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Gender inequity as a barrier to women's access to skilled pregnancy care in rural Nigeria: a qualitative study

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Background: Maternal mortality has been an issue of global importance, with continued efforts by the international development community towards its reduction. The provision of high quality maternal healthcare has been identified as a key strategy in preventing maternal mortality. Gendered intrahousehold power structures, gendered dynamics of resource allocation and women's limited ability in decision-making can have a huge impact on maternal health-seeking behaviour and overall health status. Using a gender lens, this study explores the root causes of women's limited access to and utilisation of maternal healthcare services in rural areas of Edo State, Nigeria.

Methods: This qualitative study involved the analysis of data collected from gender- and age-desegregated focus group discussions (FDGs) in 20 communities in Etsako East and Esan South East local government areas of Edo State, Nigeria. Focus group participants comprised women between the ages of 15–45 y who have been pregnant within the last 5 y and their male spouses and partners of varying ages. A total of 20 FGDs were conducted. Coded transcripts were reviewed and analysed using the gender framework as an analytical guide.

Results: Most responses indicated that women did not entirely have the power to make decisions regarding when to seek care during pregnancy. Women's experiences of access to quality care showed intersecting areas of gender and social economic status (SES) and how they impact on access to health. Many of the responses suggested high levels of economic marginalisation among women with women being financially dependent on their spouses and partners for pregnancy healthcare-related costs. Furthermore, a man's financial status determined the type of care his spouse or partner sought. Women identified a high workload as an issue during pregnancy and a barrier to accessing maternal healthcare services. The role of men within households was generally perceived as that of financial providers, therefore a husband's support was commonly constructed to solely mean financial support.

Conclusion: This paper brings attention to the role of gender and SES in producing and sustaining limitations to women's access to quality care. Interventions geared towards supporting women's financial independence is an important step towards improving their access to skilled healthcare, more so are interventions that improve women's decision-making capacities.

Keywords: gender inequality, global health, healthcare access and use, maternal health, Nigeria, women's health

Introduction

The current state of maternal mortality indicates slow progress on the reduction of maternal deaths due to pregnancy-related complications. As of 2015, the global maternal mortality ratio (MMR) saw a 44% decline from 385 deaths in 1990 to 216 deaths per 100 000 live births in 2015.[1,2] At national levels, African's most populous country, Nigeria, saw a 40% decline in MMR from 1200 in 1990 to 814 in 2015.[3,4] Despite this decline, the enormity of the current MMR can be further understood

when considered at a daily level on both national and global scales. Globally, more than 800 women die each day from pregnancy-related complications. In the sub-Saharan region, where the highest number of maternal deaths occur (two-thirds of all maternal deaths per year worldwide), there are 201 000 maternal deaths every year.[2,5] Approximately 58 000 Nigerian women die from pregnancy-related complications yearly. Numerous causes of maternal deaths such as hypertension, sepsis, embolism and unsafe abortion are mostly preventable, particularly when women utilise skilled maternal healthcare services.[5,6] The decline in maternal mortality in Nigeria has been attributed to an increase in the use of skilled maternal healthcare services in the country. Conversely, the sustained high rates of maternal deaths in the country signify unequal access to healthcare services for pregnancy and delivery. Access to healthcare has been linked to gendered power relationships in low- and middle- income countries.[7]

The United Nations calls for a human rights-based approach to maternal healthcare that makes it available, accessible and acceptable to all women. To that end, policy interventions that aim to improve access to skilled maternal healthcare services have often targeted only women as beneficiaries, the premise being that improving women's knowledge of pregnancy care will increase their use of skilled care facilities.[8,9] While health education is a crucial step to increasing maternal healthcare use, this approach incorrectly assumes equalisation of power and access to resources for women, particularly in the global south.[10,11] Gender mainstreaming is the infusion of men and women's concerns, perspectives and experiences, at the design and implementation of policies and programmes. It aims to challenge and address gender inequality across various levels.[12] International agreements such as the Beijing Declaration and Platform for Action calls for governments, non-governmental organisations and the civil society to mainstream gender with reproductive health.[13,14] The Beijing platform recognised that women's decision-making ability in matters of reproductive health affects their health outcomes. For example, in countries where women fully participated in the decision-making process about their health and bodies, women had lower mortality rates and a higher life expectancy compared with countries where women had limited decision-making abilities.[4,15] The participation of pregnant women in decisions increases their access to key health services such as antenatal care (ANC) and skilled health professionals at delivery. These are necessary strategies to reduce maternal mortality.

The WHO recommends a shared responsibility approach between mothers and fathers towards pregnancy care. Maternal health is, however, often relegated to women. In the context of sub-Saharan Africa (SSA), maternal healthcare continues to be viewed as a woman's responsibility resulting in low levels of men's support and involvement during pregnancy and childbirth.[16,17] In a SSA context, where women often have limited autonomy and control over their reproductive health,[18,19] lack of male involvement could result in challenges whereby women are unable to negotiate for necessary resources during pregnancy.[20] The UN contends that if healthcare systems are to respond adequately to problems caused by gender inequality, gender must be considered from the beginning of any developmental research, intervention or policy.[8] This study is part of a larger project that aims to improve maternal utilisation of healthcare facilities in rural Nigeria and aims to mainstream gender at the onset of the project.

Gender inequality and maternal healthcare

Mainstreaming gender into a project is crucial because it recognises gender as a determinant of health due to gendered social norms and structures that influence experiences of health and access to quality care. However, reducing health determinants to a single factor such as gender is inadequate in understanding any situation of disadvantage. Paying attention to disparities in women's access to health within the context of intersecting domains such as ethnicity, class or social economic status (SES) reduces the risk of homogenising women. Intersectionality explains the multiple and intersecting systems of oppression and disrupts categorical thinking of social identity.[21] This opens up a space to understand experiences that occur at the intersection of two or more axes (for example, gender and SES). In this paper, we use the theoretical paradigm of intersectionality to illuminate ways in which gender and its intersections impact women's access to quality care.

Women's access to quality care is associated with gender inequality at its different levels: individual level, relationship level and societal level.[22] Types of societies such as patriarchal societies influence a woman's access to healthcare. This study is based in Nigeria where patriarchal societies are common. Men are often the heads of households and act as gatekeepers.[23–25] They tend to have control of their household's economic resources and are decision-makers in all aspects of women's reproductive health. Men largely determine women's access to modern health facilities and the availability of resources for health-related expenditure. Inequities manifest in terms of restrictions imposed on women's access to education, economic and employment opportunities and reproductive health services. At the relationship level, common practices such as maternal decision-making or a partner's behaviour (including gender-based violence) affects a woman's access to quality care.[22] Individual level factors such as socioeconomic factors can also affect access to healthcare.

In Nigeria, quantitative studies have examined gender as a determinant of maternal healthcare outcomes[26,27] and others have looked at male involvement in maternal care.[28–30] There is a dearth of qualitative studies that provide rich descriptions of gender-related barriers to maternal healthcare access and utilisation. Using a gender lens, this study explores barriers to women's access to and utilisation of maternal healthcare in rural Nigeria. This paper uses participants' in-depth descriptions to identify gender dynamics and intersections that impact maternal access to care. Following the methods section, this paper describes how decision-making power, access to resources and social norms impact maternal care access and utilisation in rural Nigeria. The findings are then discussed in relation to the wider literature.

Methods

This research focuses on identifying themes within participants' understanding of barriers to maternal access to and use of

skilled healthcare. These themes will provide the scope for further investigation of the subject matter. Thematic analysis is therefore best suited as a method for this research. Braun and Clarke define thematic analysis as a method for identifying, analysing, reporting and interpreting themes within data in rich detail. They contend that a good thematic analysis is transparent in its underpinning theoretical position.[31]

The authors acknowledge that our epistemological approach to qualitative research does not espouse a naïve realist view of qualitative research whereby we 'give voice' to the participants. Instead, we aim to incorporate individual experiences of the participants and the meanings they attach to them while also considering the wider social contexts of these meanings. A 'contextualist' thematic analysis method allows us to do so. Braun and Clarke describe contextualism as being situated between essentialism and constructionism and that it works both to reflect reality and unravel the surface of reality.[31] Similarly, Willig referred to these two epistemological positions as naïve realism and radical relativism with an in-between position that argues that while individuals' experiences are constructed by their interpretation, they are nevertheless 'real' to those who have the experiences.[32] This study considers the constructed realities of participants and situates them in the broader society where these experiences and meanings are shaped. In doing so, this study uses a gender analysis framework, a type of thematic analysis in analysing findings. The framework is discussed further in the data analysis section.

This cross-sectional, qualitative study is a part of a larger original study conducted in rural Edo State which seeks to identify barriers to equity of access, accessibility and utilisation of primary healthcare services (PHCs) for maternal and newborn healthcare. The larger study is designed as a community-based, multisite cluster randomised trial using a mixed method approach, a randomised control trial with an analysis of quantitative data, and analysis of qualitative data from focus groups and key informant interviews. This qualitative part involved the analysis of data collected from gender- and age-desegregated focus group discussions (FGDs). The FGDs aimed to elicit participants' views on the links between gender roles and male involvement on maternal utilisation of PHCs in the region. FGDs were a practical means of exploring these links in a peer-group setting. Additionally, the interactive nature of FGDs offered participants the opportunity to clarify their answers with those of others. The extent of consensus or diversity was noted.

Setting

Nigeria, Africa's most populous country, has a population of 180 million people. The West African nation, with an annual 3% population growth rate, is projected to have the world's second largest increase in population by 2050.[33] The country is divided into six geopolitical zones and is made up of 36 states. About 50% of Nigeria's population reside in rural areas.[34] The study was conducted in Edo State, more specifically in the local government areas (LGAs) of Esan South East and Etsako East, both of which are in the rural parts of Edo State.

Study participants

The study participants were recruited from the rural communities and comprised women between the ages of 15–45 y who have been pregnant within the last 5 y and men of varying ages. Women were eligible to be included in the study if they were currently in a union (legally married or living together with a partner), within the required age range (15–45 y) and had been pregnant in the last 5 y before the survey. Men were included if they were in a union. Drawing on our knowledge of the role of men (male spouses, grandfathers and fathers-in-law) in women's reproductive health decisions in the study communities, we conducted more groups for men than women. Purposeful sampling was used to represent a range of the identification and selection of information-rich cases, and a gatekeeper who is an indigene of each community was used to identify and recruit participants who fit into each category through face-to-face contact. Recruitment was continued until data saturation was reached.[35]

Data collection and procedures

This was a qualitative study based on FGDs. Discussions carried out by trained investigators were conducted in Pidgin English with a few conducted in the local language. We recruited men and women who were indigenes of the communities and who had completed at least secondary/high school education. Three days of training were provided for the investigators by the Principal Investigator and members of the technical team, who are experts in qualitative research. The training featured goals of the research, the art of qualitative data collection and the role of data collectors, data collection using electronic devices (Computer-assisted personal interviewing (CAPI) and voice recorder) and expected deliverables, among others. The investigators were taken through the FGD guide using both English and the local languages. On the last day of training, the FGD guide was piloted in a community with similar characteristics to the study locations, with the trained investigators as moderators of the pilot FGDs.

The fieldwork took place from 29 July to 16 August 2017. As indicated in Table 1, a total of 20 FGDs were conducted, with 10 in each of the LGAs. FGDs were held separately for men and women. Both genders were separated in order to encourage open discussions of private experiences, and to minimise undesirable consequences such as spousal confrontation or abuse that may have threatened participants or their family's stability.[36] Female and male groups were further segmented by age: women (15–30 and 31–45 y old) and men (<41, 41–54 and >55 y old). Segmentation by age helps to minimise the effects of age hierarchy as dictated by cultural norms, which may force younger participants to stifle their opinions and listen to older participants.[36] This approach minimised the dominance of responses based on age. Female facilitators conducted FGDs with female participants and male facilitators conducted the group discussions with men. Following a recommendation by Fusch and Ness, each group consisted of 6–12 participants. The groups were small enough for members to talk and share their opinions yet large enough to create a diverse group.[37] Discussions in the focus groups lasted for 60–90 min and ended when no further issues arose.

Table 1. Total number of study participants per focus group

Focus group discussions (FGDs)	Sex	Age range	Number of participants				Total
			Etsako		Esan		
			Group 1	Group 2	Group 1	Group 2	
FGD01	Women	15–30 y	8	9	8	10	35
FGD02	Women	31–45 y	8	9	12	9	38
FGD03	Men	20–40 y	8	8	8	9	33
FGD04	Men	41–54 y	8	8	8	12	36
FGD05	Men	>55 y	8	8	12	9	37

Research instruments

Demographic data were collected (age, gender, educational attainment, marital status and number of children) to better understand the data. FGDs were conducted with guides that included open-ended questions. These questions were asked to elicit women and men's views on factors that influence maternal use of health services during pregnancy and for childbirth. The FGDs focused specifically on gender inequalities and maternal health since this has been documented as a key driver of negative health outcomes among women.[38] A sample of some of the issues discussed with participants during the FGDs included:

(1) decision-making regarding maternal and child healthcare and how culture, gender roles and economics influence decision-making;
(2) relationships between men and women and male support during pregnancy;
(3) cultural and social issues that place women in difficult circumstances to receive optimal care (in PHCs) for pregnancy and for children;
(4) how men in the community can be made (or encouraged) to support women and children for provision of optimal care.

Ethical considerations

The ethical clearance approval needed for the project was obtained from the National Health Research Ethics Committee (NHREC) after the submission of the study protocol. The project ethical clearance certificate was approved on 18 April 2017 with NHREC Approval Number: NHREC/01/01/2007–18/04/2017. To ensure confidentiality, all personal identifiers were removed from transcripts. Written informed consent was obtained from all participants prior to their participation.

Data analysis

Audio-taped FGDs were transcribed verbatim, and transcripts were compared with the recordings for accuracy and read several times for immersion in the data. The transcribers were native speakers of the local language and Pidgin English who are also proficient in the English language. Thematic analysis of the data included the following steps: first, the transcript was read line-by-line with open coding; notes and categories describing content were written in the margins of transcripts. Second, notes and categories were grouped into a coding scheme and used to create subcategories, which were compared and contrasted, with some of them then merged into larger subcategories with more general description of content. Next, these larger subcategories with similar events, understandings, trends and incidences were grouped together to formulate main categories. Concurrently, a second team member independently analysed the transcripts and two people independently coded all the FGDs using free codes. Third, two raters coded qualitative data into various themes; this was needed to establish inter-rate reliability and to ensure trustworthiness of the study. Finally, data analysis findings were audited by coauthors and the categories were further refined.

Gender analysis was carried out using the gender analysis framework presented by Morgan et al.,[39] which shows how to incorporate gender analysis into health science research: 'The gender analysis framework argues that gender as a power relation and driver of inequality in health systems can be understood by how power is constituted and negotiated in relation to its key domains'.[39] Its key domains are access to resources, decision-making power, social norms and division of labour; these are not static but reinforce each other.[39,40] Figure 1 illustrates these relationships and their application in this study. The data generated themes that emerged from the framework and are presented in the Results section. Participants' responses are either presented verbatim if they responded in English or translated if they responded in Pidgin English. Translated quotations are denoted by square brackets. Literal translation (word-by-word) was used to do justice to participants' responses and to provide readers with an understanding of the mentality of the participants.[41] In cases where literal translations were not possible due to the syntactical and grammatical structures of the original language, free translations were used to enhance the readability of a text.[41] The authors acknowledge methodological consequences in choosing this method of translation, one of which is the probability of misinterpreting participants' responses.

To improve the trustworthiness and transparency in such situations, the translations were carried out by coauthors who are proficient in both Pidgin English and the English language.

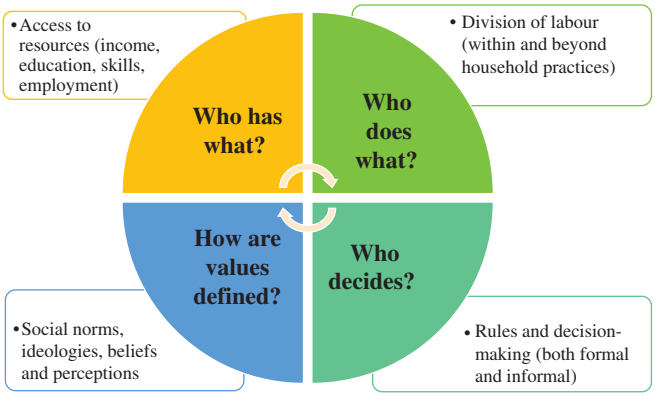

Figure 1. Gender analysis framework. Source: created by authors based on Morgan et al. [39].

As recommended by Squires, it is necessary to explain the translator's credentials and translation process.[42] One of the coauthors translated the written transcripts from Pidgin English to the English language and other coauthors with proficiency in both languages re-examined the translated transcript and screened it for any errors.

Results

Characteristics of study participants

As shown in Table 2, a total of 179 individuals participated in the study: 75 women and 104 men. In both study locations, men consistently outnumbered the women respondents. For the educational level, overall a large proportion of respondents had no more than primary education, as is commonly associated with rural communities; and this was significantly associated with both study locations: Esan South East accounted for 54/99 (55%) respondents, while Etsako East had 52/82 (63.4%) respondents with no more than primary education. There were disparities in the religious beliefs of respondents; nonetheless,

Table 2. Summary characteristics of the study participants

Item	N	Study sites	
		Esan South East	Etsako East
Sex[λ]			
Male	104	58 (55.7)	46 (44.2)
Female	75	41 (54.7)	34 (45.3)
Education[λ]			
No education	15	3 (20.0)	12 (80.0)
Primary	91	51 (56.0)	40 (44.0)
Secondary	63	36 (57.1)	27 (42.9)
Higher	12	9 (75.0)	3 (25.0)
Marital status[λ]			
Currently married/living with a partner	163	84 (51.5)	79 (48.5)
Not currently married	18	15 (83.3)	3 (16.7)
Religion[λ]			
Christianity	172	94 (54.7)	78 (45.4)
Islam	5	1 (20.0)	4 (80.0)
Traditionalist/no religion	4	4 (100.0)	0 (0.0)
Occupation[λ]			
Farmer	85	39 (45.9)	46 (54.1)
Artisan/business	85	55 (64.7)	30 (35.3)
Civil/public servants	11	3 (27.3)	8 (72.7)
Unemployed	3	1 (33.3)	2 (66.7)
Mean (±SD) age[μ]	41.1±14.9	41.7±14.9	40.5±14.5
Median (IQR) children ever born[‡]	5 (4.5)	5 (3.5)	4.5 (4)
Median (IQR) living children[‡]	5 (4)	4 (3.5)	3.5 (3)

[λ] Chi-square test for categorical variable
[μ] t-test for normally distributed variable
[‡] Mann Whitney test for skewed variable
List of communities in Esan South East: Idumuguokha (n=40), Idinwe (n=20), Oruen (n=20) and Ukpaja (n=19).
List of communities in Etsako East: Agieri (n=16), Amughe (n=8), Igiode (n=24), Iturogbe (n=8), Okhase (n=9), Okpa (n=8) and Osholo (n=9).

Christianity was the leading religion reported by the respondents. Usually, the conventional occupation for rural dwellers is farming and, as expected, respondents predominantly reported farming as their occupation. The other occupations captured were artisans and those in trading/business. The numbers in civil and public servant occupations were small and those who reported being unemployed was negligible. The overall mean (±SD) age of respondents was 41.1 (±14.9) y; there was no significant difference between Esan South East and Etsako East. The median (IQR) number of children ever born was estimated as 5 (4.5) with no statistical association between both locations. The median (IQR) number of living children for respondents was 5 (4) with no differentials by study locations.

The following sections detail how decision-making power, access to resources and social norms impact maternal healthcare access and utilisation in rural Nigeria.

Decision-making power

While there were no direct questions regarding key decision-makers in women's access to and utilisation of maternal care, most responses indicated that women did not entirely have the power to make decisions regarding when to seek care during pregnancy. From the perspectives of both men and women, men were identified as final decision-makers in women's access to skilled pregnancy and delivery care. Responses across the various age groups and in the two LGAs suggested high levels of economic marginalisation among women, with women being financially dependent on their spouses or partners for pregnancy healthcare-related costs:

> *[*Our husbands tell us when to go to the clinic*] (female participant, 15–30 y old, Esan).*

Access to resources

Women's experiences of access to quality care showed intersecting areas of gender and SES and how they impact on access to health. Poverty, as a construct of low SES, was identified as a barrier to skilled maternal healthcare services. Participants' accounts revealed that women's lack of financial autonomy resulted in delay or lack of access to skilled pregnancy care. Women were often financially dependent on their husband or partner, therefore his low SES meant that using skilled health facilitates was often impossible. Moreover, while both men and women identified poverty as a barrier to accessing skilled pregnancy care, men were identified as the decision-makers in women's use of health facilities. The responses indicated that a lack of financial resources was a barrier even when men were knowledgeable on the importance of skilled pregnancy. Some women reported that they were expected to explore alternative types of care:

> But because of poverty, some men fail in allowing their wives to go for antenatal. Some other times they give their wives money that won't even be enough. The husband can't even afford money for medication *(male participant, 41–54 y old, Esan).*

Furthermore, a man's financial status determined the type of care his spouse or partner sought. As one participant noted, the decision to patronise traditional birth attendants was influenced by a man's lack of financial resources:

> In any home, there is a head, there is a leader and that leader is the man. Though there are some women that try to overrule their husband, but that is not our discussion now. Any man who has a wife must be ready to take care of his wife. And if he has some financial challenges, he will tell his wife. And that's one thing that brings about women going to the traditional herbal homes. Because it is cheaper. *(male participant, <41 y old, Esan).*

Participants reported episodes of violence against pregnant women. While it was not a common theme among participants, their accounts show how gender intersects with other domestic issues, particularly poverty, to shape experience of violence and women's health during pregnancy:

> '… even some men beat their wives during pregnancy. Especially after drinking, they start talking nonsense, sometimes you believe it's because they don't have anything. And you may even try to calm them down, some will even carry cutlass to kill someone. If there is a way the government can assist them, that may be helpful because poverty may be the reason for their lifestyle *(female participant, 15–30 y old, Esan).*

Women's workload during pregnancy

Responses from participants illustrated the role of gender norms in the division of labour during pregnancy. For the purposes of this study, division of labour was not considered a stand-alone theme because it was heavily ingrained in social norms and perspectives of gender roles. While the majority of the participants recognised the importance of less strenuous work for women during pregnancy, women still identified a high workload as an issue during pregnancy and a barrier to accessing maternal healthcare services. For some of the women, physically demanding farm work was a necessity due to poverty, however, women were still expected to carry out household chores, sometimes with no assistance from their husbands or partners, leaving them with limited time to seek quality care. The responses suggested gender gaps in household responsibilities. Some men were hesitant to assist with household chores because they believed it would create an expectation of ongoing involvement with chores after pregnancy. Furthermore, some men did not consider pregnancy as a deterrent to hard work:

> Yes, there are some men who help their wives during pregnancy. They assist in the house job, while some men will not help. They will say if she is pregnant let her do it by herself *(male participant, <41 y old, Esan).*

> If a woman is pregnant, there should be some work she will not do. She should not still be frying garri. That situation, when a woman does not have the support she will go and

be fetching snail or palm fruit because the man does not take care. *(female respondent, 31-45 y old, Esan).*

We do farm here, without farming here you can't eat. So, women cannot leave only their husbands in labour *(male participant, 41–54 y old, Esan).*

Perceptions of male support during pregnancy

There were divergent perceptions among women regarding male involvement and support during pregnancy. Across all age groups, men and women identified instances where men supported their wives or partners during pregnancy, but experiences were shaped by an intersection of gender expectations and SES. Participants' responses suggested gendered constructs of support as defined by social norms. The role of men within households was generally that of financial providers, therefore their support was commonly constructed to solely mean financial support and not any other form of support such as involvement in household chores or pregnancy care. A man was not deemed supportive if he lacked the financial resources to enhance his spouse or partner's access to quality care:

*[*Some men don't support because they are unemployed*] (female respondent, 31–45 y old, Etsoka).*

As it is now, we don't have any other means to assist them because farming is our only source of income. If we could get a better means of income, we can get more money and care more for them *(male participant, >55 y old, Esan).*

Some women, however, described their husband or partner in other supportive roles, such as participation in household tasks. Even then, the descriptions tended to reinforce the man's role as a financial provider; the men in FGDs confirmed this. Some men in the two regions (Esan and Etsokan) reported belonging to tight-knit communities where members supported each other and were also held accountable for their actions towards their wives or partners. Therefore, greater male support during pregnancy and childbirth was reported among men in such communities across all age groups and in both regions:

In this community we feed our wives well because we are the one who married them. When our wives are pregnant, we begin to save some money for their feeding and clothing, any man that refuse to take care of his wife will be reported to the community and they will punish him, that is why we take care of our wives *(male participant, >55 y old, Etsoka).*

Reports of support notwithstanding, female participants >30 y old reported a lack of male support. These women identified the lack of male involvement as key barriers to seeking and accessing maternal health services. However, none of the women between 15–30 y old reported a lack of support from their husbands or partners.

Yes, what she said is true. The men in this village, we don't know if they are sick. They don't take care of us. Some after

Furthermore, male and female participants perceived that women's negative attitudes during pregnancy were a reason for the lack of male support. Negative attitudes included rudeness, aggressiveness and laziness:

If a woman is pregnant it doesn't mean that you should not respect your husband because men need respect from their wives, we need to pet our husband not to use harsh tone because of pregnancy they will run away when you pet they will do more *(female participant, 15–30 y old, Esan).*

Some women when they are in labour they will insult their husband because of the pains after delivery. The man will say he can't continue with the marriage again *(female participant, 15–30 y old, Esan).*

Discussion

When considering categories of experience, a key question from an intersectional perspective is: Who has power and control over whom?[21] Gender analysis helped the authors of this study move beyond focusing on the differences between men and women, but instead explored how gender as a power relationship drives inequality and limits access to health systems. Findings from our study illustrated how gender inequalities affect maternal access to and utilisation of healthcare services in rural Nigeria. This was further exacerbated by experiences of poverty. Various aspects of gender inequality such as women's decision-making power, their access to and control of financial resources, and social norms influence maternal healthcare use during pregnancy.

Participants identified men as key decision-makers in the timing and the type of care women received during pregnancy. As female participants indicated, their husbands and partners 'tell them' when to seek pregnancy care in healthcare facilities. The men were further recognised as 'leaders in any home'. Similar studies in Nigeria and Ghana confirmed the role of men as decision-makers in their wives' and partners' access to care, with women in rural areas being much more limited in their power to decide on issues related to skilled care during pregnancy.[43,44] Gender norms that assign superior power and value to men have been shown to increase the likelihood of gender-based violence, which negatively affects maternal health. Furthermore, the role of men as decision-makers, particularly in regard to women's reproductive health, restricts women's autonomy, limits women's power to negotiate with their partners and limits access to knowledge on reproductive health.[12] Examining maternal health through a gender perspective creates opportunities to access environments within which maternal health-related decisions are made.[45]

Findings from this study indicated that men had more access to and control of financial resources within the home. Most women were financially dependent on their spouses or partners for healthcare-related costs. Thus, the timing and the type of care a woman received depended on her husband or partner's financial status. The women indicated that this resulted in delayed access to and limited utilisation of skilled pregnancy

care. These groups of women were less likely to have access to pregnancy healthcare despite their significant need for it. This observed relationship between the need for healthcare and its actual utilisation was recognised by Julian Tudor Hart in 1971 in his law of inverse care,[46] which describes the inverse relationship between those who need medical healthcare and those who can actually use it. In other words, vulnerable groups such as those who are socioeconomically deprived and who need access to quality medical care the most are the least likely to receive it. This inverse law exists due to income inequalities and the findings from this study can be understood in those terms.

Similar studies in Nigeria indicated that pregnant women with access to and control of financial resources were more likely to utilise skilled ANC and delivery care.[27] Interestingly, other studies contradicted this finding, showing an inverse relationship between women with control over earnings and their utilisation of skilled maternal delivery services.[47] While this seems counterintuitive, it is important to consider the possible impacts of cultural norms and gender dynamics. Namasivayam et al. make a distinction between earning money and having the power to decide how that money is spent.[22] They explain that for some women the decision on how their earnings are spent is determined by their husbands or partners.

A key dynamic for consideration is the intersection of access to resources, social norms and how they combine to influence maternal access to and utilisation of healthcare services. Social norms dictate gender roles regarding activities that are restricted to either men or women. As our findings indicate, gender roles assign the responsibility of being financial provider to men. Men were therefore perceived as being responsible for providing the financial resources for healthcare-related costs. However, not all men were able to fulfil this role due to high levels of poverty. Participants identified a man as being non-supportive if he was not able to cover the cost of pregnancy-related healthcare. From a gender perspective, this strict interpretation of gender roles fails to consider other forms of support a husband can provide to his wife or partner during pregnancy, such as active involvement in maternal health.

Some participants in this study affirmed men's support for their wives or partners during pregnancy. Supportive roles included taking women to the hospital, providing money for healthcare costs and cooking for them. Men's involvement during pregnancy has been shown to positively impact maternal health behaviour, such as skilled medical care utilisation.[17,29] A study in Malawi[48] showed that when men played active roles in maternal health then they were better informed and aware of pregnancy-related risks, they encouraged women to attend ANC visits (and accompanied them), and also encouraged them to meet their dietary requirements. They provided emotional support and other necessary requirements during delivery. The study reported that when men took up these otherwise non-conventional gender roles, it improved their attitudes towards fatherhood.

Interestingly, our findings show that younger female participants between the ages of 15–30 y had positive perceptions of support from their spouses or partners during pregnancy and delivery. However, more women >30 y of age perceived their spouses or partners as less supportive during pregnancy and childbirth. A possible explanation for this disjuncture could be the lack of acknowledgement of male involvement in various ways in the household. A non-participant observational study conducted in South Africa demonstrated that female respondents and research assistants alike often perpetuated the dominant perception that men were not caring for their families and underreported diverse ways in which men were involved in the family.[49] Cultural ideas about the gendered division of labour which align men's roles to providers could detract from acknowledging other tasks that they undertake that do not conform to the norm. Another possible explanation could stem from the attitudes of older women towards male involvement. Another South African study indicated that women can sometimes be complicit in maintaining the strict gender laws that prevent men from increasing their involvement. In this study, while younger women would often be accompanied by their male partners to ANC visits, older women were not enthused by the idea of involving their male partners on pregnancy areas and did not bring them along for ANC visits.[50] It is therefore important to consider the inaccessibility of spaces for men to step outside gender boundaries and engage in maternal health.

Furthermore, findings from this paper show that due to gendered social norms and the combined effects of poverty, women were sometimes still expected to undertake physically strenuous farm work and household chores when pregnant. A heavy workload limited women's opportunity to access and utilise healthcare services. A similar study in rural Gambia confirmed this finding, reporting that rural women were still expected to endure heavy workloads while pregnant.[51] Because they were constantly engaged in non-remunerable household chores, they had limited opportunities and resources to access ANC. Moreover, strenuous activities during pregnancy can result in adverse health outcomes, both for women and their unborn children. Pregnant women who engaged in strenuous activities were at higher risk of preterm delivery.[52]

The gender analysis described above demonstrated that gender inequality impacts maternal access to pregnancy care. To improve maternal health outcomes and women's access to healthcare, issues related to gender inequality need to be addressed. In Zambia, a community-based intervention successfully enhanced women's access to skilled healthcare facilities.[53] The intervention's strategy included improving the status of women, thereby increasing their decision-making capacities, and creating a wide range of educative programmes and services aimed at increasing men's support of women's reproductive health. Men were made to understand their impact on women's health during pregnancy. Drawing on this intervention, which challenged decision-making structures, similar interventions are needed in rural Nigeria. Interventions that challenge the gendered norms and attitudes can help to break down barriers to maternal healthcare access and utilisation. Social norms that view men solely as providers can be expanded upon and men can be empowered to become more involved in pregnancy care. Furthermore, with the support of their husbands and partners, interventions can support women's financial independence, thereby reducing the pressure on men to be the sole financial providers.

This study is not without its limitations. One possible limitation could be the potential of incurring reporting bias due to participants' fear of being judged by other FGD participants. Additionally, the gender analysis framework was incorporated

in the analysis of the study and not in its design or implementation. It is possible that this study failed to account for other gender-related factors not reported in the analysis. Furthermore, while participants identified socioeconomic status as a key determinant of health, this topic was not explored in its entirety, for example, women's employment status was not a focus in the study and this could have impacted the interpretation of the findings. Finally, as the goal of qualitative research is not to generalise but to provide a rich and contextualised understanding of human experiences, the interpretation of the findings in this study may not be generalisable to other parts of the country.

Conclusion

This paper brings attention to the role of gender and SES in producing and sustaining limitations to women's access of quality care. Approaches to women's health, particularly in the global south, has often incorrectly assumed equalisation of power and access to resources for women. Mainstreaming gender into health research, while a crucial step, runs the risk of homogenising women's experiences without seeking to understand multiple forms of oppression that intersect to create experiences. FGDs revealed important gender dynamics and how they create barriers to women's access to and utilisation of maternal healthcare in rural Nigeria. Participants revealed that women's limited decision-making power restricted their use of skilled care facilities. Also important was the role of SES in exacerbating gender norms. Men were identified as final decision-makers in women's access to skilled pregnancy and delivery care. This was exacerbated by poverty. A husband or partner's low SES meant that using health facilities was often impossible and they made the decision to seek alternative pregnancy care. Social norms that predict gender roles and unequal division of labour within households restricted women's use of skilled health facilities during pregnancy. Women from poor households do not only have to endure physically strenuous farm work but also household chores, sometimes with no assistance from men. Interventions geared towards supporting women's financial independence is an important step towards improving their access to skilled healthcare, more so are interventions that improve women's decision-making capacities. Successful intervention strategies that aim to improve women's decision-making capacities through community education programmes have been observed in Zambia. Drawing from this intervention, which challenged decision-making structures, similar interventions are needed in rural Nigeria. Interventions that challenge gendered norms and attitudes can help to break down barriers to maternal healthcare access and utilisation.

Authors' contributions: SY, FO and LN contributed to the study design. SY, OU and GB conducted the review and analysis of literature and manuscript preparation. SY and OU wrote the first draft of the manuscript. SY had final responsibility to submit for publication. All authors read and approved the final manuscript.

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