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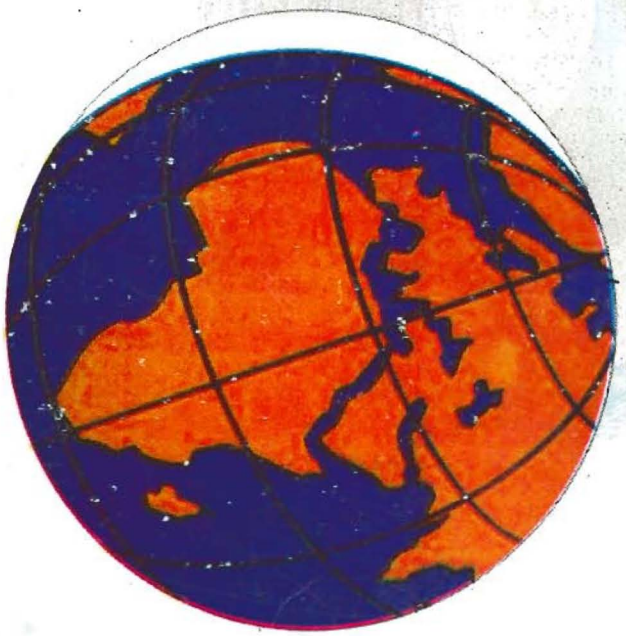

LACK OF PROMPT AND ADEQUATE MEDICAL ATTENTION: BARRIER TO MATERNAL HEALTH IN NIGERIA

IDOWU ADENIKE ESTHER
Department of Sociology
Covenant University, Ota
idowu_adenike@yahoo.com
08060234696

Abstract
Reduction in maternal mortality has been identified as a prominent component of MDGs. For any effort to be effective it requires the compliance of the main stake holders. How prompt and adequate response to health during pregnancy is required for early detection and prevention of complications during pregnancy. This paper examines how women see pregnancy related health challenges and how timely their reactions to it. The study from which the paper is derived was carried out to comprehend and clarify among other objectives, how prompt and adequate is mothers' health seeking behaviour. Data was generated by questionnaire and in-depth interviews while analysis was made by simple percentage and content analysis respectively. The findings were discussed and recommendations were given at the end of the paper.
Key words: *Pregnancy, maternal mortality, MDG, Health, Adequate.*

Introduction

Pregnancy and the period of lactation of the newborn by mothers is a difficult period for most women in their lifetime. The mother's body goes through a lot of psychological, anatomical and physiological metamorphosis that need to be handled properly in order to reduce the morbidity, mortality rates of most maternal health problems (Hunter, 1994). This has been very difficult to achieve in most of Sub-Saharan Africa, mostly because of lack of adequate care. According to WHO (2008), every year, many women suffer pregnancy-related complications that lead to death. High risk of death are secondary to such complications as obstructed labor, ruptured uterus, postpartum hemorrhage, postpartum infection, hypertensive disease of pregnancy, and complications stemming from unsafe abortion (Mavalanka and Rosenfield 2005), are associated with pregnancy. The same factors that cause maternal mortality and morbidity, including complications and associated poor management of pregnancy and childbirth, contribute to an estimated 8 million stillbirths and new born deaths each year (UNFPA, 2000).

Although maternal mortality has declined dramatically in the developed world, the risk of such death remains a serious threat for women in Nigeria. Truly, every minute a day, somewhere in the world, a woman dies due to complication arising from pregnancy and child birth, almost all of these deaths occur in developing countries. In Nigeria, 150 of such women die daily; it is the leading cause of death among women of reproductive age (Idris, 2010). According to the estimates from the World Health Organisation, published in 2007, Nigeria's maternal mortality rate is the second highest in the world, after India with about 1,100 maternal deaths per 100,000 live births. The country is home to two percent of the global population, but 10 percent of all maternal deaths take place in the country (Abdul'Aziz, 2008).

A large number of these deaths could be avoided if women had access to timely, appropriate and adequate care. However, providing free maternal and infant care alone will not solve the problem, but the need for adequate and prompt medical attention. This situation is particularly tragic because no new technologies or drugs are needed to radically lessen maternal mortality.

Rather, it is believed that widespread access to emergency obstetric care (EmOC), and more to community-based and hospital maternity care services, would lead to dramatic reductions in these unacceptably high ratios (Ufford and Menkiti 2001, Mavalanka, and Rosenfield, 2005).

Every pregnant woman is assumed at risk of complications and the problem that mostly result into complications during pregnancy does not start in a day. It is as a result of constellation of many precautions that ought to have been in place before and during pregnancy. Availability of health care service is only one component of care and support necessary throughout pregnancy. There are lots of personal effort and preventive choices that need to be in place to ensure healthy pregnancy and to prevent maternal mortality.

Women have a right to health, but protecting that right often depends on their response to health issues. According to UNFPA (2007) the target of reducing maternal deaths by 75 per cent by 2015 will not be met without the concerted efforts of all involved. Women who are the main focus in maternal health must be conscious of their health. Adequate and prompt medical attention is critical to the reduction in maternal mortality. With regard to the issue of provision of health care, too little attention has been paid to assessing how prompt the pregnant women seek care can influence early detection and prevention of complication during pregnancy. This paper examines how women see pregnancy related health challenges and how timely their reactions to it.

Area of study

This study was carried out in Badagry Local Government area of Lagos State, in October, 2008. Badagry is an emerging city, in which will be appropriate to study maternal welfare. The approved population of Badagry Local Government is 1.8 million, 121,232 male and 119,861 female and (Badagry, 2006; National Bureau of Statistic, 2006). Lagos State is one of the 36 States that make up the Federal Republic of Nigeria. Although small in size, it has the second largest population currently estimated at more than 9 million (Population Census, 2006). The State's population growth rate is put at 300,000 per annum, and its population density at 1,308 persons per square kilometer, making it the most densely populated state in the country.

Methods of the Study

The targeted population for this study was women of reproductive age from 15-49 years, that have given birth in the last two years and presently in pregnancy in Badagry. Existing information shows that there is one main constituency in Badagry Local Government Area of Lagos State divided into ten (10) wards. By design, three hundred and fifty (350) women of reproductive age of 15 to 49 years were selected as respondents, to represent seventy (70) women in each of the 5 selected wards in the Local Government. These comprised both educated and non literate women, who were married or unmarried and have ever given birth in the last two years and those that are pregnant.

From the targeted population, the unit of sample of study was a household where multi-stage sampling technique was used to select sample for the study. The first stage was to divide the Local Government into wards. The second stage was to pick five (5) wards out of ten (10), and the third stage was to divide the wards into streets and the fourth stage was to divide the streets into houses.

The systematic sampling technique was used in selection of the houses involved. And for every house accidental sampling was used i.e. choosing only those who are available and also meet the purposes of the study. Where there is no house hold that fits the description of the respondent,

the next unit was chosen and added at the end. Also, any household where there was more than one woman of specified age; random sampling was used to select the respondent. Also, respondents for in-depth interview were selected systematical within each selected wards, four (4) from each wards.

Data collection for this study involved both primary and secondary sources. The primary data was obtained through survey method and In-depth Interview. Therefore, the instrument for the collection of this data was the use of structured questionnaire which was administered at the first stage of the research work. The secondary source of data for this study, include the review of books, journals, magazines, reports from libraries, internet, dailies etc. These provided necessary information pertaining to the background and the extent of related studies.

Data management and Analysis

The quantitative data gathered was analyzed for theme and relationship using appropriate soft ware. First, characteristics of the study sample were described, and then frequency distributions were used to highlight the socio-demographic status of participants. Secondly, simple percentage was used to detect statistically significant proportions of people in relation to the variables, to achieve the objective of the study. This entails an examination of the patterns of association between the dependent and some selected independent variables. The analyses were done on the basis of the theoretical model (the Anderson and Newman model). The tape and notes from the In-depth Interview were analyzed with the use of content analysis. After discussions conducted in the local language had been translated and transcribed, common responses within and between groups were identified for each topic included in the interview guide. In addition, divergent responses were identified to determine the range of beliefs, opinions, knowledge, attitude and behaviours among participants. Responses to each topic were summarized and important quotations are reported verbatim to highlight common individual views.

Result

Socio-demographic Characteristics of Respondents

This table presents the data on age, marital status, educational qualification, and religion of the respondents. As shown in table 1 below, 47% of the respondents were not educated beyond junior secondary school, which has a significant consequence on the occupation and the level of income. The dominant religion was Christianity, with only 28.3% and 2.3% of the respondents representing the Islamic and Traditional religions respectively. This is not surprising because the people of Badagry have been known with their indigenous religion which is usually characterized by the worship of the supreme God but serviced by numerous divinities called Vodun, and ancestors, even though they still claim to be either Christians or Moslems and see Vodun as traditional, which Asiwaju and Owonikin (1994), Simpson, (2001).

Table 1: Socio-demographic characteristics of respondents

Variables	Frequency	%
Current Age		
15-19	24	6.9
20-24	44	12.6
25-29	132	37.7
30-34	85	24.3
35-39	37	10.6
40-44	15	4.3
45-49	13	3.7
Total	350	100

Marital Status		
Single	9	2.6
Married	330	94.3
Divorced	6	1.7
Widowed	5	1.4
Total	350	100
Educational Qualification		
No Formal Education	55	15.7
Primary	90	25.7
Junior Secondary	22	6.3
Senior Secondary School	95	27.1
Tertiary	88	25.1
Total		
Religion		
Christianity	243	64.9
Islam	99	28.3
Traditional	8	2.3
Total	350	100
Occupation		
Petty Trading	180	51.4
Farming	31	8.9
Civil Servant	56	16
House Wife	30	8.6
Artisan	53	15.1
Total	350	100

Socio-demographic characteristics of respondents' cont.

Income		
Below 10,000	99	28.3
10,000-15,000	145	41.4
16,000- 20,000	66	18.9
Above 20,000	40	11.4
Total	350	100
Spouse Educational Qualification		
No Formal Schooling	23	9.4
Primary	26	7.4
Junior Secondary School	50	14.3
Senior Secondary School	100	28.6
Tertiary Education	141	40.3
Total	350	100

Source: Field Survey, October, 2008.

Many ailments exist among women but will never receive attention from the medical profession, for one reason or the other. To examine the response to any health challenge during pregnancy, the respondents were asked whether they experience any health challenge during pregnancy and where they go for treatment.

Table 2. Distribution of responses to health challenge when Pregnant

Respondents	Frequency	%
Yes	60	17.1
No	119	34.0
Normal	171	48.9
Total	350	100.0

Source: Field Survey, October, 2008.

Table 3: Cross Tabulation of the Challenges and where they receive treatment

	Where they Receive Treatment				
Health Challenge	Health center	Traditional BA	Mission Home	Home/friends	Total
Yes	42	6	5	2	55
No	0	0	6	0	6
Normal	57	9	8	97	171
Total	99	15	19	99	232

Source: Field Survey, October, 2008.

The table above shows that 42 respondent who said yes to health challenges during pregnancy received treatment from the health center, comprising 6 from TBA, 5 from mission home and the remaining 2 stay at home. Only 57 out of 171 who claimed that the health challenge is normal to pregnancy received treatment from the health center, 9 and 8 received treatments from TBA and mission home respectively, while 97 stayed at home and relied on local herbs.

Discussion

The analysis in this section reveals women's patterns of response to health challenges when they are pregnant. The data presented shows that majority of the women believe that, maternal challenges are normal during pregnancy and as such are not so disposed to proper and adequate antenatal care. The fact that they see every health challenge as normal to pregnancy will not allow them to seek appropriate medical attention. One respondent I tagged noted that,

> *"no woman will feel the same way they feel when they were not pregnant, some time I feel dizzy, it is normal to experience it and immediately I take my dose of herbs I will be Ok".*

Another respondent recalled her experience this way:

> *I had miscarriage once; people said it was because of worm. It happened in the house. I used herbal concoction to see if it will stop, but it increased and I now went to the hospital".*

While some rely on professional help from health centers, majority prefer to stay at home, perhaps to rely on herbs. In an attempt to understand why, it has been observed that the level of assistance that their spouses give in terms of finance for adequate antenatal care is largely dependent on their levels of income. For others the proximity to the antenatal centres is vital

considerations. This also largely depends on the level of education of the woman. A woman with National Diploma (ND) said,

> *I don't have to stress my self. No pregnant woman must do self medication, only what doctor says.*

According to the health seeking behaviour model, the predisposing factors reflect the fact that there is uniqueness of predisposition to health care utilization within household. At the same time, the enabling factors reveal that even when there is predisposition to utilization of health service there must be means of achieving it. In Andersen and Newman, the need factor is the most immediate cause of health service use (Andersen and Newman, 1973). The need factor reflects the perceived health status, as indicated by severity of the morbidity conditions or the number of morbidities. The existence of predisposing and enabling apparatus may not be enough for a mother to seek health care. She must also perceive the disease as serious and believe that the treatment will provide the expected benefits.

Recommendations

In this regard, the role of men regarding knowledge and importance of antenatal care should be encouraged and they should support their pregnant spouses for antenatal care with finances as much as possible.

Also, the immediate community can be encouraged to increase the level of enlightenment for women and their spouses especially on the importance of adequate and proper care during pregnancy.

Furthermore, favorable government policies can engender subsidized antenatal service delivery to women during maternity, also creation of close health post where referral can easily be made. Government and Non-Governmental Organizations should expand their services in creating knowledge and awareness of the fact that not all pregnancy related illnesses are normal. Women must go for check up and if the physician adjudge them to be in good condition then, they are ok.

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