Challenges of Women Access to Maternal Health Services in Nigeria: Implications for Community Development

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ABSTRACT
The paper examined the challenges of women access to maternal health services in Nigeria: implications for community development. Maternal health refers to the health of women during pregnancy, childbirth, and the postpartum period. It encompasses the health care dimensions of family planning, preconception, prenatal, and postnatal care in order to reduce maternal morbidity and mortality. The paper explained the concept of maternal mortality and also highlighted it causes. The challenges of women in accessing the maternal health care services were also discussed which include amongst others inadequate number of trained health care personnel, decision to seek for medical care, lack of education and distance of the health facility. However, implications for community development were discussed which include based on the challenges identified recommendations were given; to sensitize the community on the need for advocacy and lobby to the authorities for more trained and qualified health personnel, mobilize community members on the need to allow women to attend health facility for any emergency or need arises, to create awareness on the need to have community volunteers who will transport women on emergency to the nearest health facility.

Keywords: women, maternal health, community development, family planning

INTRODUCTION
Maternal health refers to the health of women during pregnancy, childbirth, and the postpartum period. It encompasses the health care dimensions of family planning, preconception, prenatal, and postnatal care in order to reduce maternal morbidity and mortality (WHO, 2012). Motherhood is a thing cherished by most women; yet this valued and precious part of life is among the most hazardous experience that women often engage in without being aware of the risk or danger they are in (UNPFA, 2008). Pregnancy and childbirth complications are leading causes of death and disability among women of reproductive age, especially in developing countries. In 2008, an estimated 358,000 women died due to complications developed during pregnancy and childbirth (WHO, 2010). One out of every 31 women dies during pregnancy or childbirth in sub-Saharan Africa, compared with just one in 4,200 in Europe (WHO, 2010).
For every woman who dies, at least 20 more suffer injury, infection or disability from maternal causes; approximately seven million women every year (WHO, 2005).

Maternal and Child mortality is not an uncommon event in several parts of the developing world. Mothers and children are at the highest risk for disease and death. While motherhood is often a positive and fulfilling experience, for too many women, it is associated with ill-health and even death (Olatoye, 2009). The death of a woman during pregnancy, labour or pueperium is a tragedy that carries a huge burden of grief and pain, and has been described as a major public health problem in developing countries.

Majority of Nigerian people, especially women, are poor and very vulnerable to illness, disability and even death due to lack of access to comprehensive health services, especially maternal health services. These women need quality maternal health services such as medical care, planned family, safe pregnancy, delivery care and treatment and prevention of sexually transmitted infections, such as HIV/AIDS (SOGON, n.d.). With accessibility to comprehensive health services, women are less likely to die in pregnancy, more likely to have healthier children and better able to balance their family and work life.

Nigeria is the most populous Black Country in Africa with 140 million people including 75 million children (Ogbonaya and Aminu, 2009). The child and maternal mortality rate of this country is very significant and has implications for the attainment of the MDGs. It has been noted that Nigeria is lagging behind in achieving universal coverage of key maternal and child health intervention and will unlikely meet the target of the MDGs. According to UNICEF Executive Director, Ann Veneman, “midway to 2015 deadline for MDGs, Nigeria continues to record unacceptably high maternal, newborn and child mortality”. Nigeria ranks as one of the 13 countries in the world with the highest maternal mortality rate and is still not listed among the 10 countries seen to have made rapid progress to meet the goals. Without healthy mothers, you cannot have healthy children.

High-quality accessible health care has made maternal death a rare event in developed countries, where only 1% of maternal deaths occur; these complications are often fatal in developing world (WHO, 2012). It is projected that providing skilled health care workers at delivery and emergency obstetrics care could save nearly three-fourths of mothers’ lives. Yet each year, 50 million women give birth in their homes without any professional help (Save the Children, 2010). Previous reviews have assessed the health effects of planned hospital birth compared to planned home birth in low-risk women (Olsen, & Clausen, 2012).

However, despite these efforts, Nigeria continues to have one of the highest rates of maternal mortality ratios in the world (1,100 maternal deaths per 100,000 live births) justifying the need for more research to determine the best approach to resolve the problem (WHO/ UNICEF, 1990).

What is Maternal Mortality?

Maternal Mortality is the death of a woman while pregnant or within 42 days of termination of a pregnancy, irrespective of the duration or site of the pregnancy, from any cause related to, or aggravated by the pregnancy or its management, but not from accidental causes. Maternal Mortality has been and still continues to be a public health problem particularly in developing countries. It is made more tragic because women die in the process of performing this essential physiological function of childbearing, and in efforts to fulfill their natural role of perpetrating the human race (Chukudebelu, 2003).

Maternal Mortality constitutes one of the major indices for assessing the development of any nation. With the commencement of the Safe Motherhood Initiative in Nairobi 1987, most nations have tried to devise strategies and policies for reducing maternal mortality. Therefore, this study examines the challenges of women access to health services in Nigeria: implications for Community Development.

Causes of Maternal and Child Mortality

There are a lot of causes of maternal and child mortality. Saraki (2008) observes that child and maternal mortality have many triggers, both direct and indirect. Poorly funded and culturally inappropriate health and nutrition services, food insecurity, inaccurate feeding practices and lack of hygiene are direct causes of mortality in both children and mothers. The indirect causes may be less obvious externally, but play just as large a role in mortality statistics. Female illiteracy adversely affects maternal and child survival
rates and is also linked to early pregnancy. In many countries, especially where child marriage is prevalent, the lack of primary education and lack of access to healthcare contribute significantly to child and maternal mortality statistics. It also notes that discrimination and exclusion of access to health and nutrition services due to poverty, geographic and political marginalization are factors in mortality rates as well (Saraki, 2008).

The challenges of women access to maternal health services in Nigeria

The following are some of the challenges facing women in accessing maternal health care services in Nigeria:

1. Inadequate number of trained health personnel:
   In the past years Nigeria has invested in the training and re-training of doctors, nurses and midwives to meet the needs of the population. Despite this positive trend, the doctor-population ratio is still one to 6000; a far cry from the WHO recommended one doctor to 650 people. The doctor-population ratio is even worse in 24 of the 44 nations in sub-Saharan African where there is an estimated 10 doctors for 100,000 people (Weeks cited in Ndep, 2014). These nations also have the following in common: high fertility rates, low GDPs and high MMR. It has been argued that the higher a nation’s GDP, the more quality healthcare is made available and better access to this higher quality healthcare by a larger proportion of the citizenry is achieved. It is also the same when compared with the ratios of the other health workers needed. There are virtually dearth’s of qualified health personnel especially in the rural areas which make deliveries very worrisome and also the attitude of the health workers is very bad to the patients. A lot of women felt disenfranchised by the attitude of the health workers towards them and prepared to deliver at home than to go to the health facility.

2. Decision to seek for medical care:
   Decisions to seek maternal health care is very complex and distressing and a lot of women had to die because decisions had not been taken whether she should go or not. The amounts of time, money, information and authority for decision making women have at their disposal are very essential for their well being (Sundari, 1992). Decisions to seek medical care are often made not by a woman on her own, but by her husband, or his family (e.g. mothers-in law, senior sister amongst others) and as well as community members. However, many women and families may already be aware of the danger signs of obstetric complications, and cannot not seek for medical care automatically until permission is granted. Reasons for this can be to do with community perceptions of poor quality of care as well as costs. Women’s autonomy in deciding to seek care can be hampered by their economic dependence and the prohibitive costs of emergency intervention. If the community is asked for help, community leaders may make a decision which overrides the husband’s wishes. Women’s autonomy can differ according to their age and seniority within the family. For example, pregnant teenagers may be dependent on the decisions of older members of the extended family for economic reasons (Prevention of Maternal Mortality Network, 1992). And where this happens she has no right to take decision on her own concerning accessing maternal health care services, thus this has further prevented pregnant women in accessing maternal health services.

3. Lack of education
   Widespread ignorance as a result of lack of basic education as well as the result of low level awareness and poor knowledge level in relation to maternal health. Many believed it is only lazy that will give birth in a health facility. Education is a distant factor which offers the possibility of affecting the magnitude of maternal mortality in a number of different ways. As a result of lack of education many women do not know what are the danger signs and effect of prolonged labour therefore they stay in their houses without seeking medical care. Women’s social status, self image and decision making powers may all be increased through education, which may be a key in reducing their risk of maternal death, resulting from early marriage and pregnancy or lack of information about health services. Family pressure often forces pregnant teenagers to drop out of school. Adolescents may seek unskilled abortions in order to avoid expulsion from school on the grounds of pregnancy (Correa, 1994). Some schools in Africa and Asia expel pregnant teenagers as a matter of policy. A study in Nigeria showed that 52 percent of pregnant adolescents were expelled from school (Isis International, 1992). Educated women may have more
understanding of the physiology of reproduction and be less disposed to accept the complications and risks of pregnancy as inevitable, than illiterate or uneducated women. Education has been described as a medication against fatalism. (Royston 1989). Educated women may also be less likely to accept dangerous practices aimed at alleviating complications in pregnancy. Amongst the Hausa people of Nigeria, for example, girishi cuts are a traditional surgical operation to treat obstructed labour by cutting the vagina with an unsterilized blade. Whilst it is commonly performed on uneducated women, educated women rarely accept the practice (Royston, 1989). Uneducated women are less likely to seek the help of professional health services because they are probably less aware of what is available, and probably find the culture of health services more alienating and frightening. Areas with low female literacy rates are also often areas where the fewest births are attended by trained personnel (Royston, 1989).

4. **Accessibility of the Health Facility**

Distance and transport issues in rural areas are a highly significant factor affecting women’s access to maternal health services, especially emergency care. Even if women do attempt to get to hospital for treatment, they may arrive too late for their lives to be saved because of poor roads and a lack of adequate transportation. Delays may also occur in referral from one health facility to another. A woman in a remote rural area must leave her family behind, and have a large amount of money to spend on transport if she is to reach a hospital which can deal with obstetric complications. If she is accompanied by a friend or relative, this person must also find the time and resources to stay near the hospital during the time of treatment. If she dies in hospital or on route, then transporting the body back home is both difficult and expensive. If she is accompanied by a friend or relative, this person must also find the time and resources to stay near the hospital during the time of treatment. It may also be distressing to die far away from family and friends (Sundari, 1992). Furthermore, it was revealed that in most rural communities, roads are inaccessible and transportation systems are chaotic (Ibekwe, 2010). Thus, when a person takes a decision to seek medical attention, it may take days to reach healthcare facility. This is clearly the situation in rural Nigeria; where access to maternal healthcare services means to travel a long distance from the rural place to urban area through bad roads. This is one of the major factors that deter women from accessing maternal healthcare services because after such long journey, one may even develop health problems due to stress.

5. **Poverty**

Direct costs associated with maternal health care services are very high for many who viewed themselves as too poor to deliver in a facility (Ajaebu, 2013). Considering the poverty level in the country many cannot afford to pay their medical bills as such they prefer to stay at home and look for the services of traditional birth attendants who charge less or in some cases is even free of charge. Low-resource households may have trouble acquiring funds to pay for facility-based care at the time-of-service, particularly those families who rely on seasonal labor. Collecting necessary funds were a difficult task as few moneylenders lent to the poor, and if they did, exorbitant interest rates could make the principle escalate rapidly (Ajaebu, 2013). Family members were often sent around the community to collect money from their neighbors (Afsana, 2004). Women viewed costs outside of the direct for a delivery as “hidden” and said they were difficult to prepare for even in settings where direct delivery costs were subsidized, families were expected to pay for transportation to the facility, and other costs related to treatment at the facility. Woman’s chances of dying a maternal death by working through the intermediate factors. Mortality is almost always higher among the poor and disadvantaged than among the wealthy, and this is also true of maternal mortality (Oxaal & Baden, 1996). Some women may have no or limited cash available in times of emergency unless they are given it by their husbands. This can cause delays in seeking care. If the husband lacks funds, he may ask for contributions from other relatives or the community.

6. **Traditional Influences**

Traditional influences including local understandings of disease etiology and externally-focused loci of control play complex but important roles in understanding decision making on location of delivery (Moyer, Adongo, Aborigo, Hodgson, Engmann, & Devries, 2013). Care-seeking may be delayed in situations where certain health problems are viewed as spiritual in nature rather than physical, such as
 eclamptic seizures (Magoma, Requejo, Campbell, Cousens, & Filippi, 2010). Despite the role of tradition in delivery practices, several women preferred to home birth as “old time” and desired the modernity of facility-based delivery (Afsana & Rashid, 2001). In several contexts, women preferred to deliver at home, where they were in a familiar and convenient setting. During a homebirth, a woman would not need to arrange for child care or transportation, could rest in her own bed after delivery, and be catered to by her family and friends. The perception that birth is a natural life event rather than a medical procedure emerged as a common belief amongst many women therefore they saw no rationale for delivering at a facility, and paying to do so is considered illogical and superfluous.

7. Traditional Birth Attendants
TBAs played an important role as first-line providers for many women. Women emphasized the close bond that they felt with TBAs, due to their status in the community and the trust they developed over years of experience. This relationship often prompted women to desire home-based births attended to by a TBA rather than a facility. Women perceived TBAs as providing high quality delivery care, often emphasizing the supportive and emotional role that TBAs play. A lot of women believed that TBAs have innate skills gifted to them from God and are more dependable providers than facility-based health workers.

Implications for Community Development
These challenges have implications for community development. One of the key assumptions of Community Development is the emphasis on the people as the rallying point for community development in the following ways:

This will give room for the communities to identify their needs and proffer solutions in the following ways
a. Sponsoring of females members of the community to go and read health related courses that will help in solving the problems.

b. Mobilization for support at the grassroots level by all and sundry to give maximum support towards solving the menace.

b. It promotes sustainable and participatory development and it is a participatory planning which involves communities in decision making process.

c. It can make people to come together towards the community development process.

d. People will believe that the challenges are their own and chart for way out.

RECOMMENDATIONS
Based on the above challenges the following recommendations are made:

1. Community members should advocate and lobby to the authorities concerned on how to provide more and trained health personnel in their respective health facility.

2. Awareness campaign should be intensified to those who are responsible be it husbands or their parents for taken decision so as to allow them to be attending maternal health care during emergency or otherwise. All stakeholders should be educated on the importance of given standing permission for their wives or who ever they may be on going to the health facility when ever the need arises.

3. Community members should be enlightened on the knowledge of maternal danger signs so that when ever there is an emergency they should be rushed to the nearest health facility.

4. Community should as a matter of urgency creates an enabling environment where by people should volunteer as transporters to convey women on emergency for the necessary care.

5. Community members should establish a maternal savings where by members of the community should be donating either weekly to help members who are in the need for emergency obstetric care, it can either be a loan or assistance depending on the person in need of the assistance.

6. Community members should establish a mechanism for advocacy to the authorities for the provision of necessary health care facilities in their domain.

7. Public enlightenment should be vigorously pursued so that people should eschew bad practices on maternal health.
CONCLUSION
This paper demonstrates the challenges of women access to maternal health care services in Nigeria is influenced by some many factors. Factors identified in this review that influenced the use of maternal health care services by Nigerian women are: inadequate number of trained health personnel, decision to seek for medical care, lack of education, poverty, distance of the health facility, traditional and cultural influences amongst others. However, recommendations were given as to intensify efforts on advocacy and lobbying in order to get trained health personnel and also mobilize community members on the importance of allowing their wives to be attending health facility as the needs arises and also to get volunteers who will transport women during emergency to the health facility.

REFERENCES
Zed Books
Isis International, (1992), Teenage Pregnancy in the South, Quezon City, Isis International


