COMPARATIVE ANALYSIS OF MATERNAL CRISES AND COMPLEMENTARY MATERNITY ACCESSIBILITY IN IJEBU DIVISION OF OGUN STATE NIGERIA

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Abstract

This study examined the relationship between maternal crises and the accessibility of complementary maternity services in Ijebu Division, Ogun State, Nigeria. This phenomenological study explored women's experiences during maternal crises, from pregnancy to postpartum. Data were collected from 800 participants through structured and unstructured interviews. The participants were purposively selected. Structured Interview was used to collect data while the data was transcribed and analyzed with frequency, percentage and mean analysis, correlation and ANOVA. Four (4) research questions and four (4) hypotheses were used to guide the study. The results showed relationship between maternal crises (r =.751, p<001), consequences of crises improper management (r=.568, p<001), maternal crises experienced (r=.557, p<001) and complementary maternity service accessed by the participants. The results further showed that maternal crises are not significantly different before, during, and after delivery because the p – values were greater than 0.05 levels of significance; Based on the findings, it was concluded that increase in complementary maternity service accessibility increase the maternal consequence due to improper management of maternal crises in Ijebu division of Ogun State. The recommendations were, government should ensure that the complementary maternity service units employ skilled workers, standard of operation complementing their cultural, religion and traditional patterns of service rendition should be ensured among others.

Keywords: Complementary Maternity Service, Maternal Crisis, Maternal Mortality, Nigeria

Introduction

The situations crucially involving an impending change in the health of pregnant women which can lead to either recovery or death if not properly manage is maternal crisis, (Aoife et al. 2020; Dada, et al. 2023; Petersen, 2019) and it is a sudden change in the course of pregnant women`s health toward deterioration. It is an event that is emotionally stressful and post traumatic change in the life of women experienced if not properly managed (Evenson, & Hesketh, 2023; Saldanha, et al. 2023; Shen, et al. 2018). According to Keats, et al, (2019) maternal crisis is a pressing and urgent maternal situation, it is a maternal care exigency that needs immediate attention of skilled care giver because of its capability to incur damage on either both or mother or the child, (Harley, 2021). It is a critical maternity intricacy that either sudden or foreseen before, during or after pregnancy most often at the point of delivery when a critical decision needs to be made in other to guide against maternal mortality. It is a maternity critical point in need of prompt skilled or professional attention because after the crisis the mother or baby dies or the baby is left with life threaten issues as survivor, (Lai, et al, 2020; Nair,& Kumar, 2016; Rumbold, et al, 2015).

This crisis has creeping, slow-burn, and sudden patterns. The Creeping Maternity Crises are prefigured by a series of screening events but neglected by the maternity decision makers. The key decision makers are the pregnant women, their family, and maternal care giver. The decision of pregnant women is influenced by several factors which include family, economy, belief, and social

network, (Mishra, 2019; Lyons, 2015). Discomforts before pregnancy are indicators of this crisis pattern.

Slow-Burn Maternity Crises are noticeable with advance warning signs before causing actual damage. Several Discomforts such as bleeding, abnormal weight gain, poor pelvic size, and excruciating pains during pregnancy are indicators of this crisis pattern. The Sudden Maternity Crises are situations where damage has already occurred and get worse due to late response, (WHO. 2021; Zegers-Hochschild, et al, 2017).The late response is usually influenced by delay in personal respond of the pregnant women, family response and care giver response.Late or delay in respond to the maternal crisis irrespective of its patterns tend to cause maternal mortality, (Xiao, 2015; Zaichkowsky, 2015).

The death of women due to complications from pregnancy or childbirth is known as maternal mortality, (WHO. 2021). It is the death of women while pregnant or within the period of 42 days before termination of foetus, irrespective of the length and situation of the pregnancy, but not from unintentional or minor causes. This is hard-headed among the major causes of demise among women with vestiges of careful public health concern in developing countries, (Onwujekwe, et al, 2016). Though, Direct Obstetric Death (DOD) may occur from obstetric complications of the pregnant state (pregnancy, labour and peuperium), or from interventions, omissions as well as direct treatment but it can also occur from previously existing disease developed during pregnancy which has no direct link to obstetric causes but infuriated by the physiological properties of pregnancy. Such diseases include malaria, diabetes, fever, HIV/AIDS, Covid 19 and its variants, (WHO., 2021; Tieu, et al, 2017; Shehan 2016).

In order to guide against the mortality, the systematic approach to women well-being management and stabilization is ensured. This approach which is maternal health includes women well-being during pregnancy, childbirth, and the postpartum period with extent of family planning, preconception, prenatal, and postnatal care. It is the health and wellness of women, particularly before, during, and after pregnancy, during delivery i.e labour, as well as during child-raising. Motherhood is a fulfilling natural experience with emotions but some women pass through health-wise challenges which sometimes lead to death, (WHO, 2021; Bearak, et al, 2018).

Thus investing in the health of women through quality maternity service alleviates maternal mortality because it promotes their health during pregnancy, childbirth and the postpartum period. Maternity care refers to the health services provided to women, babies, and families throughout the whole pregnancy, during labour and birth, and after birth for up to six weeks. It can include monitoring the health and well-being of the mother and baby, health education, and assistance during labour and birth, (WHO., 2021; Keats, et al, 2019; Tieu, et al, 2017; Zegers-Hochschild, et al, 2017; Shehan, 2016; Xiao, 2015; Zaichkowsky, 2015).

Maternity service includes antenatal care (ANC), delivery care and postnatal care (PNC) services (WHO., 2021). The lives of millions of pregnant women can be saved through the utilization of quality maternity services which will reduce the global burden of maternal mortality, (Kifle, et al, 2017).The maternity services accessibility and utilization has imperativeinfluence on maternal, infant and child morbidity and mortality. Since the initiation of safe motherhood, maternal mortality is still soaring high in most developing nations, (Harley, 2021). The availability, accessibility, and utilization of quality maternity service will pin down this scourge of maternal crisis. Its availability should be made to the grassroot not at the expense of the urban dwellers, (Nair & Kumar, 2016), because it plays a crucial role in improving health women. They deserve to be well informed and empowered to have unhindered access to safe, effective, affordable, acceptable and appropriate maternity service.

Research has confirmed that several factors influencing the usage of maternity centres provided by the government among these are proximity, accessibility, and labour action (Strike), (Onwujekwe, et al, 2016). Some of these factors favour the use of complementary maternity services rendered in maternity homes, (Nair, & Kumar, 2016; Lyons, 2015). The maternity service rendered by individual or organization outside government jurisdiction with or without proper certification, (Mishra, 2019). Some of the providers harmonize medical process with traditional or religion process

in managing women health before, during and after pregnancy while some use either traditional or religion process. Also, some have blended western maternity care methods with their chosen pattern of maternity service for the sake of government or people recognition, (Al Khalaf, et al. 2021; Lai, et al, 2020).

The religion influence women mission home patronage during, and after pregnancy, (Onwujekwe, et al, 2016; Rumbold, et al, 2015). It is a maternity home set up by individuals and religious groups for the purpose of antennal care delivery. In low or medium income countries, a substantial amount of delivery still occurs at home. Home birth attendance is a maternity care set up and rendered at home mostly owned by individuals. This exists in rural and sub-urban areas. Traditional birth attendance utilization is mostly favoured by culture, accessibility and economy like other maternity homes. It renders maternity care using traditional process, (Mishra, 2019; Abel & Alagh, 2020; Lai, et al, 2020).

Experts affirm that pregnant women visit different and several unapproved maternity homes. This has been proven to be dangerous due to different complications which may require the attentions of skilled care, (Shehan, 2016). The death of women before, during and after pregnancy has become a source of worry. The United Nations Millenium Declaration goal 5 adopted by the world leaders focused to reduce maternal mortality by 2015, yielded 3.1% declination in global maternal mortality ratio per year. Some developing countries still lag behind even in this era of sustainable development, (WHO., 2021; Tieu, et al, 2017; Zegers-Hochschild, et al, 2017; Xiao, 2015; Zaichkowsky, 2015). The SDG goal 3 targets sustainable health for all irrespective of gender; but death of women before, during and after pregnancy is still on high side in some sub-Sahara Africa countries including Nigeria, (Crear-Perry, et al. 2021; Harley, 2021; Keats, et al, 2019; Troiano, & Witcher 2018).

The dismal maternal deaths figure from this region and country contribute 98% of maternal deaths to global burden. When 99% of pregnant women in developed countries use skilled obstetric care, 53% of their counterparts in developing countries access same care (WHO, 2021).It is also observed that there are complications and crisis before, during and after the delivery sometime lead to maternal mortality in this study location. Studies confirm that some women before, during and after pregnancy patronize mission homes and other customary health facilities. In 100 pregnant women, over 50% visit maternity homes and 25% out of this have complications, (Harley, 2021, Bearak, et al. 2018). Therefore, this study is examining the maternal crisis in connection to the maternal health service units in Ijebu division of Ogun State.

Objectives

Main Objective: This study primarily examined the relativity of complementary maternal service accessibility and maternal crises as perceived by women who have accessed complementary maternity service as well as experienced maternal crises.

Specific Objectives: The study specifically, identified maternal crises women experienced in the study location and the consequences of its improper management. It examined the maternal crises experienced by the women, the time they experienced it, the implication of the experience, and the service they accessed after the Crises. It also examined the link between the maternal crises, consequences of its improper management, the experienced status of the women and complementary maternity service accessibility; and explored the difference in maternal crises (before, during and after the delivery of pregnancy) due to complementary maternity service accessibility in the study location.

Research Questions

1. How complementary maternity services do influenced the frequency, timing, and implications of maternal crisis in Ijebu division of Ogun State?
2. What is the status of maternal crises experienced Ijebu division of Ogun State?
3. What are the maternal crises identified in Ijebu division of Ogun State?

4. What are the consequences of maternal crises improper management in Ijebu Division of Ogun State?

Hypotheses

The following research hypotheses were formulated and tested to guide the conduct of this study.

1. There is no significant relationship between the maternal crises and complementary maternal health service units in Ijebu division of Ogun State.
2. There is no significant relationship between the consequences of maternal crises improper management and complementary maternal service accessibility in Ijebu division of Ogun State.
3. There is no significant relationship between the maternal crises experienced status and complementary maternity service accessibility in Ijebu Division of Ogun State.
4. There is no significant difference in the maternal crises (before, during and after the delivery of pregnancy) and complementary maternity service accessibility in Ijebu Division of Ogun State.

Methodology

This study is a phenomenological study. This method is considered appropriate because the participants described the maternal crisis based on their experience. The experience is examined and discussed as they perceived them. The population of this study was all women in Ijebu Division of Ogun State, Nigeria who use Complementary Maternity Service during delivery and have experienced crises before, during and after delivery. The entire state was divided into 4 groups, using division as a criterion. The divisions were Remo Ijebu Yewa and Egba (RIYE). Fish bowl method was used to select one division. The division selected was Ijebu. Four (4) out of five (5) existing Local Government Areas were randomly selected from the division picked for the study. The researcher purposively drew a total of 200 women from each Government Area, to make 800 samples size for the study. The use of Local Government Areas and 80% of these Areas in the study location permits fair representation for the generalization of the findings.

The researcher first identifies the bracket and deliberately put them aside, in other to be able to understand the experienced of the participants from their vantage point. This is a bracketing process which enables the researcher to see the issues understudy the same way the participants have seen it. Structured and unstructured interview are used for this study. The structured interview was trial runwith women outside the study location. The women have similar background with the participants under studied. This helped the researcher to identify unclear or confusing questions. Such questions were restructured to ensure that they were representative of the variables understudied and relevant to the study. This process ensured content validity of the structured interview.

Among the question asked include “Have you experienced crisis during pregnancy or delivery?” How often have you experienced complication during pregnancy or delivery?, Do you experience it before, during or after pregnancy?, What is like to have complications during pregnancy? Should women still use complementary maternity service in the face of complications? Do you experience it before, during or after pregnancy? The themes and patterns are sought in the data collected through interview. The data collection and analysis occurs simultaneously. That`s the data is analyzed as it is being collected, rather than waiting until all data are gathered. This approach allows the researcher to identify emerging themes, patterns, or gaps in the data early, which shape subsequent data collection. The data is transcribed and analyzed using frequency, mean, and standard deviation to answer the research questions, while correlation and regression was used to determine the acceptance and non - acceptance of the hypothesis formulated at 0.05 level of significant.

Results and Discussion

The outcome of data collected, transcribed and analyzed was discussed based on the perception of the participants.

Research Question 1: How do complementary maternity services influenced the frequency, timing, and implications of maternal crisis in Ijebu division of Ogun State?

Table 1: Frequency, Percentage and $\bar{X}$ Analysis of the Participants' Crises Experienced, Time Experienced it, Implication and Service Accessibility after Crises

	Score	**%**	**$\bar{X}$**	**SD**	**Decision**
How often have you experienced complications during pregnancy or delivery?					
Crises experienced					
Rare	40	5.0	37.20	0. 74	Significant
Often	760	95.0	37.20	0. 74	Significant
Do you experience it before, during or after pregnancy?					
Time experienced it					
Before Delivery	200	25.0	37.20	0. 74	Significant
During Delivery	328	41.0	37.20	0. 74	Significant
After Delivery	272	34.0	37.20	0. 74	Significant
What is it like to have complications during pregnancy?					
Implication of the experience					
Incomplete term	272	34.0	37.20	0. 74	Significant
Term and life birth deliver	200	25.0	37.20	0. 74	Significant
Term and stillbirth deliver	328	41.0	37.20	0. 74	Significant
Should women still use complementary maternity service in the face of complications?					
Service Accessibility After Crises					
Accessed and not used for delivery	160	20.0	33.10	0.47	Significant
Accessed and used for delivery	600	75.0	33.10	0.47	Significant
Accessed after delivery	40	5.0	37.20	0. 74	Significant

The response of the participants to the question "How often have you experienced complication during pregnancy or delivery?" indicated that 5% rarely and 95% frequently experienced crises during pregnancy which implied that participants frequently experienced crises due to their accessibility of complementary maternity service. This implies that the crisis experienced by the women before, during, and after delivery were significant. The finding is in line with the observation of Keats, et al. (2019); Lai, et al. (2020) and Mishra, (2019) that maternal crises loom in location where complementary maternal care is uncontrollably patronized. It is also supported with Lai, et al, (2020) observation that women who accessed substandard maternity service are frequently prone to maternal crises due to improper service rendition.

The response of the participants to the question "What is it like to have complications during pregnancy?" indicated that the maternal crises experienced had implications on their maternal well being and the implications were significant has shown in table 1 above. 34% participants did not carry the pregnancy to term, 25 % carried to term with life birth while 41% that carried to term gave birth to stillbirth. The implication was that they had experienced foetal and neonatal mortality which indicated that this mortality type seemly occurred in the study location. This finding is in line with the opinion of Keats, et al, (2019) that death of neonate as well as controllable abortion is inevitable in location where substandard maternal care is accessed.

The response of the participants to the question "Should women still use complementary maternity service in the face of complications?", also indicated that they significantly accessed complementary maternity service amid their crises experienced. 75% of the participants still accessed the service for subsequence deliveries while their accessibility before and after delivery was also significant. This is supported with Nair, & Kumar, (2016); Onwujekwe, et al. (2016) submission that most women still used substandard maternal service in the face of crises experienced at the expense of their well being.

Research Question 2: What is the status of maternal crises experienced in Ijebu division of Ogun State?

Table 2: MeanAnalysis of the status of Maternal Crises Experienced

ITEMS	$\bar{X}$	SD	Decision
Mild	27.20	0.67	Significant
Severe	32.10	0.48	Significant
Hopeless	32.10	0.48	Significant

The table 2 indicates that the status of maternal crises experienced due to complementary maternity service accessibility were significant in Ijebu division of Ogun state. The bench mark is 2.0; the results indicated that all the maternal crises experienced by the participants were significant. This finding is in line with the assertion of World Health Organization (2021) and Zaichkowsky, (2015) that women patronizing substandard maternity centres are prone to maternal crises due to poor service given to them during pregnancy. The result also indicated that participants significantly experienced mild, severe, and hopeless maternal crises. This is in line with the view of Onwujekwe, et al. (2016) and Shehan, (2016) that women experienced rigor which could be mild or severely bad maternal crisis amid poor maternity care accessibility.

Research Question 3: What are the maternal crises identified in Ijebu division of Ogun State?

Table 3: Mean Analysis of the maternal crises identified due to complementary maternity service usage

S/N	ITEMS	$\bar{X}$	SD	Decision
1	Postpartum hemorrhage	37.20	0. 74	Significant
2	Sepsis	33.10	0.47	Significant
3	Eclampsia	32.10	0.48	Significant
4	Obstructed labour	27.20	0.67	Significant
5	Miscarriage	33.10	0.47	Significant
6	Abortion	32.10	0.48	Significant
7	Complications from unsafe abortions	33.10	0.47	Significant

The table 3 shown the mean range of maternal crises identified due to complementary maternity service accessibility in Ijebu division as 27.20 (0.67) to 37.20 (0.74). This implied that the crises identified were significant in ijebu division of Ogun state. This finding is in line with the observation of Zegers-Hochschild, et al. (2017);Tieu, et al. (2017) and Zaichkowsky, (2015) that maternal crises loom in location where complementary maternal care is uncontrollably patronized. The result also shown that maternal crises such as Postpartum hemorrhage, Sepsis, Eclampsia, Miscarriage, and Complications from unsafe abortions were more significant than the others in Ijebu division of Ogun State; This is in line with Keats, et al, (2019), and Lai, et al, (2020) assertion that among the crises women could experienced when patronized sub standard maternity service include hard labour, excessive bleeding before or during delivery, infection is, diabetes crisis, and complications from unsafe abortions.

Research Question 4: What are the consequences of maternal crises improper management in Ijebu Division of Ogun State?

Table 4: Mean Analysis of the consequences of maternal crises improper management

S/N	ITEMS	$\bar{X}$	SD	Decision
1	Maternal Distress	27.20	0.67	Significant
2	Postpartum Depression	35.43	0.47	Significant
3	Post-traumatic Stress Disorder	32.10	0.48	Significant

The table 4 had shown the significant of maternal crises improper management consequences due to complementary maternity service accessibility in Ijebu division of Ogun state. The bench mark

was 2.0, the results indicated that all the consequences of improper management crises were significant. This is supported with the observation of WHO (2021) and Lyons (2015) that poor maternal service rendition is evidence of lack of qualified personnel resulting to improper management of maternal crises. The improper management causes considerable consequences such as maternal distress, postpartum depression and Post-traumatic stress disorder, (Mishra, 2019; Zegers-Hochschild, et al, 2017; Xiao, 2015).

Hypothesis 1: There is no significant relationship between the maternal crises and complementary maternal health service units in Ijebu division of Ogun State.

Table 5: Correlation (r) for relationship between the maternal crises and complementary maternal health service units

	Mission Homes	TBA	Home BA	Maternal Crises
Mission Homes	1			
TBA	.691**	1		
Home BA	.580**	.711**	1	
Maternal Crises	.751**	.697**	.691**	1

Key: TBA (Traditional Birth Attendance), Home BA (Home Birth Attendance)

The table 5 showed the relationship between maternal crises and complementary maternal health service units. It was revealed that there was a statistical relationship between complementary maternal health service units and maternal crises (r=.751, p<001). The direction of relationship was positive, meaning that the two variables increased together, the Mission Home accessibility and maternal crises increased. The findings also showed positive statistical relationship between TBA, Home BA, and maternal crises (r=.697, r=.580, p<001). The direction of relationship was positive, indicating that the patronage of Traditional and home Birth Attendance increased together with the maternal crises.

This finding is supported by the view of Zegers-Hochschild, et al. (2017), and Shehan (2016) that as long as there is little or no effort to hinder women from using this service the crises due to this service will also continue to exist. This is corroborated with the assertion of Rumbold, (2015), and Xiao, (2015) that health seeking behaviour is personal and women patronize sub-standard maternity centres because most of these centres appease their psychosocial personality.

Hypothesis 2: There is no significant relationship between the consequences of maternal crises improper management and complementary maternal service accessibility in Ijebu division of Ogun State.

Table 6: Correlation (r) for relationship between the consequences of maternal crises improper managementand complementary maternal service accessibility

	Mission Homes	TBA	Home BA	CMSA
Maternal Distress	1			
Postpartum Depression	.841**	1		
Post-traumatic Stress Disorder	.735**	.802**	1	
*CMSA	.568**	.875**	.891**	1

*Complementary Maternity Service Accessibility CMSA

Table 6 indicates that the relationship between complementary maternal service accessibility and consequences of maternal crises improper management were related statistically (r = .568, p <001). It was revealed that there was a statistical relationship between complementary maternal service accessibility and consequences of maternal crises improper management such as Maternal

Distress (r=.568); Postpartum Depression (r=.841); and Post-traumatic Stress Disorder(r=.735) at p<001). This implied that the increase in the participants' complementary maternal service accessibility increased the consequences of maternal crises improper management among them. The finding is supported with the view of Nair, & Kumar, (2016) that as long as there is little or no effort to hinder women from using this service the crises and it consequences due to the improper service rendition will continual exist. This is corroborated with the assertion of Lyons (2015) and Rumbold, et al, (2015) that health seeking behaviour is personal and women patronize sub-standard maternity centres at the expense of their well being because most of these centres appease their psychosocial personality. This in turns makes maternal crisis and consequences to abound in most areas especially rural communities, (Bearak, et al, 2018).

Hypothesis 3: There is no significant relationship between the maternal crises experienced status and complementary maternity service accessibility in Ijebu Division of Ogun State.

Table 7: Correlation (r) for relationship between the maternal crises experienced status and complementary maternity service

	Mild Experience	**Severe** Experience		**Hopeless** Experience	CMSA
Mild Experience	1	1			
Severe Experience	.713**	.672**	1		
Hopeless Experience	.650**	.758**	.672**	1	
CMSA	.557**	.650**	.758**	.743**	1

CMSA: Complementary Maternity Service Accessibility

The table 7 showed the relationship between complementary maternity service accessibility and the participants maternal crises experienced status. It was revealed that there was a statistical relationship between complementary maternity service accessibility and the crises experienced status such as Mild (r=.557); Severe (r=.758); and Hopeless experienced (r=.743) at p<001) were significantly related with complementary maternity service accessibility in Ijebu division of Ogun State. This implied that the increase in the participants' complementary maternal service accessibility increased their maternal crises experienced status. The finding is supported with the view of Tieu, et al. (2017) that women patronizing sub standard maternity service experienced mild as well as severe crisis which could be hopeless if ignore during pregnancy. This is corroborated with Bearak, et al, (2018) who asserted that the experience of crisis abound in most areas especially rural communities lead to maternal morbidity and mortality.

Hypothesis 4: There is no significant difference in the maternal crises (before, during and after the delivery of pregnancy) and complementary maternity service accessibility in Ijebu Division of Ogun State.

Table 8: One-way analysis of variance of difference in maternal crises before, during and after the delivery of pregnancy

Source	**Df**	**SS**	**MS**	**F**	**P**
Before Delivery					
Between groups	3	90383.449	60127.816	2.331	. 78
Within groups	797	81480290.35	229190.936		
During Delivery					
Between groups	3	1385937.327	861979.109	6.820	. 65
Within groups	797	417889785.6	678538.148		
After Delivery					
Between groups	3	1618872.169	589624.056	1.434	. 62
Within groups	797	229521574.8	804754.921		

Table 8 above shown the result of one-way ANOVA conducted to explore the differences in the maternal crises before, during and after the delivery of pregnancy. This indicated that there was no significant difference in the maternal crises. Before Delivery, F (3,797) = 2.331, P = 0.78; During Delivery, F(3,797) =6.280, P = 0.65; After Delivery, F(3,797) = 1.434, P = 0. 62. Since the P – values were greater than 0.05 levels of significance, the null hypothesis was accepted. This implied that maternal crises were not different before, during and after the delivery of pregnancy through complementary maternity service units in division of Ogun State. This finding is supported with the view of Onwujekwe, et al, (2016) that women who patronized substandard maternity centres experienced maternal crises maternal crises before, during and after their delivery of pregnancy. While Shehan (2016) asserted that some of the crises can be averted with standard maternal care timely rendered with standard facilities. But, Lai, et al. (2020); Keats, et al. (2019); Mishra, (2019), and Nair, & Kumar, (2016) observed that most women failed to use the available skilled care service due to number of factors such as religion, cultural belief, and economy despite their odd experience due to sub standard maternal service accessed.

Conclusion

Based on the findings of this study, it was concluded that increase in complementary maternity service accessibility increase the maternal consequence due to improper management of maternal crises in Ijebu division of Ogun State. The mostly experienced crises include postpartum hemorrhage, Sepsis, Eclampsia, Miscarriage, and Complications from unsafe abortions. The improper management of these crises causes maternal distress, postpartum depression and Post-traumatic stress disorder in women due to the mild, severe, and hopeless maternal crises experienced through complementary maternity service accessibility. The increase in the accessibility increases the foetal and neo-natal mortality in Ijebu division of Ogun State.

Recommendations

Based on the finding of this study, the following recommendations were made:

1. Government should enforce the maternity homes to employ skilled worker such as nurses, community health workers, and health educators to complement their cultural, religion and traditional patterns of service rendition.
2. Government should enforce and ensure training as well as retraining of the owner and the workers of the complementary maternity homes to ensure standard maternity service rendition.
3. The training of individual owner should be locked on licensure while the worker`s training should be locked on licensure and employment in other to logically enforce it.
4. Rigorous campaign and education should be seriously floated in all spheres while community as well as market place should not be exempted.
5. Government should ensure and enforce standard pattern of maternal service delivery at complementary maternity service units such as mission homes, traditional and home birth attendance with guide line clearly spelt out.
6. Safe Motherhood literacy should be floated on media and in public on maternal crisis, consequences of its improper management, and maternal crisis management guide as well as the involvement of women in safe guiding them self.
7. Consumer literacy and education should be seriously floated in all spheres and should be included in the curriculum at all level of education. This should also be infused into the mission homes, traditional birth and home birth attendance with strong focus on ensuring good service delivery.

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