (2011). Physical access and utilization of primary health care services in rural Nigeria. In *Sixth African Population Conference*. Online at: http://uaps2011.princeton.edu/papers/110053
3. Ukpabi, M. C., & Okpan, S. O. (2017). Traditional birth attendants and maternal mortality. *International Journal of Health and Social Inquiry*, 3(1).
4. Ayowumi, O. ('nd') Impact of Traditional Birth Attendants on maternal health in Nigeria https://www.academia.edu/7020316/impact_of_traditional_birth_attendants_on_maternal_health_in_Nigeria
5. Itina, S. M. (1997). Characteristics of traditional birth attendants and their beliefs and practices in the Offot Clan, Nigeria. *Bulletin of the World Health Organization*, 75(6), 563.
6. Imogie, A. O. (2000). The practice of traditional birth attendants and women's health in Nigeria. In *25th Congress Medical Women's International Association*. Medical Women's International Association Online at http://www.regional.org.au/au/mwia/papers/full/28
7. Babalola, S., & Fatusi, A. (2009). Determinants of use of maternal health services in Nigeria-looking beyond individual and household factors. *BMC pregnancy and childbirth*, *9*(1), 43. BIOMED *Central Pregnancy and Childbirth* 9(43) Online at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2754433/pdf/1471-2393-9-43.pdf
8. Ebuehi, M., & Akintujoye, I.A. (2012). Perception and utilization of traditional birth attendants by pregnant women attending primary health care clinics in a rural local government area in Ogun State, Nigeria. *International Journal of Women's Health,* Vol. 4, Pp 25-34.
9. Nigeria Demographic and Health Survey (NDHS) (2013). *Infant and Child Mortality* **Demographic and Health Survey Fact Sheet, NPC, Abuja**

10. Wekesah, F. & Izugbara, C. (2017). Maternal Health in Nigeria: Facts and Figures. Accessed on 26th September, 2017. http://aphrc.org/wp-content/uploads/2017/06/APHRC-2017-fact-sheet-maternal-health-in-Nigeria-facts-and-figures.pdf
11. Nigeria Urban Reproductive Health Initiative (NURHI, 2013). Benin City. Accessed on the 13th December, 2018. Retrieved from http://www.nurhitoolkit.org/program-cities.benin-city#WfG0L1tSzIU
12. Castello, A., & Azad, K. (2006). Alternative study to reduce maternal mortality. http://www.enwikiipediaorg/wiki/maternaldeath.org
13. Dairo, M.D. & Owoyokun, K.E. (2010). Factors affecting the utilization of antenatal care services in Ibadan, Nigeria. *Maternal and Child Health Journal*, Vol. 12, (1) Pp 3-13
14. Digest of Education Statistics (2018). Young Adult Literacy Rate in Nigeria/ State by State. Federal Ministry of Education. http://educeleb.com
15. John-Abede, R.O. & Osirike, A.B. (2015). Determinants of utilization in antenatal health care services in Oredo Local Government of Edo State. *EBSU Journal of Social Sciences Review*, Vol. 5(2) Pp 94-110.
16. Ibor, U. W., Anjorin,O.A., Ita, A.E., Otu, M.A., & Bassey, T.I. (2011). Utilization of antenatal care in Ibadan North local Government Area, Oyo State, Nigeria. *Trends in Medical Research*, Vol. 6. Pp 273-280
17. Igbokwe, C. C. (2009). Levels and determinants of non-acceptance of family planning practices (FPPs) among couples in Ezeagu LGA of Enugu State. *West African Journal of Physical and Health Education*, Vol. 12, Pp 217-227
18. Stange, K.C., Crabtree, B.F., & Miller, W.L. (2006). Publishing multi method research. *Annals of family Medicine*, Vol. 4 (4), Pp 292-294
19. Osagie, J. I. & Egbefo, D.O. (2016). Impact of Colonial Rule on Inter-group Relations Between the Benin and the Esan Peoples of Nigeria. *Romanian Journal of History and International Studies*, Vol. 3 (2), Pp 57-62
20. National Population Commission (NPC) (2010). *Population and Housing Census.* Priority Table -Volume IV
21. Federal Ministry of Health (2012). *A directory of health facilities in Nigeria*, 2011. Akinsvillem Abuja
22. Edo State Ministry of Health (2016). Health Facilities in Edo State as at April 2015. Accessed on 30th September, 2018. http://data.edostate.gov.ng/home.dataset/health-facilities=in-edo-state-as-at-april-2015.html
23. Yamane, T. (1967). *Statistics: An Introductory Analysis* (2nd ed.). Harper and Row.