

Mass Media and Maternal Healthcare: A Critical Discourse

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Abstract

The mass media have a role to play in raising awareness about issues and calling attention to whatever threatens our well-being. Maternal and child health, the focus of this critical study, is one of such issues to which the mass media must call the attention of all – government, men, women, children and all other stakeholders. As the fifth of the eight Millennium Development Goals (MDGs) of the United Nations (UN), maternal health is thus a key development issue because matters relating to wellness are central to human development; the quality of a country's healthcare system impinges on the level of social conditions available to citizens, and determines its rating on the global human development index. Exploring health, healthcare, maternal health, this critical study, which drew from global and local statistics on the success achieved in curbing maternal mortality rate (MMR) globally, found that the extent to which the mass media have been reporting women and children's health in Nigeria and other countries is not yet desirable. Therefore, in order to set the necessary agenda for maternal health, the study recommends that mass media organisations, health agencies and institutions as well as media educators collaborate to devise strategies on how best they can equip journalists with specialized knowledge and skills to enable them write articles on health problems based on their expertise on such issues.

Keywords: mass media, health, maternal health

1. Introduction

The mass media in any society within which they function play roles that are germane to the development of that society, and of the members within the society, thus creating a social ecosystem that in turn impinges on the operations of the mass media. Mass media, as the phrase implies, are mass-based pathways to reaching a mass audience that comprises people of varying backgrounds, who need the media to keep up with the pace of events around them. There is an 'umbilical cord' relationship between the mass media and society. Scholars interested in media-enhanced socio-economic development (Schramm, 1964; Mowlana, 2000; and Oso, 2012) agree that there is a causal relationship between the mass media (radio, television, newspapers and magazines as well as other associated platforms for mass-based engagements and interactions) and the society. Stressing the role of information, and thus communication, in the process of social change Mowlana (2000) notes:

“...the role of the press as an organiser, agitator...was recognised...attention was given to the role of the press in urban development and the role of the radio in agricultural and rural extension services (p. 20).

Lasswell's (1960) functionalist perspective of thinking about the mass media has to do with the roles that they ought to play in society. Lasswell assigned to the mass media three roles for the society within which they function: surveillance, correlation, and transmission of cultural heritage from one generation to the next. Surveillance as the first function of the mass media refers to how the mass media look out for both threats and opportunities in society. The second function implies how the mass media correlate the different elements of society, allowing its segments work together. Transmission of cultural heritage from one generation to the next is the third. In addition to Lasswell's three, Wright (1960), cited in Hanson (2005), handed the mass media a fourth function – entertainment. For the purpose of this study, the surveillance function becomes quite useful. Hanson (2005) emphasises that much of what we know we learn from the mass media through the process of surveillance, by which the mass media inform us about what happens not only around us but also in other societies. Surveillance is necessary because our only other sources of knowledge about the world we live in are our experiences and the direct experiences that others share with us.

2. Why Health Matters

Good health should be the business of all (the government, social institutions as well as individuals) in every country of the world, whose members' productive, reproductive usefulness and responsibilities to themselves and to those who look up to them for social support, are dependent on wellness. The organisation overseeing the health of the world, World Health Organisation (WHO)'s definition broadens the definition of health to mean a state of complete physical, mental, and social well-being and not merely the absence of illness in humans.

Therefore, good health is an individual's mental, physical and social well-being, a state that completely ensures that an individual functions as optimally as possible, and is a necessary condition for self-actualisation. This is especially so in communally oriented societies of Asia and Sub-Saharan Africa, like Nigeria, where extended family ties ensure what Baran and Davies (2012) refer to as organic solidarity, their way of describing cohesive social relations in agrarian societies, as distinct from those individualistic ones of the West.

2.1 Healthcare and Humanity

Healthcare, in simple terms, can mean caring about health, whose goal is to achieve an acceptable general level of wellness that enhances productive, normal life for those concerned, for instance pregnant women and their unborn babies. In Nigeria, the provision of healthcare is on the concurrent legislative list, meaning that both the central and state governments can care for the well-being of citizens by providing such healthcare delivery infrastructure as hospitals, medical equipment, support personnel, medical consumables that are necessary in addressing the medical needs of citizens. There are a number of ways of thinking through what healthcare entails. The American Heritage Medical Dictionary (2008) says healthcare is the prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions. It also refers to the maintaining and restoration of health by the treatment and prevention of disease, especially by trained and licensed medical professionals (Merriam Webster's Online Dictionary, 2014). Healthcare encompasses the preventive and the curative, as provided by experts in the medical field and allied professionals. The provision of healthcare is at three levels: primary healthcare, secondary healthcare and tertiary healthcare. It can be a form of public service to citizens at subsidised rates through the public health system; self-funded trained and licensed private professionals in the private healthcare industry can also provide it, usually at higher rates than what the government may charge.

2.2 Primary, Secondary and Tertiary Levels of Healthcare

According to WHO (2014), primary healthcare is essential healthcare that is affordable, universally accessible to all in the community and fully participatory, and whose goal is better health for all. In Nigeria, primary healthcare (PHC) is usually available at community-based healthcare facilities, such as primary healthcare centres. Primary healthcare centres are the closest and the nearest to the people, and serve as a first point of contact for medical consultation by members in the communities they are located. At this level, primary care providers (PCPs), who may be doctors, nurses, community/public health experts, attend to some basic health needs relating to high blood pressure, vaccination, immunisation, hypertension, as well as maternal and child health-related services like family planning. It is part of an inclusive healthcare support plan of governments globally. The primary care providers refer patients to this care provider.

Secondary healthcare comprises healthcare services provided by medical professionals who do not have first contact with patients. It is the care given by someone, who has more expertise than the consultant working at the primary healthcare centre does. It is a mid-level sort of healthcare that emphasises specialisation; for instance, cardiologists are heart specialists; oncologists are cancer treatment specialists, while gynaecologists handle the health needs of women (Torrey, 2014). Medical expertise defines the care given at this level. In Nigeria, general hospitals fall under this level.

Tertiary healthcare involves an even higher level of specialty care, and requires highly specialised medical equipment and support such as plastic surgeries, vaginal reconstruction, renal dialysis, surgery to separate conjoined twins, chemotherapy, and other complex health needs. In Nigeria, teaching hospitals are at this level (Torrey, 2014).

3. Maternity: a Biological Necessity

Since nature leaves no room for vacuum, continuity and growth of the human population depends on the ability of humans to 'create' new lives. The size of human population is a reflection of the number of persons belonging in it; that is, males and females. Hence, for humanity to survive, it is pertinent that the mature ones among the males and females biologically parent offspring that will in turn multiply. This way, the human population grows and expands. Adults with fully developed sexual reproductive cells called gametes are the means to that human population growth. The biological process of reproduction begins with the man, continues and completes in the woman, or the mother. The journey to becoming a mother begins when a man and a woman have sexual intercourse, during which millions of 'fast-swimming' spermatozoa leave the male's testicles and head for the fertile eggs (ovaries) of the woman. Only one of the sperms fertilises the waiting eggs of the woman.

Fertilisation eventually leads to pregnancy.

3.1 Maternal Health as a Millennium Development Goal (MDG)

At the turn of the 21st century, leaders of the then 189 (now 193) member-states of the United Nations (UN) converged on the New York headquarters of the body for the year 2000 United Nations Millennium Summit, where, after adopting the United Nations Millennium Declaration, they pledged their commitment to achieving a set of eight development-related goals. As Adeniran (2009) recalls, their vow was to “spare no effort to free our fellow men, women, and children from the abject and dehumanising conditions of poverty” (p. 30). In other words, their vow was an all-out war against conditions that impede human development. They drew the battle line between humanity and poverty when they set a deadline for year 2015, now less than a year away. Goal Five of the eight MDGs, maternal health is a key development issue, especially for African countries like Nigeria; the targets of this goal are:

- To achieve a reduction in maternal mortality (childbirth-related death of women) by three-quarters between 1990 and 2015;
- To achieve universal access to reproductive health by year 2015

3.2 Nigeria's Maternal Health Statistics

The health of the mother is important; only healthy mothers beget healthy children. Therefore, of particular concern to this review is goal five, which has to do with maternal health and some of the available statistics on it. Maternal health is the health of women, and comprises all the forms of care that a woman can possibly get when she is pregnant, at childbirth and after. Statistically, in Sub-Saharan Africa, a woman dies from childbirth-related complications every minute, totaling about 529,000 annually. Majority of such deaths occur in developing countries, where women have a 1 in 16 chance of dying in pregnancy or at childbirth, compared to a 1 in 4,000-risk in developed countries; this is the largest difference between poor and rich countries of any health indicator (UNICEF, 2014: ¶ 1).

Maternal mortality, also known as maternal death, is the largest difference between poor and rich countries of any health sector. According to the United Nations Children's Fund (UNICEF, 2014), every single day, Nigeria loses about 2,300 under-five-year-olds and 145 women of childbearing age. This makes the country the second largest contributor to the under-five and maternal mortality rate in the world. As Mojekwu and Ibekwe (2012) observe, while an annual decline of 5.5 per cent in maternal mortality ratios between 1990 and 2015 is required to achieve MDG 5, figures released by WHO, UNICEF, UNFPA and the World Bank show an annual decline of less than 1 per cent. For instance, although UNICEF recognises Nigeria's efforts at improving maternal healthcare and reducing maternal mortality, the agency's verdict is that the pace of such efforts is very slow. On Nigeria, UNICEF says:

Underneath the statistics lies the pain of human tragedy, for thousands of families who have lost their children. Even more devastating is the knowledge that, according to recent research, essential interventions reaching women and babies on time would have averted most of these deaths. Although analyses of recent trends show that the country is making progress in cutting down infant and under-five mortality rates, the pace still remains too slow to achieve the Millennium Development Goals of reducing child mortality by a third by 2015 (ibid: ¶4, 5).

When one also considers the World Health Organisation (WHO) Statistics (WHO 2013, p. 26), the verdict by UNICEF becomes more understandable. WHO Statistics, which is an annual summary of the progress made towards achieving the health-related Millennium Development Goals (MDGs) and associated targets, has found that Nigeria is yet to do enough in terms of maternal healthcare. It estimates that the country's annual average rate of decline (AARD) percentage for maternal mortality ratio (the number of maternal death per every 100, 000 live births) for the period 1990-2010 stands at 630, which, according to Cooke and Tahir (2013), is a higher proportion than in Afghanistan or Haiti, and only slightly lower than in Liberia or Sudan.

Cooke and Tahir (2013) note that, within Nigeria, there are significant disparities among regions, and Northern Nigeria has far higher maternal mortality rates than the wealthier South. The extremely poor North East has an estimated maternal mortality rate of 1,549, more than five times the global average. Poverty, a lack of investment in health systems, low educational levels, and infrastructure have each contributed to the disparity; cultural

factors that give women limited mobility and contact with the formal health care system and little say in household and personal decision making also contribute — measures of women's empowerment are consistently lower than in most of Nigeria's southern states.

There have been instances of leadership on maternal health in the North (Kano State was the first in Nigeria to introduce free maternal care in 2003), but they have not always been sustained. Today, terror attacks by the extremist group Boko Haram have forced many health and development implementers to shut down or scale back operations in the North, and public health experts fear that prolonged insecurity will very likely reverse or eliminate the gains of the last decade (Cooke & Tahir, 2013). Maternal mortality depends on the quality of healthcare that women get during pregnancy, at childbirth and after childbirth. Hence, the target of 'MDG Five' is to enhance, significantly, access to universal healthcare for women and their children by the 2015 deadline. Besides, the global target set by the International Conference on Population and Development (ICPD) is 100 per cent coverage by 2015. The ICPD target deals with the percentage of women who received antenatal care from skilled health personnel at least once and at least four times during pregnancy.

Within each WHO region, the survey (WHO, 2013) sorted countries by the latest available data since 2005 for at least one visit. Concerning Nigeria, WHO says that, between 2005-2012, more women (53%) received antenatal care from skilled health personnel at least once than did women (45%) who received care during pregnancy per every 10,000 population (WHO, 2013, p. 102). Births attended by skilled health personnel was 34 per cent (for 2005-2011), and those by Caesarean section (surgery) stood at 2 per cent, while mothers' postnatal care visits within two days of childbirth was 38 per cent. Infants less than four weeks old, who received vaccination against neonatal tetanus, stood at 60 per cent.

Findings concerning maternal health in Nigeria's 2013 National Demographic and Health Survey (NDHS) still reflect a key finding in an earlier study (Butawa et al., 2010:1) which found that maternal healthcare utilisation by mothers depends on whether they are urban or rural dwellers, or whether educated or not. Buttressing Butawa et al.'s position, the 2013 NDHS discovered that the recorded percentage of urban mothers age 15-49 who received antenatal care from skilled health providers surpasses (at 86%) that of their rural counterparts, which stands at 46%.

The 2013 NDHS also found the percentage of urban mothers delivered by a skilled provider to be 67% as opposed to 21.9% of rural mothers. Therefore, more urban mothers (76.9) got protection against neonatal tetanus than did rural mothers (39.5%). Besides, urban mothers (61.7%) had their babies in healthcare facilities, as opposed to their rural counterparts (21.9%). Besides, mothers' educational statistics for the period (five years preceding the survey) show that, of the 31,828, those classified as having had no education accounted for the highest rate of births (15,657). Those who had only primary education recorded 6,127 babies; secondary school leavers among those surveyed were mothers to 8,211 children, while those who had more than secondary education accounted for the 1,834 births. The findings representatively suggest that educational level played a role in maternal health.

State-by-state maternal health statistics show that, most births occurred in Kano, with 3,024, followed by Katsina and Jigawa, where 1,703 and 1,594 births occurred respectively. Ekiti recorded the lowest number of births. Comparatively, Osun State had the highest percentages both for antenatal (98.2%) and for neonatal tetanus protection (94.1). According to the survey, the three states where the lowest births (five years preceding the survey) occurred were Ekiti (200) Territory Abuja (209) and Bayelsa (233).

3.3 Maternal Mortality

Maternal mortality is the death of a mother from birth-related complications. It can occur during pregnancy, at childbirth or after. Having babies in Africa can be quite challenging, given the current level of healthcare delivery to citizens in the continent. Better experienced than imagined are the pains that women have to bear during before and at childbirth alone; the death of a woman in labour is usually a blow to her family.

WHO (2006) defines maternal death as the death of women while pregnant or within 42 days of termination of pregnancy irrespective of the duration and site of the pregnancy from any cause related to, or aggravated by the pregnancy or its management but not from accidental or incidental causes (cited in Ogunjimi, Ibeh & Ikorok 2012: 34). While noting that deaths of infants/children under five are peculiar and closely related to

maternal health, Ogunjimi et al, 2012 declare that the social tragedy of maternal mortality places a huge burden on the shoulders of the society and the deceased's children:

Maternal mortality is a multi-dimensional problem, which does not only affect the family involved but has a great effect on the society as a whole. When a mother dies, the children's chances of reaching adult life is slim. This is majorly due to lack of everyday care and security. The young children may have to take care of themselves and this may in turn affect their school attendance. Lack of proper education may in turn weaken the child's chances of reaching better life standards (Ogunjimi et al., p. 34).

Having babies in developing nations may be life threatening. Literally every minute, a woman dies from avoidable complications caused by pregnancy – this adds up to approximately half a million fatalities per year. In Nigeria alone, maternal mortality rate reaches up to 3,200 women (number of mothers per 100,000 births that die within 42 days after childbirth). In Northern Nigeria, this rate is even higher. The maternal mortality rate is even higher in areas where many women have many babies in short time spans under malnutrition, bad hygienically conditions and lacking access to medical treatment (<http://www.maternal-health.org/nigeria/maternal-health-in-nigeria/index.html>).

In 1995, Nigeria had the third highest number of maternal deaths in the world (approximately 45000 deaths). By the year 2000, for every 100,000 live births, about 800 women died in the process of childbirth. Out of the 27 million Nigerian women of reproductive age back then about 2 million did not survive either pregnancy or childbirth. In 2008, according to UN report, the figure stood at between 1000 and 1500 deaths per 100,000 live births. The State of the World Children Report 2009 stated that 1 out of 9 global maternal deaths occurred in Nigeria (Ogunjimi et al., 2012). On Nigeria's maternal health situation, Cooke and Tahir (2013) observe thus:

Nigeria has the 10th - highest maternal mortality ratio (MMR) in the world, according to UN estimates, with 630 women dying per 100,000 births — a higher proportion than in Afghanistan or Haiti, and only slightly lower than in Liberia or Sudan. An estimated 40,000 Nigerian women die in pregnancy or childbirth each year, and another 1 million to 1.6 million suffer from serious disabilities from pregnancy - and birth-related causes annually. 8 Nigerian women have an average total of 5.7 births in their life, with each pregnancy exposing them to the risk of maternal complications. Over her lifetime, a Nigerian woman's risk of dying from pregnancy or childbirth is 1 in 29, compared to the sub-Saharan average of 1 in 39 and the global average of 1 in 180. In developed regions of the world, a woman's risk of maternal death is 1 in 3,800 (p.7).

Reducing a social scourge threatening the female population is the fifth goal of the United Nations' Millennium Development Goals (MDGs), which the UN launched in 2000 as a global initiative to “spare no effort to free our fellow men, women, and children from the abject and dehumanising conditions of poverty” (Adeniran, 2009:30). They hoped to achieve that by focussing attention, resources, and action on improving the well-being of all peoples (Ogunjimi et al, 2012). Closely related to this goal are the proposed targets of reducing maternal mortality by two-thirds between 1990 and 2015; and to enhance universal access to reproductive health within the same period. Nigeria, a member-state of the UN, is a signatory to the MDGs. There are reasons the scourge has held Nigeria (and the world) ‘hostage’ so much that, as Nigeria's 2013 NDHS notes, Nigeria still has a long way to go.

4. Mass Media and Maternal Health

Since the mass media are purveyors of messages from sources to receivers, the mass media owe society the responsibility of generating awareness about issues and calling attention to whatever constitutes a threat to our well-being. Maternal health cum maternal mortality is an issue of general concern by all; it ought to be one of the issues of interest to the mass media, who have been credited with the power to influence behaviour. What should the mass media, especially newspapers, then do concerning maternal health in Nigeria? Scholars remain united on the potency of messages in the mass media in engendering desired social goals. Bankole (1994) believes that the mass media – radio, television and the mass media – can be effective in influencing people's behaviour. Piotrow et al. (1990), cited in Bankole (1994: 1), adds that mass media can be a powerful tool not only for creating awareness about innovations but also for stimulating desires in people for more information, and for facilitating their efforts to apply the information to their own behaviour. Similarly, the use of entertainment-education approach, which uses the entertainment components of mass media to deliver intended messages, is

alternatively becoming attractive to communication experts. This approach uses songs and dances to drive home the salient messages (Kincaid et al., 1992, cited in Bankole, 1994: 1).

Mass media coverage of maternal health-based issues has attracted interests from a number of scholars (Bankole, 1994; Firmansyah, Hegazi, Darwisyah & Amaliah, 2001; Adeniran, 2009; Abubakar et al., 2013) who have found out a number of things about media coverage of such issues. One of such studies (Firmansyah et al., 2001) found that few journalists have had experiences in covering women's health, or possess a network of informed sources of news on the health of women. This led (Firmansyah et al., 2001) to conduct a project (FRONTIERS) in Indonesia with the objective of getting the country's journalists to step up reportage of critical reproductive issues. Findings from their project revealed a slight rise (7 %) they carried.

A core network of 22 journalists representing both national and regional media participated in the project. In September 1999, the researchers organized a roundtable dialogue between health editors from the print media and experts in reproductive health. A training workshop for journalists was held in January 2000 to increase their understanding of reproductive health and to upgrade their ability to write articles using research findings. They used training modules that utilized multiple approaches, including role-playing, simulation, testimony, and field visits, to investigate different techniques for gathering information and to practice writing short articles on interesting topics. Findings from the 18-month media information-dissemination project had a positive impact on the coverage of reproductive health in the Indonesian print media (120 articles out of 1,836). News articles were the dominant type of story, followed by features. Impliedly, the reportage of maternal health only increased in the mass media after some interventions, although the percentage was still low.

Abubakar et al. (2013) conducted a study with the objective of ascertaining the depth of media reportage of cervical cancer – another maternal health issue – using two purposively selected national weekly newsmagazines, nine copies each of which they qualitatively content-analysed. Three editions were selected from each month, using simple random sampling method. Thus, they randomly picked nine (9) editions each, representing three per month from *Tell* and *The News* magazines to arrive at a sample size of 18 editions, whose content categories dealt with nature of story, its focus, position, source, and length. They found a very low level of coverage of maternal health-related issues in the two magazines' whose contents were quite largely devoted to politics, business and advertising. Thus, their findings echoed earlier findings (such as the preceding study).

Adeniran (2009) did a study that examined media coverage of the Millennium Development Goals (MDGs) of which maternal health is one. Adeniran, who content-analysed two Nigerian newspapers – *The Punch* and *The Guardian* – used editorial, straight news, news analyses, features and opinions as units of analysis for stories in the two newspapers over a period of six months. The study found that MDGs about hunger and poverty, environmental sustainability and global partnership were the most reported, while MDGs concerning maternal health, child health and universal primary education were the least reported.

Adeniran also revealed that, in *The Punch*, out of the 22,750 stories published across 182 editions of *The Punch*, only 592 (2.6%) were about MDGs, very few of which bordered on maternal health, as earlier stated. Similarly, *The Guardian*, which published 25,480 stories across 182 editions, only 'accommodated' 830 MDGs-related issues, a slightly higher portion (3.3%). The aggregate of stories in the two newspapers was 48, 230 of which only 1,422 (2.9%) were about MDGs. Just like the other studies discussed earlier, this one also found similar trend of low awareness creation on maternal health, an issue for which Nigeria has been 'notoriously' popular, according to the statistics (630 per every 100,000 live births).

Although the mass media are relevant in the development process, to which they serve as vehicles of message dissemination. The newspaper, which is 'literacy-intensive', is more useful in urban settings, where literacy is usually higher; the radio is more popular than television among rural dwellers. The foregoing statement was among the findings of an explorative study (Asp et al., 2014) of the relationship between exposure to mass media and birth preparedness among the women living in the Mbarara District, southwest of Uganda. Besides, high media exposure, i.e. regular exposure to radio, newspaper, or television, showed no significant association with birth preparedness of the women interviewed for the study (Asp et al., 2014: 1).

In view of the findings of the studies alluded to, the implication is the mass media must 'rev up' reportage of maternal and child health. Because the mass media have the power to shape opinions and mould behaviours (Asp

et al., 2014: 1), it is reasonable to believe that a much higher level of reporting on the health of the mother and her child will help deepen awareness about the issue. Consequently, doing so will help reduce Nigeria's maternal mortalities, currently at 630 (WHO, 2013), even as the President Goodluck Jonathan reportedly said last year (Embu, 2013) that the figure dropped to 350 in June. Another media report (Obinna & Olowoopejo, 2013) estimates a far higher figure of 11,000 maternal mortalities between January and March 2013.

5. Conclusion and Recommendations

This study has explored a number of key concepts that border on health, healthcare, maternal health, and maternal mortality, which is an issue of global concern and fifth of the eight Millennium Development Goal (MDGs) launched in 2000 by the United Nations (UN) and member-states. Relevant global and local statistics on the current level of success achieved through efforts aimed at curbing maternal mortality rate (MMR) globally and Nigeria have helped in better appreciating the issues involved. They have also called attention to a need for urgent intensification of efforts by countries still lagging behind on MDGs. Studies done by scholars on the extent to which the mass media have been reporting women and children's health in Nigeria and other countries reflect one trend: mass media coverage of maternal health is not yet desirable.

In all these troubling times for our women, who, as statistics show, Nigeria keeps losing to birth-related complications, media should be more proactive about the issue of maternal health. The mass media should be proactive because researchers have found that exposure to mass media provides increased awareness and knowledge, as well as changes in attitudes, social norms and behaviors that may lead to positive public health outcomes.

One of them (Adeniran, 2009: 110) recommends that the mass media must pay more attention to the under-reported issue of maternal health in order to not only inform the public about it, but also deepen analyses and interpretation for citizens' use. The study also urged the mass media to intensify their watchdog role on government's efforts on MDGs. It called for better mobilisation of the mass media by the government, development agencies and urged individuals to speak to the mass media on problems affecting them.

Firmansyah et al. (2001) encourage the use of reproductive health training programs for journalists as a part of all health-sector projects, during which writing comprehensive stories and using research findings to support the coverage should be among key points to emphasize. It called for motivation of senior editors to devote more space to reproductive health issues, expand the media network to include more journalists from radio and television, who should work together to increase the visibility of reproductive health issues, leading to a larger impact on the general public as well as programme managers and policymakers.

Kreigal et al. (2011) infer that a consequence of the failure of newsmagazines to report health issues adequately is that, there arise "medically underserved communities". The implication of this is that a society may arise, where citizens remain unaware of the gravity of certain health challenges, and are clueless as to the level of seriousness they should attach to health issues such as cervical cancer (cited in Abubakar et al., 2013, p. 13). Abubakar et al. warn:

The likely danger of this reportorial failure is the gradual 'planting' of a health 'time bomb' that has a potential to 'explode' existing records, thus constituting great hazard to lives of women especially. This study has also similarly discovered paucity and vacuum, with respect to media coverage of life-threatening health issues like cervical cancer, as seen in the two magazines studied and which studies in other lands have confirmed. Nigerian magazines should also give additional emphasis to health related issues by increasing the number of pages, in the case of Tell, while The News should allot some pages, for health issues (pp. 13-15).

If the mass media would heed these recommendations so far cited, the possibility of actually achieving Nigeria's target of 250 maternal mortalities per 100,000 live before the 2015 deadline might be possible. Diedong (2013) believes that the mass media can play an important role in not only stimulating discussion on the problems and challenges of the health situation of our society. More importantly, if the stories are effectively framed, they can serve as very good sources of empowerment and direction towards better health. Therefore, it is important that media organisations, health agencies and institutions, and schools of communication studies collaborate and devise strategies on how best they can equip journalists with specialized knowledge and skills to enable them

write articles on health problems based on their expertise on such issues.

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