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Mitigating Maternal Mortality Rate Through Social Marketing Practices

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ABSTRACT

The mitigation of maternal mortality rate over the years has been a thing of concerned to government, health practitioners, WHO, UNICEF, USAID, the World Bank and other local faith-based organizations in developing nations. The study examined the social marketing factors (product, price and place) as essential health tools in mitigating the maternal mortality rate in developing nations. Desk and phenomenological research designs were used to obtain data for the study. Structure interview was used in collecting data and responses from a sample of 309 pregnant women in private, public and home healthcare facilities. The result evaluation showed a poor utilization of social marketing factors in the implementation of various antenatal services meant to improve maternal mortality rate. The study recommended the incorporation of social marketer and social marketing practices in the implementation of antenatal care services. The sample may not be representative of pregnant women in private, public and home healthcare facilities. Although the sample size is large and appropriate for this kind of descriptive analytic method. To encourage and positively change the behavior of pregnant women toward antenatal care services in mitigating maternal mortality rate in developing nations. This study is one of few that adopts social marketing as a panacea in encouraging private and public hospital antenatal care services rather than homecare health services to pregnant women in mitigating maternal mortality rate in developing nations.

Keywords: Social Marketing, Product, Price, Place and Maternal Mortality Rate

INTRODUCTION

The use of social marketing practices in the private sector resulted in solving core business issues which in turn generated profit through satisfaction. The core of marketing is achieving social goal by meeting people's need (Lefebvre, 2013). Social marketing as well can be used by human to enhance the quality of life in the society through its principles, applications and available institutions. Social marketing is a frame work for planning and implementing social change (Kotler & Zaltman, 1971). Social marketing focuses on four behavioural changes

that could also be referred to as (target behaviour): accepting a new behavior (willingness to accept antenatal and postnatal services), reject a potential undesirable behaviour (the harmful practice of traditional birth attendance), modify a current behaviour (adhering clinic visitation days) and abandon an old behaviour (having confidence in the new formed behaviour of medical services received) (Cheng, Kotler & Lee, 2009). In an attempt to reduce maternal mortality rate in developing nations, social marketing practices need to be adopted. Maternal mortality rate (MMR) is the death of a woman while pregnant within 42 days of termination of pregnancy, irrespective of duration and state of the pregnancy Africa (Shah & Say, 2007). This occurrence is predominantly common in Africa, precisely Sub-Saharan Africa. Ujah, Aisien, Mutihir, Vanderagt, Glew and Uguru (2005) noted that while 25 percent of female of reproductive age lived in developed countries, they contributed only 1 percent of maternal death worldwide. Nigeria and other African countries have maternal mortality ratio least 450 maternal deaths per 100,000 live (World Health Organization, 2008). Nigeria has one of the highest maternal mortality rates in the world, second to India whose population is eight times larger than Nigeria (Mohekwu & Ibekwe, 2012).

The spread of primary health centers in all the 774 local government was meant to achieve antenatal, postnatal and other cares required by pregnant and nursing mother within each region of Nigeria. The millennium development goal target which was aimed at reducing the number of death occurring from child birth by three quarters by the year 2015, is declining too slow to meet the MDG (Mairiga, Kawuwa & Kulima, 2008). The fight against child mortality death is fought by the Federal Ministry of Health Nigeria (FMOH) supported by WHO, UNICEF, USAID, the World Bank and other local faith organization in Nigeria, seems to be unproductive. In order to achieve the set goals, an active social marketing team becomes inevitable, since health action is conceived as a function of a social action. Social marketing has a desired behavioural change that would have made the pregnant mothers go for regular antenatal check in various primary health care centers in Nigeria. Studies on social marketing and maternal mortality rate rarely exist to show how other non-medical approaches are employed to sell the health product available to the target audience. The social marketing variables (product, price and place factors) have the potentials to drive the goal of ameliorating maternal mortality rate in Nigeria and other developing nations. Product is the quality of the service, infrastructure, and the attitudinal factor of the service provider to the target audience (pregnant women). Price is the old behaviour (fear, traditional belief, stigma of earlier pregnancy, etc) that must be abandoned by way of change for a new found behaviour (adhering to clinic treatment and others services to prevent pregnancies complications). It is the cost and benefit for accepting a new idea or change in modern antenatal care services. Place is the location of the product delivery centers in relation to target audience homes who seek such services. The study will be significant to various agencies involved in the fight against MMR in Nigeria and other developing nations. It will become a source of valuable literature for scholars and the public will appreciate the social implication of the study to improving MMR in developing nations. A good public health practice should operate more on preventive and less of curative measure, most cases curative becomes more expensive to handle on the part of the individual and the society at large. Base on the foregoing, the following research questions are drawn for this study:

RQ1: Is product element of social marketing a panacea for maternal mortality rate?
RQ2: Will price element of social marketing assist to improve maternal mortality rate?
RQ3: Can maternal mortality rate be reduced through place element of social Marketing?

The Concept of Social Marketing

Social marketing is the application of marketing discipline to social issues (Lefebvre, 2013). Gordon, McDermott, Stead, and Angus (Gordon, McDermoh, Stead & Kathryn, 2006), reported that social marketing can form an effective framework behaviour change interventions and can provide a useful 'toolkit' for organization that are trying to change health behaviour to use public health service delivery. In UK potential of social marketing was recognized in the white paper on public health, which talks of the 'power' of marketing and marketing tools applied to social 'good' being "used to build awareness and change behaviour (Department of Health, 2004). The benefit of social marketing is to improve the individual welfare and society, not of benefit to the organization doing the social marketing; this differentiates social marketing from other forms of marketing (McDermott, Stead & Hastings, 2005). Social marketing as social product involves the changing of behavior without a tangible product or service being marketed.

The Product Element of Social Marketing and Maternal Mortality Rate

Product factor represent the design of the product in terms of the quality of the service, infrastructure, and the attitudinal factor of the service provider and persons to the target audience (pregnant women) during antenatal and postnatal services. Ndep (2014) reports that Nigeria's current MMR of 630 per 100,000 live births is indicative that critical aspects of the healthcare delivery system like financial and geographic access to care and

good quality healthcare delivery services in Nigeria continue to fail women and children. In government hospitals in one location in North-central Nigeria, poor child birth techniques, including for example substandard caesarean section procedures, accounts for 40% of all fistula injuries suffered by women (Global One, 2015). World Health Organization (2008) reports show that improved healthcare services delivery including better training for midwives, improved sanitary conditions and access to skilled care before during and after the birthing process could reduce MMR considerably. The products of antennal care service have been poorly marketed to the target audience by the service providers. The availability of healthcare centers has not justified the primary mandate.

The Price Element of Social Marketing and Maternal Mortality Rate

Price factor is the cost and benefit for accepting a new idea or change to modern antenatal care services. Price in social marketing often times refer to as what should be sacrifice in terms of time, belief, stigma and inconveniences that should be overcome in order to gain positive responses to desired change. High maternal mortality has been explained by some researchers to be caused by a combination of individual level factors such as attending antenatal clinics but choosing to deliver at home, at a church or by a traditional birth attendant (Igberase & Ebeigbe, 2007). Most men (husbands) in the rural areas belief that antenatal and postnatal cares are the functions of women alone. Men have little involvement in the things of antenatal and postnatal services, until serious emergency recurs. They do not encourage women (wives) to take antenatal services serious rather premium is put on agriculture and health seen as secondary, women are seen as success factor to a man's agricultural wealth.

There is increasing utilization of traditional birth attendant (TBA) and spiritual houses, most women belief that hospital are not safe for their child birth even from the educated elite. Some pregnant women live in some spiritual clinics with isolated cases of successful delivery, because of the confidence they have in such places, often make them neglect antenatal services. They only present themselves for treatment in hospital when their cases are worst off. Mojekwu and Ibekwe (Mojekwu & Ibekwe, 2012) reported that unplanned pregnancies result in MMR among women by 40% at home and 20% enroute to hospital. The stigma associated with unwanted pregnancies by churches and peers especially among teenagers are factors that must be overcome by social marketing communication. Currently, there is a strong traditional conservatism and resistance including health belief and practices, which increase the patronage of the services of traditional healers (Sule, Mandong & Iya, 2001).

Place Element of Social Marketing and Maternal Mortality Rate

Globally, the place (distribution) of health product has yielded gain to positive behavioural change. Distribution is the location of the product delivery centers in relation to the target audience homes who seek such services. In Uganda, Protector sold condom through their commercial distributors' outlet and have a desired effect on the target audience behaviour in the use of condom during sex. Time and place utilities were satisfied, especially in places where there are needed particularly in high-risk situations and environment where people feel comfortable to purchase them.

Abah (2022) reports that from survey Nigeria healthcare delivery system has some loopholes because health planners have failed to entrench a culture that could deliver holistically, all the healthcare delivery component such as essential drug distribution. To ensure sustained behavioural change, in health delivery services, government, in collaboration with the United States agency for international development has embarked on massive renovation of five (5) warehouses at the central medical stores of essential drug programme in Calabar, Nigeria. Onokerhoraye (1999), research findings revealed that inaccessible healthcare facilities affected the utilization of modern care facilities by a vast proportion of the people who could be used them in changing their health and treatment behaviour. This was responsible for the dependence on traditional health in Bayelsa State in Nigeria.

MATERIALS AND METHODS

The study adopted the desk and phenomenological research designs. A careful exploration of literature was done on related study of qualitative studies. Exploratory research focuses on collecting either secondary or primary data using unstructured informal procedures to interpret them. It is used to gain additional insights before and approach can be developed (Shukla, 2008). The study got secondary data from literatures related to the maternal mortality rate. However, this research was premised on phenomenological philosophy due to its flexibility that allows explanations for different context (Munyoro, Chikombingo & Nyandoro, 2016; Kraemer et al., 2000) and deals with the source, nature and development of knowledge as is the case with this study. Furthermore, the adoption of the phenomenological philosophy was done because this research philosophy is

based on the belief that reality is subjective and therefore can be observed and described without interfering with the phenomena under study (Saunders, Lewis & Thornhill, 2009; Ghauri & Grønhaug, 2005). Thus, the phenomenological study attempts to set aside biases and preconceived assumptions about human experiences, feelings and responses to a particular situation (Jankowicz, 2005). A sample of 309 respondents (pregnant women) in public, private and home healthcare facilities were used for the study. The research instrument used for primary data collection was a structured interview, made up of two parts. Part A obtained data on respondents' demographic characteristics, while Part B obtained their responses to statements and questions regarding the social marketing dimensions of the study (product, price and place). The data obtained during the questionnaire survey were analyzed using descriptive statistics (frequencies, percentages, pie chart, bar chart and columns) on the Microsoft Excel software. The study was conducted from the period of January to July, 2022.

RESULTS

Data Presentation and Analysis

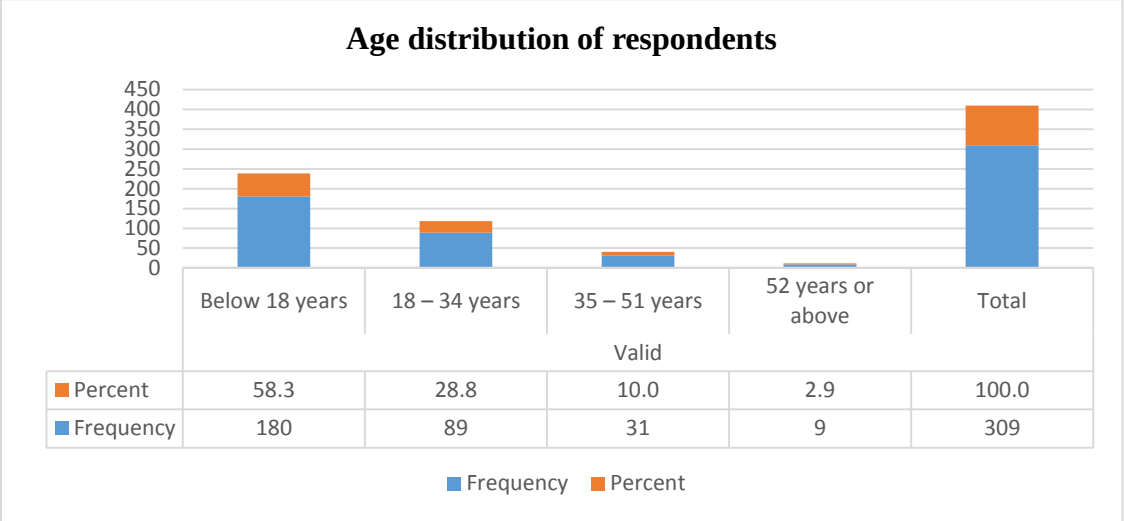


Figure 1: Distribution of Respondents by Age
Source: Authors' Computation via Microsoft Excel (2022)

The data in Figure 1 revealed that out of the 309 respondents surveyed in the study, 180 respondents (representing 58.3 percent) were below 18 years, 89 respondents (representing 28.8 percent) were within the age bracket of 18 – 24 years, 31 respondents (representing 10.0 percent) were between the age bracket of 35 – 51 years, while 9 respondents (representing 2.9 percent) were 52 years or above. This entails that the vast majority (58.3 percent) of the respondents that constituted the survey were teenage pregnant women who were not up to adulthood yet.

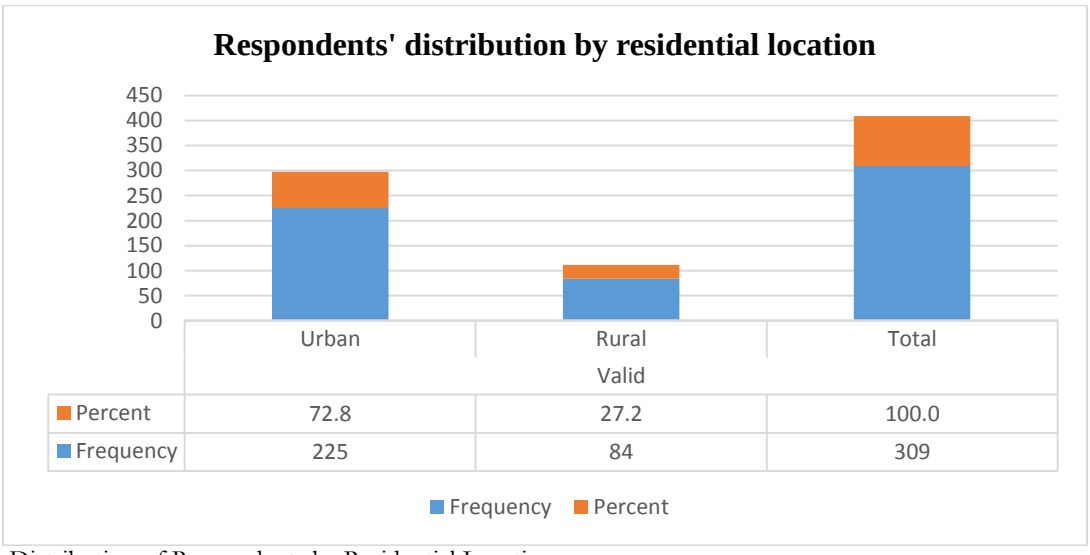
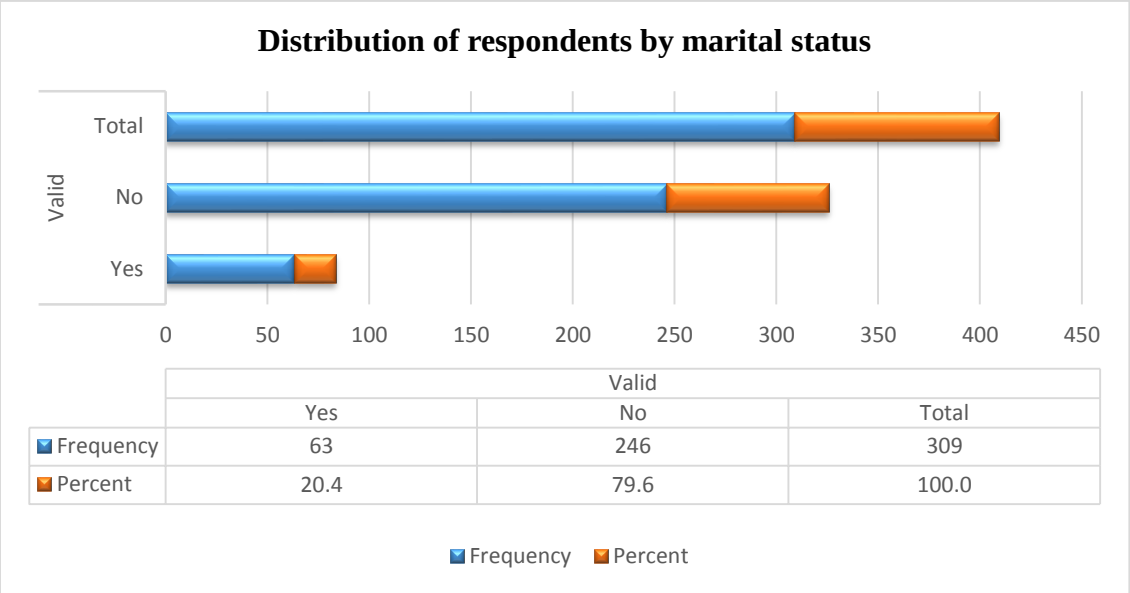


Figure 2: Distribution of Respondents by Residential Location

Source: Authors' Computation via Microsoft Excel (2022)

The data in Figure 2 revealed that out of the 309 respondents surveyed in the study, 225 respondents (representing 72.8 percent) were residents of urban areas, while 84 respondents (representing 27.2 percent) resided in rural areas. The implication of this data is that the vast majority (72.8 percent) of the respondents that constituted this survey were pregnant women who resided in urban areas.



	Valid		
	Yes	No	Total
Frequency	63	246	309
Percent	20.4	79.6	100.0

Figure 3: Distribution of Respondents by Marital Status
Source: Authors' computation via Microsoft Excel (2022)

The data in figure 3 revealed that out of the 309 respondents surveyed in the study, 63 respondents (representing 20.4 percent) were married, while 246 respondents (representing 79.6 percent) were unmarried. This entails that the vast majority (79.6 percent) of respondents that constituted the survey were unmarried. This helps to explain why most of the respondents are teenage pregnant girls, as reported in Figure 1. Hence, the survey comprised mostly unmarried teenage girls who were pregnant out of wedlock.

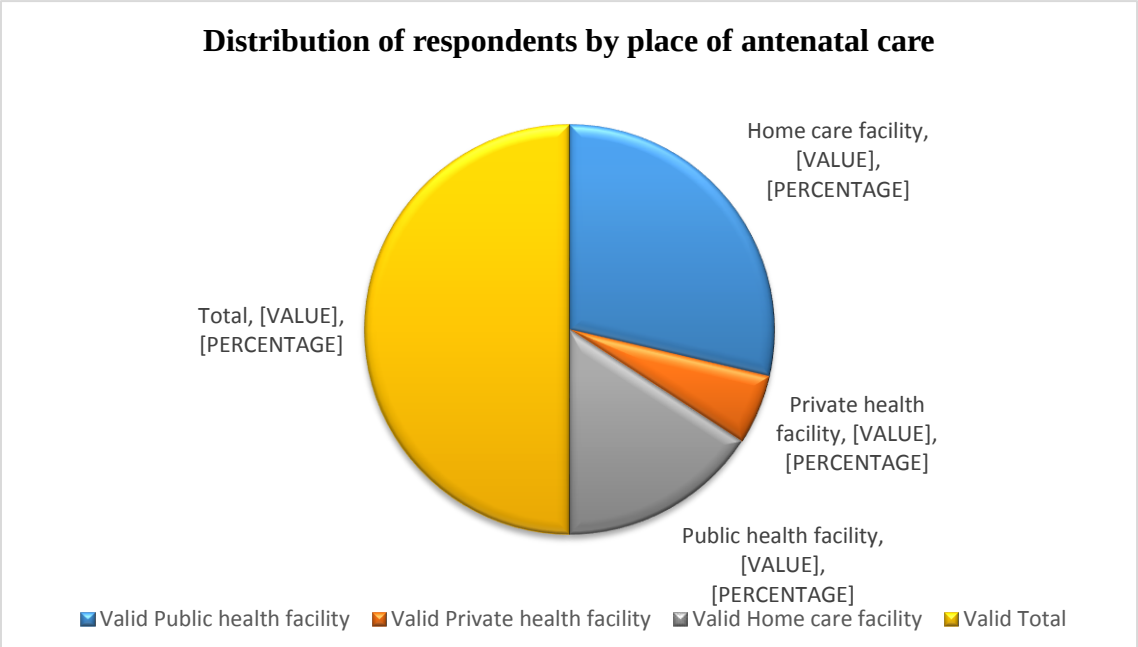


Figure 4: Distribution of Respondents by Place of Antenatal Care
Source: Authors' Computation via Microsoft Excel (2022)

The data in figure 4 revealed that out of the 309 respondents surveyed in the study, 177 respondents (representing 29.0 percent) patronized the antenatal care services of home care facilities, 34 respondents

(representing 5.0 percent) patronized the antenatal care services of private health facilities, while 98 respondents (representing 16 percent) patronized the antenatal care services of home care facilities.

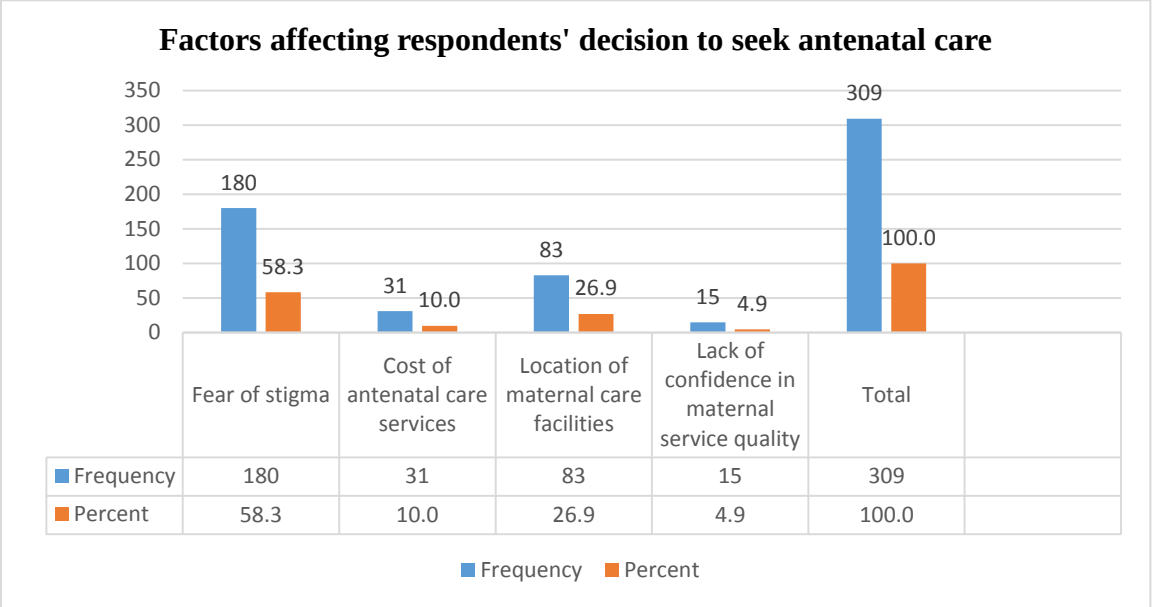


Figure 5: Factors Affecting Respondents' Decision to Seek Antenatal Care
Source: Authors' Computation via Microsoft Excel (2022)

The data in figure 5 revealed that out of the 309 respondents surveyed in the study, the decision of 180 respondents (representing 58.3 percent) to seek antenatal care service was influenced by the fear of stigma. The data also showed that the decision of 31 respondents (representing 10.0 percent) to seek antenatal care service was influenced by the cost of antenatal care services. It was also revealed that the decision of 83 respondents (representing 26.9 percent) to seek antenatal care service was influenced by the location of maternal care facilities, while the decision of 15 respondents (representing 4.9 percent) to seek antenatal care service was influenced by the lack of confidence in maternal service quality. The implication of this data is that for the vast majority (58.3 percent) of respondents surveyed in this study, their decision to seek antenatal care service was influenced by fear of stigma. This could be so since the vast majority (58.3 percent) of the respondents were unmarried teenage girls who got pregnant out of wedlock, as presented in Figures 1 and 3. And so, because they were teenage girls who got pregnant out of wedlock, they were often afraid of being criticized by members of their societies as they went out for antenatal services. However, if they were adult women, formally married and pregnant, the fear of stigma would not influence their decision to seek antenatal care services.

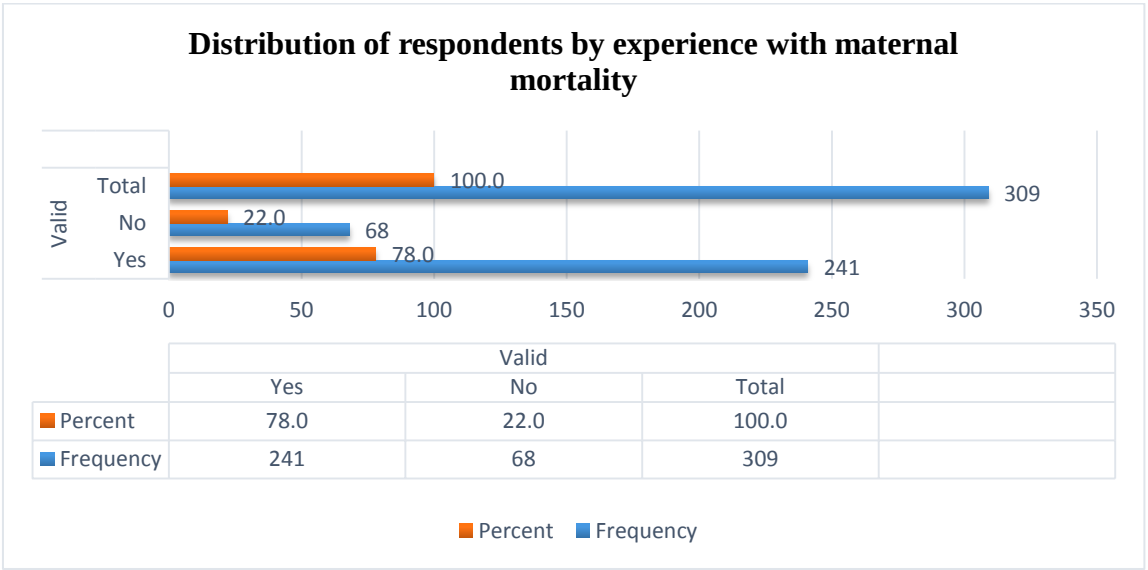


Figure 6: Distribution of Respondents by Experience with Maternal Mortality
Source: Authors' Computation via Microsoft Excel (2022)

The data in figure 6 revealed that out of the 309 respondents surveyed in the study, 241 respondents (representing 78.0 percent) had experienced some form of maternal mortality in their lives, while 68 respondents (representing 22.0 percent) had no experience with maternal mortality. This entails that the vast majority (78.0 percent) of respondents that constituted the survey were victims of maternal mortality.

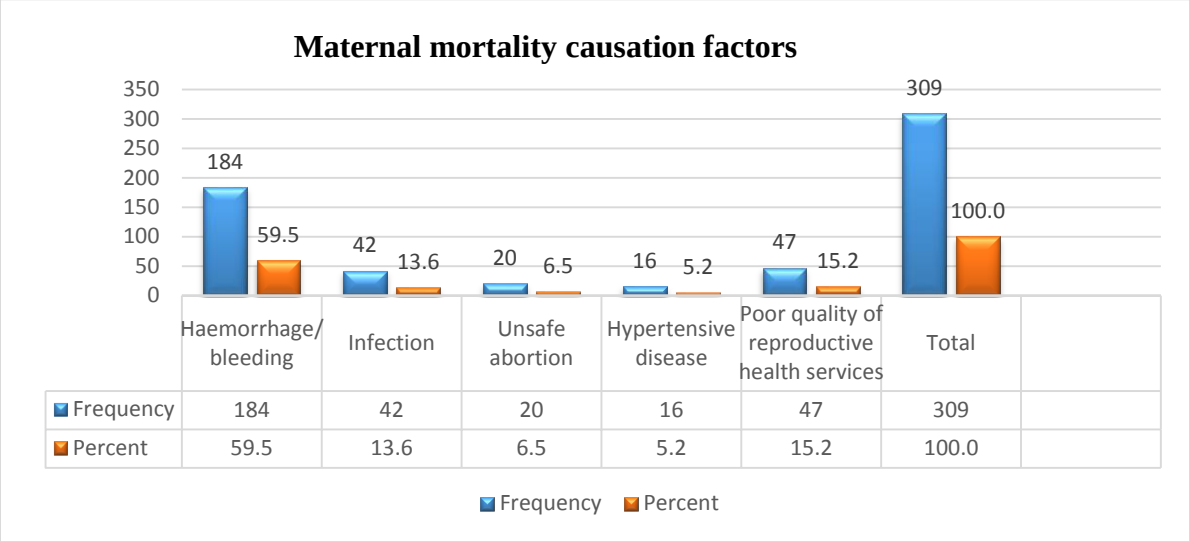


Figure 7: Distribution of Respondents by Maternal Mortality Causation Factors
Source: Authors' Computation via Microsoft Excel (2022)

The data in figure 7 revealed that out of the 309 respondents surveyed in the study, 184 respondents (representing 59.5 percent) were of the opinion that haemorrhage/bleeding was the highest cause of maternal mortality. The data also showed that 47 respondents (representing 15.2 percent) were of the opinion that the second-highest cause of maternal mortality was the poor quality of reproductive health services. Infection (13.6 percent) and unsafe abortion (6.5 percent) were the third and fourth leading causes of maternal mortality, while hypertensive disease (5.2 percent) emerged as the least cause of maternal mortality. In summary, the data in figure 7 reveals that the vast majority (59.5) of the victims of maternal mortality surveyed in this study maintain that the leading cause of maternal mortality was haemorrhage/bleeding, while hypertensive disease ranked least. This means that most of the cases of maternal mortality in the surveyed communities were mostly causes by haemorrhage/bleeding and poor quality of reproductive health services.

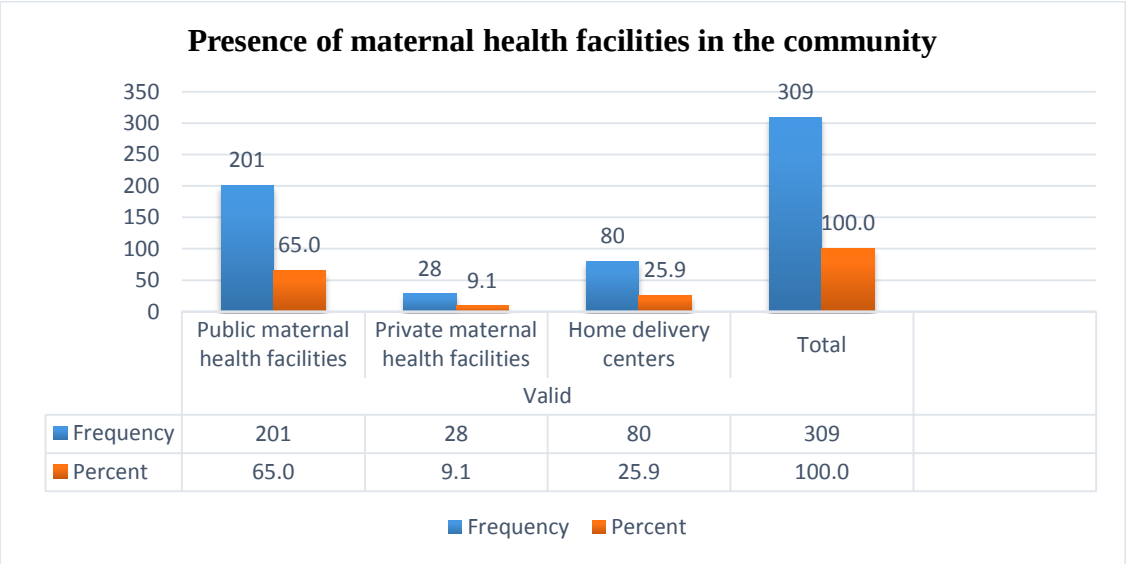


Figure 8: Distribution of Respondents by Presence of Maternal Health Facilities
Source: Authors' Computation via Microsoft Excel (2022)

The data in figure 8 revealed that based on the responses of the 309 respondents surveyed, Public maternal health facilities had the highest presence (65.0 percent) in the respondents' communities. The data also showed that home delivery centers had the second-highest presence (25.9 percent) in the respondents' communities,

while private maternal health facilities had the least presence (9.1 percent) in the respondents' communities. The implication of this data is that respondents surveyed in this study were more exposed to the presence of public maternal health facilities in their communities than other facilities. After public maternal health facilities, home delivery centers had the second-highest presence in the respondents' communities. Hence, if respondents were not attending public maternal health facilities, their nearest location would be home delivery centers.

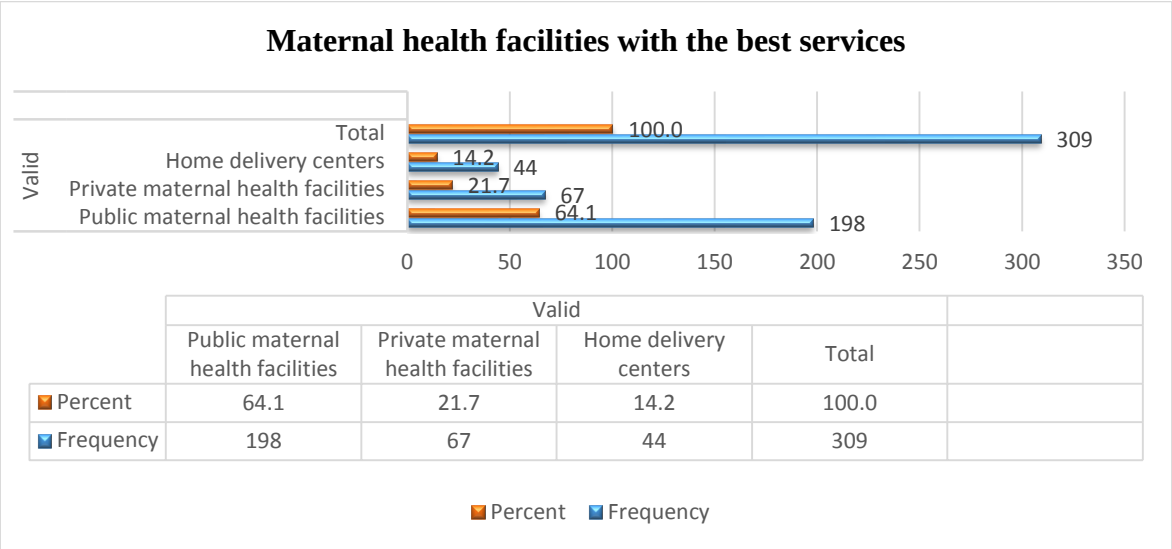


Figure 9: Maternal Health Facilities with the Best Services
Source: Authors' Computation via Microsoft Excel (2022)

The data in figure 9 revealed that based on the responses of the 309 respondents surveyed, Public maternal health facilities offered the best service quality (64.1 percent) to pregnant women, private maternal health facilities offered the second-highest service quality (21.7 percent), while home delivery centers offered the least service quality (14.2 percent) to pregnant women. The implication of this data is that in the surveyed communities, pregnant women could receive the best quality of maternal health care services from public health facilities. Private maternal health facilities could offer pregnant women the second-highest quality of service, while the quality of service in home delivery centers is poor. This is probably one of the reasons why the vast majority (29.0 percent) of the pregnant women surveyed in this study would prefer to receive antenatal care services from public health facilities, as presented in Figure 4.

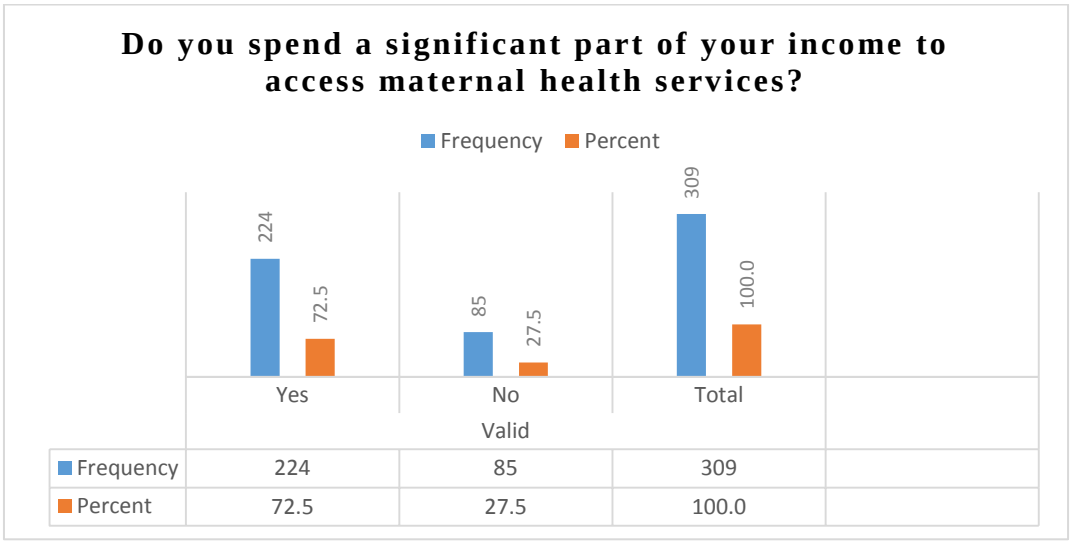
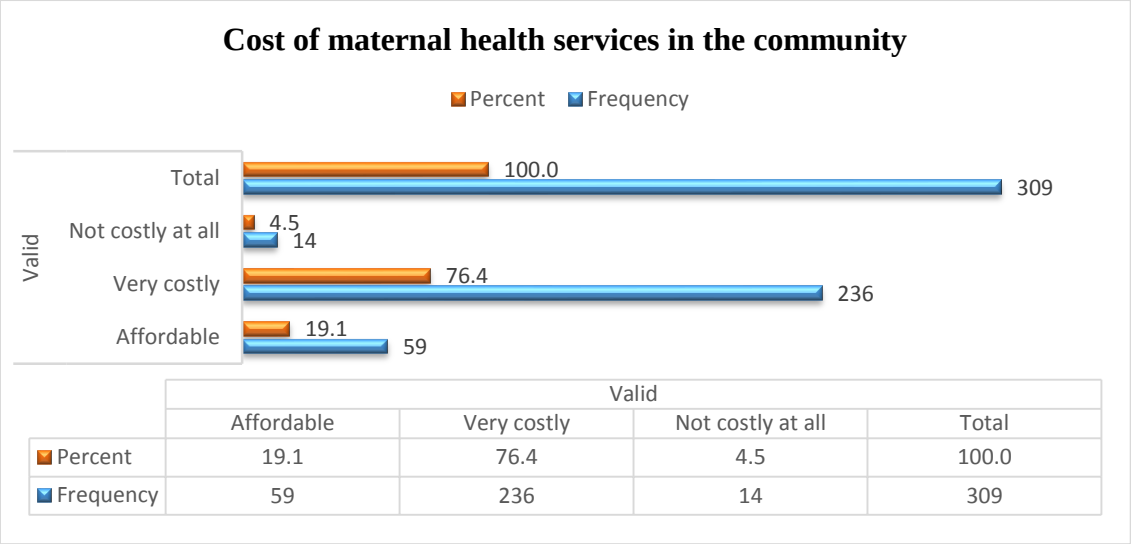


Figure 10: Income Spent on Maternal Health Service Access
Source: Authors' Computation via Microsoft Excel (2022)

The data in figure 10 revealed that out of the 309 respondents surveyed in this study, 224 respondents (representing 72.5 percent) spend a significant part of their income to access maternal health services, while 85 respondents (representing 27.5 percent) did not spend much of their income on maternal health services. This entails that access to maternal health care services consumes a significant portion of the income of the vast

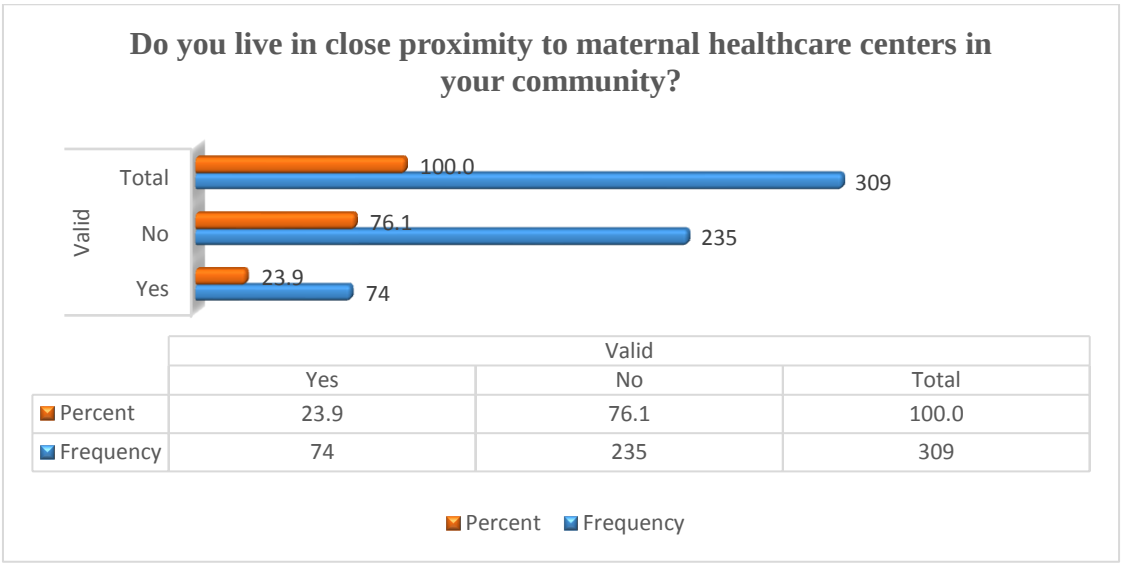
majority (72.5 percent) of pregnant women surveyed in this study. The implication of this scenario is that the income of most pregnant women in the surveyed communities is vastly depleted by their patronage of antenatal and postnatal health care services.



	Valid			
	Affordable	Very costly	Not costly at all	Total
Percent	19.1	76.4	4.5	100.0
Frequency	59	236	14	309

Figure 11: Cost of Maternal Health Services in the Community
Source: Authors' Computation via Microsoft Excel (2022)

The data in figure 11 revealed that out of the 309 respondents surveyed in this study, 59 respondents (representing 19.1 percent) were of the opinion that the cost of maternal health services in their community was affordable, 236 respondents (representing 76.4 percent) said it was very costly, while 14 respondents (representing 4.5 percent) were of the opinion that the cost of maternal health services in their community was not costly at all. From this data, it can be seen that the vast majority (76.4 percent) of the respondents surveyed maintained that the cost of maternal health services in their community was very costly. It is no wonder why the majority of pregnant women surveyed (72.5 percent) maintained that access to maternal health services was responsible for consuming a significant sum of their income, according to Figure 10. Therefore, it can be implied that for most pregnant women in the study area, access to maternal health services is very expensive and it depletes a large portion of their income.

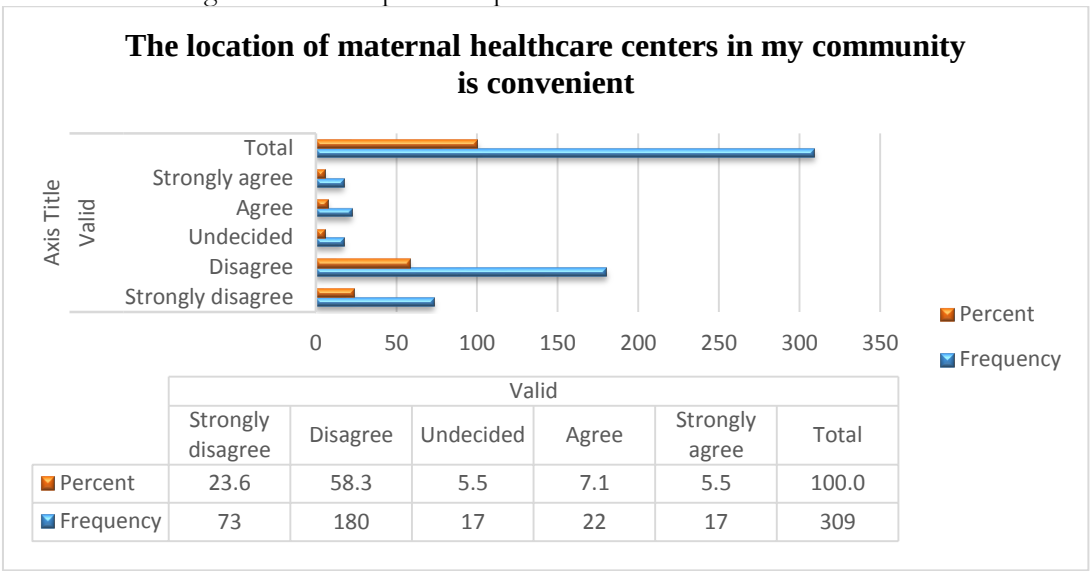


	Valid		
	Yes	No	Total
Percent	23.9	76.1	100.0
Frequency	74	235	309

Figure 12: Proximity of Maternal Healthcare Centers in the Community
Source: Authors' Computation via Microsoft Excel (2022)

The data in figure 12 revealed that out of the 309 respondents surveyed in this study, 74 respondents (representing 23.9 percent) said that they lived close to maternal healthcare centers in their communities, while 235 respondents (representing 76.1 percent) said that they lived far from maternal healthcare centers in their communities. The implication of this data is that majority of the pregnant women surveyed (76.1 percent) lived

far away from the locations of maternal healthcare centers in their communities, which may cause huge discomforts to them during antenatal and postnatal periods.



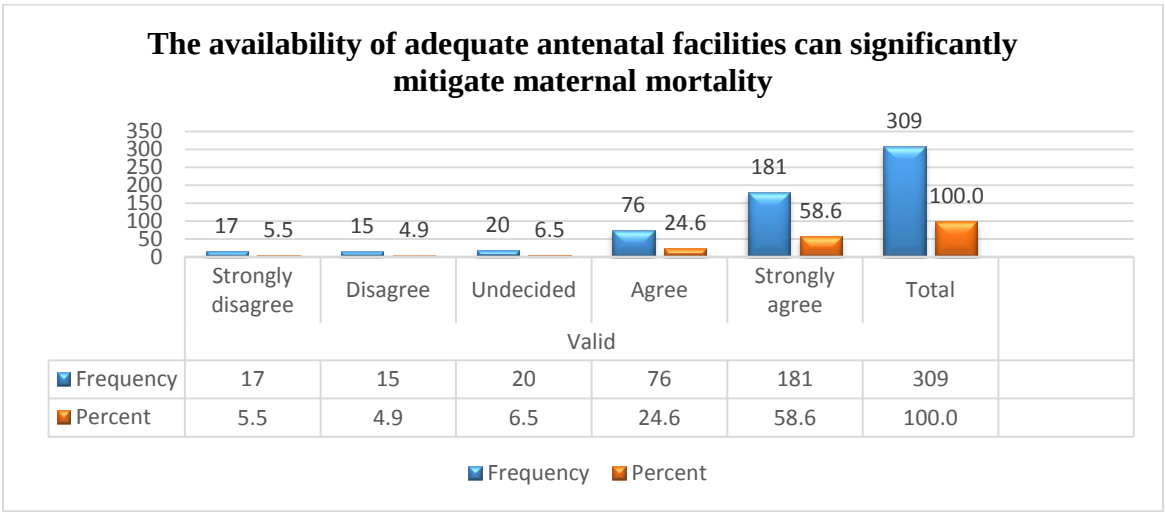
	Valid					
	Strongly disagree	Disagree	Undecided	Agree	Strongly agree	Total
Percent	23.6	58.3	5.5	7.1	5.5	100.0
Frequency	73	180	17	22	17	309

Figure 13: Convenience Status of Maternal Healthcare Centers
Source: Authors' Computation via Microsoft Excel (2022)

The data in figure 13 revealed that out of the 309 respondents surveyed in this study, 17 respondents (representing 5.5 percent) strongly agreed, 22 respondents (representing 7.1 percent) agreed that the location of maternal healthcare centers in their community was convenient, 17 respondents (representing 5.5 percent) remained undecided, 180 respondents (representing 58.3 percent) disagreed, while 73 respondents (representing 23.6 percent) strongly disagreed with the statement. This entails that most of the pregnant women disagreed (58.3 percent) and strongly disagreed (23.6 percent) that the location of maternal healthcare centers in their communities was convenient to them. Hence, it could be implied that the locations of maternal healthcare centers in the study area were far away from pregnant women, and thus caused them inconvenience during antenatal and postnatal periods.

Analysis of Research Questions

Research Question One: Is product element of social marketing a panacea for maternal mortality rate?



Frequency	17	15	20	76	181	309
Percent	5.5	4.9	6.5	24.6	58.6	100.0

Figure 14: Respondents' Responses to Research Question One
Source: Authors' Computation via Microsoft Excel (2022)

Figure 14 above presents data on respondents' responses to research question one regarding the product element of social marketing. The data shows that out of the 309 respondents surveyed, 181 respondents (representing 58.6 percent) strongly agreed, and 76 respondents (representing 24.6 percent) agreed that the availability of adequate antenatal facilities can significantly mitigate maternal mortality. 20 respondents (representing 6.5 percent) remained undecided, 15 respondents (representing

4.9 percent) disagreed, while 17 respondents (representing 5.5 percent) strongly disagreed with the above the above statement. The implication of this data is that the vast majority of the respondents surveyed strongly agreed (58.6 percent) and agreed (24.6 percent) that if adequate antenatal facilities are made available in their communities, the rate of maternal mortality would significantly be mitigated. Therefore, based on the perceptions of the respondents surveyed, this study finds that the product element of social marketing is a significant panacea for mitigating maternal mortality rate.

Research Question Two: Will price element of social marketing assist to improve maternal mortality rate?

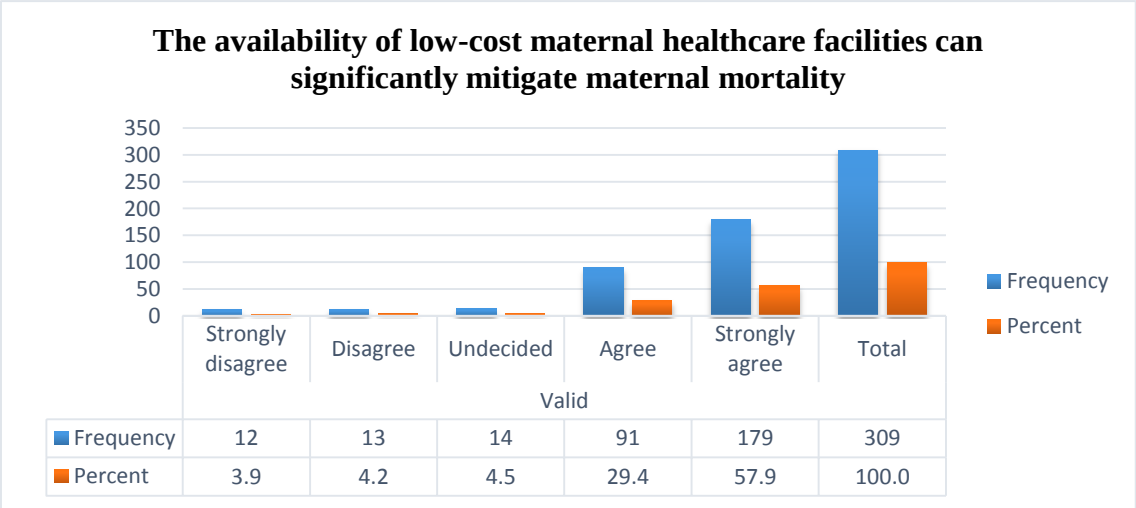


Figure 15: Respondents' Responses to Research Question Two
Source: Authors' Computation via Microsoft Excel (2022)

Figure 15 above presents data on respondents' responses to research question two regarding the price element of social marketing. The data shows that out of the 309 respondents surveyed, 179 respondents (representing 57.9 percent) strongly agreed, and 91 respondents (representing 29.4 percent) agreed that the availability of low-cost maternal healthcare facilities can significantly mitigate maternal mortality. 14 respondents (representing 4.5 percent) remained undecided, 13 respondents (representing 4.2 percent) disagreed, while 12 respondents (representing 3.9 percent) strongly disagreed with the above the above statement. The implication of this data is that the vast majority of the respondents surveyed strongly agreed (57.9 percent) and agreed (29.4 percent) that if more low-cost maternal healthcare facilities are made available to pregnant women in their communities, then the rate of maternal mortality would significantly be mitigated. Therefore, based on the perceptions of the respondents surveyed, this study finds that the price element of social marketing has the capacity to significantly mitigate maternal mortality rate.

Research Question Three: Can maternal mortality rate be reduced through place element of social Marketing?

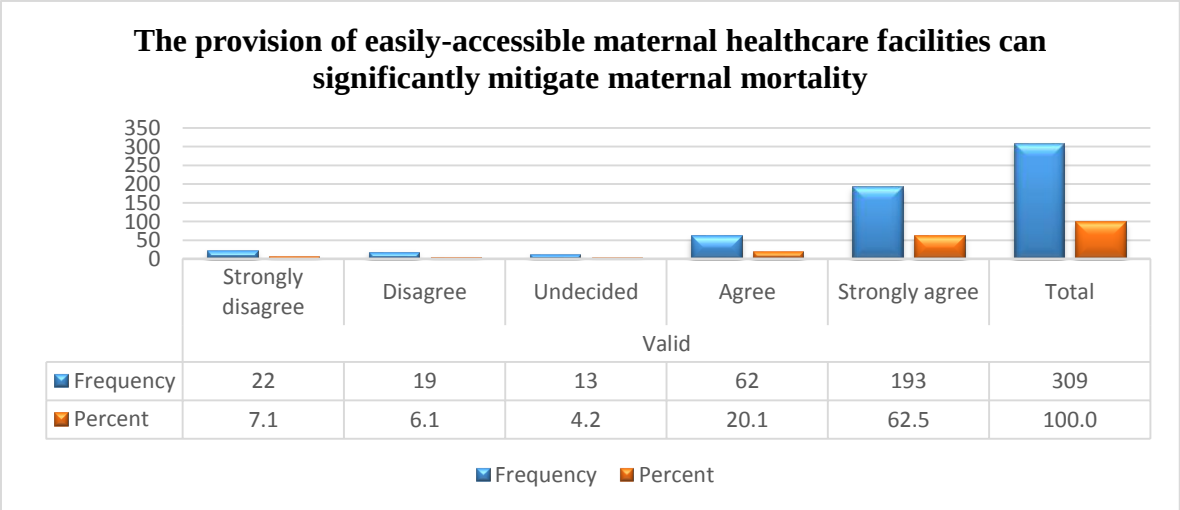


Figure 16: Respondents' Responses to Research Question Three

Source: Authors' Computation via Microsoft Excel (2022)

Figure 16 above presents data on respondents' responses to research question three regarding the place element of social marketing. The data shows that out of the 309 respondents surveyed, 193 respondents (representing 62.5 percent) strongly agreed, and 62 respondents (representing 20.1 percent) agreed that the provision of easily-accessible maternal healthcare facilities can significantly mitigate maternal mortality. 13 respondents (representing 4.2 percent) remained undecided, 19 respondents (representing 6.1 percent) disagreed, while 22 respondents (representing 7.1 percent) strongly disagreed with the above the above statement. The implication of this data is that the vast majority of the respondents surveyed strongly agreed (62.5 percent) and agreed (20.1 percent) that if maternal healthcare facilities can be made more easily-accessible to pregnant women in their communities, then the rate of maternal mortality would significantly be mitigated. Therefore, based on the perceptions of the respondents surveyed, this study finds that the place element of social marketing has the capacity to significantly mitigate maternal mortality rate.

DISCUSSION

After a descriptive analysis of research question one, it was found that the product element of social marketing is a significant panacea for mitigating maternal mortality rate. This entails that the availability of adequate quality (reliable, responsive and empathy) health workers, antenatal and postnatal facilities can significantly mitigate maternal mortality in Nigeria. This is because through these facilities and services, pregnant women would be able to receive the best medical services during pregnancy, at child birth and even after child birth to ensure the survival of both mother and baby. Therefore, this study provides substantive survey-based evidence that confirms that the rate of maternal mortality in Nigeria could sustainably be reduced through the product element (antenatal and postnatal facilities) of social marketing. In tandem with this study, WHO (2012) reports show that improved healthcare services delivery including better training for midwives, improved sanitary conditions and access to skilled care before during and after the birthing process could reduce MMR considerably.

Also, after a descriptive analysis of research question two, it was found that price element of social marketing has the capacity to significantly mitigate maternal mortality rate. This entails that the sacrifice in terms of time, belief, stigma and inconveniences can significantly mitigate maternal mortality in Nigeria. As such, if pregnant women involve in consistent antenatal activities in public and private health care centres, absent of stigmatization towards unplanned pregnant women, then the rate of maternal mortality would significantly be mitigated. Therefore, this study provides substantive survey-based evidence that confirms that the rate of maternal mortality in Nigeria could sustainably be reduced through the price element (sacrifice in terms of time, belief, stigma and inconveniences) of social marketing. In support of this study, high maternal mortality has been explained by some researchers to be caused by a combination of individual level factors such as attending antenatal clinics but choosing to deliver at home, at a church or by a traditional birth attendant (Igberase & Ebeigbe, 2007).

Furthermore, after a descriptive analysis of research question three, it was found that the place element of social marketing has the capacity to significantly mitigate maternal mortality rate in Nigeria. This entails that the provision of easily-accessible maternal healthcare facilities can significantly mitigate maternal mortality in Nigeria. As such, if maternal healthcare facilities can be made more easily-accessible to pregnant women in their communities, then the rate of maternal mortality would significantly be mitigated. This implies that it is essential for maternal healthcare facilities to be located close to the residential locations of pregnant women in Nigeria in order to make sure that they can access antenatal and postnatal services on a timely basis. Therefore, this study provides substantive survey-based evidence that confirms that the rate of maternal mortality in Nigeria could sustainably be reduced through the place element (accessibility of antenatal and postnatal facilities) of social marketing. This findings is in tandem with Ndep (2014) reports that Nigeria's current MMR of 630 per 100,000 live births is indicative that critical aspects of the healthcare delivery system like financial and geographic access to care and good quality healthcare delivery services in Nigeria continue to fail women and children.

Finally, findings shows that greater number of pregnant women preferred home care facilities to public and private facilities for antenatal care. This was as the results of stigmatization, mostly teenage females who were victims of unplanned pregnancies. This have equally resulted to high maternal mortality rate from bleeding, poor quality of reproductive health services, infections, unsafe abortions, hypertensive owing to poor health care services. In support of this study high maternal mortality has been explained by some researchers to be caused by a combination of individual level factors such as attending

antenatal clinics but choosing to deliver at home, at a church or by a traditional birth attendant Igberase & Ebeigbe, 2007). Mojekwu and Ibekwe (2012) reported that unplanned pregnancies result in MMR among women by 40% at home and 20% enroute to hospital.

CONCLUSION

The application of social marketing in public health problem has been looked upon holistically from the point of medical personnel intervention without a corresponding input from the social marketing actors. The package of the product (Antenatal care services) requires a social marketer to better market the service correctly. Medical personnel may not be able to do formative research studies to ascertain what should be required to ensure successful execution of the product. Religious places (Churches and Mosque) are expected to have pregnancy care unit, this will help identify and handle serious issues associated with pregnancy care. This is because religious leaders tend to command high influence on their subjects in many contemporary issues.

The price factor of social marketing had not been incorporated as means of influencing positive behavioural change. These are factors that may make a product to be poorly utilized against the intended benefit of such product, especially in the use of antenatal care services. Stigmatization on the part of early/unplanned pregnancy is discouraged through a serious social marketing campaign programmes. The convenience of accessing treatment have resulted in decreasing use of antenatal in developing nations such as Nigeria. An extensive distribution of primary healthcare/public health care facilities centers especially in rural area will assist handle maternal mortality issues. Social marketing communication campaign in various media will help to correct the perception on the ills of using traditional birth attendance (TBA) and inform the society about the need for public and private antenatal care. Consequently, the following recommendations are made;

1. The package of the product, antenatal care should be reexamined through research on both the service providers and the target audience in order to identify gaps especially on the consistency of treatment, review of their knowledge on what is taught at antenatal and their understanding on the part of the target audience.
2. Social marketing communication campaign should be extensively used throughout various media to correct pregnant women perception on the ills of using Traditional Birth Attendance (home care facilities) and inform them about the need for hospital antenatal care.
3. Stigmatization on the part of early/unplanned pregnancy should be discouraged through a serious campaign programmes. This will encourage most unplanned pregnant mothers to visit public or private healthcare facilities instead of home care facilities.
4. Churches and Mosques should be educated to have pregnancy care unit, this will help identify and handle serious issues associated with pregnancy care. This is because religious leaders tend to command high influence on their subjects in many contemporary issues.
5. There should be extensive distribution of primary healthcare/public health care facilities centers with responsibility to handle maternal mortality programme.

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