Accessing Maternal, Newborn and Child Healthcare Services in Underserved Rural Communities: Users Challenges in Delta State and Recommendations for Improvements

About CPED Policy Brief

Centre for Population and Environmental Development (CPED) policy brief series is designed to draw attention of stakeholders to key findings and their implication as a research is conducted. The general objective is to contribute to a body of evidence that can influence the development, modification and implementation of policies across various sectors in Nigeria. The primary focus, therefore, is to outline actionable recommendations for policy influence and result utilization by government institutions and other key stakeholders in Nigeria.

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Introduction

The goal of primary health care (PHC) was to provide accessible health for all by the year 2000 and beyond. Unfortunately, this is yet to be achieved in Nigeria and seems to be unrealistic in the next decade (Abdulraheem et al., 2011).

The main reason for the establishment of Primary Healthcare Centres is for the sole benefits of the local people especially those residing in the rural areas. Though PHC centers were established in both rural and urban areas in Nigeria with the intention of equity and easy access, regrettably, the rural populations in Nigeria are seriously underserved when compared with their urban counterparts.

The PHC is the window to any health system and primary healthcare indicate the quality care of health system reflected by patients' perception in terms of their satisfaction with the services they are provided in through the PHC centres. The experiences of the users with the service provided in the PHC centres will in no doubt influence their attitude toward PHCs, determine their return visit, compliance with treatment and achievement of better treatment success.

Accessibility is one of the principles of "Health for ALL" stated in Alma Ata declaration on primary health care but still, due to lack of universal access, equality in health status cannot be assured. Moreover, because there are other important social determinants of population health and its distribution, even with the increasing catchment of tertiary health care facilities, utilization of primary health care is low due to costs, attitude of health provider as well as location of facilities, etc.(Sinmayee K.D.). Making pregnancy safer and drastically reducing mortality

Background

This Policy brief is part of an on-going implementation research project of *Centre for Population and Environmental Development (CPED)* supported by *Think Tank Initiative (TTI)* program of *International Development Research Centre (IDRC)*, Ottawa, Canada. The policy brief presents key findings of the challenges users face in receiving maternal and child healthcare services in underserved rural communities in Okpe local government area of Delta state. Key informant interviews and focus group discussion with the help of unstructured questionnaires which lasted between 60-90 minutes each, were used to extract useful information about the quality of MNCH care services rendered by the PHC facility from users and key stakeholders. The interviews were recorded to prevent loss of data and thereafter transcribed by research assistants. The transcribed recordings and notes from the focus group discussions and key informant interviews were analyzed using content analysis

of children under 5 years of age have been the central to population policies since post International Conference on Population and Development (ICPD) regime. In Nigeria for instance, the Reproductive and Child Health Programme aims at providing at least four antenatal checkups which should include a weight and blood pressure check, abdominal examination, malaria, immunization against tetanus, and iron and folic acid prophylaxis, as well as anaemia management.

However, more than two decades into the war against maternal deaths, Nigeria still has one of the worst maternal mortality statistics in the world. With a maternal mortality ratio of 545 per 100,000 live births, Nigeria is second only to India in the global estimates of maternal mortality. Nigeria loses about 145 women of childbearing age every day (Chigozie et al., 2013). A woman's chance of dying from pregnancy and childbirth in Nigeria is 1 in 13. According to United Nations, seventy-five percent of maternal deaths occur during childbirth and the postpartum period, and the vast majority of maternal deaths and injuries are avoidable when women have access to health care before, during and after childbirth (Okechukwu O, 2013). Although many of these deaths are preventable, the coverage and quality of health care services in Nigeria continue to fail women and children. Presently, less than 20 per cent of health facilities offer emergency obstetric care and only 35 percent of deliveries are attended by skilled birth attendants (Okechukwu O., 2013).

Key Findings on Challenges in Accessing Maternal, Newborn and Child Healthcare in the Rural Areas in Nigeria

1. Educational level of Women

The major and consistent determinant of using maternal health care is the level of education of expectant or nursing mothers. Maternal education has been shown repeatedly to be positively associated with the utilization of maternity care services. From the survey, 20 per cent of the members of the households are illiterate (i.e. educational level not up to primary education). The implications of this is that the demand and use of primary health care services by most of the women in the above category will be low because they basically have little or no knowledge of maternity services.

2. Cultural Perspectives/Male Dominance

Even when the awareness is there, there are some cultural practices that tend to limit the ability of the woman from accessing maternal healthcare services. In some rural communities, maternal health services coexist with indigenous health care services; therefore, women must choose between the options. The use of modern health services in such a context is often influenced by individual perceptions of the efficacy of modern health services and the religious beliefs of individual woman. Some of these women even have to wait for permission by their spouses before they could go to the PHC centres for medical care.

Nevertheless, male dominance is another issue that is highly common in most of these rural communities. In most of the rural homes, the husband determines when the woman leaves home and where she goes to. They even dissuade their wives from visiting the PHC facilities or abiding by their counsels especially in the area of usage family planning commodities.

3. Economic Power

Economic situation of the woman is another factor that hinders access to maternal healthcare in Nigeria. Finance also reduce women's use of maternal health services and keeps millions of women from having hospital-based deliveries or from seeking care even when complications arise.

From our data available, over 45 per cent of the members of the households are less than 29 years most of whom are not in employment while about 5 per cent are beyond the age of 60 years which indicates that they may not be in employment any longer. This pattern has considerable implications for primary health care demand and use. While the demand for PHC services is obviously high among the people who are dependent

on the working population, the ability to pay for primary health care services is low considering the fact that they depend on the less than 50 per cent of the household members that are probably working. This is the reason why many women patronise the Traditional Birth Attendants (TBAs) in their localities since the birth attendants allow them to pay on instalment when they deliver their babies.

4. Political interference in PHC facilities distribution

Another challenge of accessing maternal healthcare services in Nigeria is availability and accessibility of health facilities. Availability of healthcare facilities is a serious problem as there is gross deficiency in the distribution of health facilities. Many health centres due to political interferences are sited in locations where they are not needed and not accessible by many. 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 to access maternal healthcare services means to travel a long distance from the rural place to another. 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. Lack of Commodities, Equipment and Drugs at the Facilities

In-depth interviews with the various facility heads at Okpe LGA reveal that Less than 50 per cent of ANC facilities in PHCs have all five essential supplies for basic ANC services (blood pressure apparatus, foetoscope, iron and folic acid tablets, and TT vaccine) for basic ANC. All infection control items (soap and running water or else hand disinfectant, latex gloves, disinfecting solution, and sharps box) are available in less than 40 per cent PHC ANC facilities. About 40 per cent of the facilities that offer normal delivery services have all infection control items (soap and running water or else hand disinfectant, sharps box, disinfecting solution, and clean latex gloves) at the service site. They said most of the drugs maternity users complained of were actually provided on a personal basis and not through the primary health care agency or local government authority. They said that since they buy with their money they also need to sell to get their money back. Some health staff claim that it is better there is something in the health centre for those who can afford it than nothing instead of waiting for government for free drugs which does not come regularly. This affordability again boils down to the financial power of the women.

6. Availability of Health Providers

This is another issue inhibiting access to MNCH services by mothers at the PHC facilities. The mothers interviewed in a focus group discussion pointed out that sometimes when they get to the facility, they usually meet the absence of the skilled personnel or find the PHC centres locked up. They also said that most PHCs in their region hardly give 24 hours services and that there is no way someone who finds herself in child labour at night will visit the PHC for delivery. Instead, they will go for the services of a traditional birth attendant (TBA) who is always at their beck and call.

Recommendations by Stakeholders to Improve Access to MNCH Services in Rural Areas

1. The level of education in the rural areas should be improved upon by the government. Also, there should be massive awareness campaigns on motherhood education and MNCH services being rendered by the PHC facilities in the rural communities. This is where the institutionalization of the Village Health Workers (VHW) in these rural areas is very vital. The VHW should be trained and then handed the responsibility of bring MNCH service awareness to the doorstep of every household in the community
2. Proper education should be given to pregnant and nursing women at intervals to make them understand clearly some basic health issues. These campaigns should be geared towards debunking cultural ideas or beliefs from their minds and behaviours. The religious leaders should be engaged by various health

CBOs, NGO, etc., on the importance of PHC services to their followers.

3. Campaigns with respect to the utilization of MNCH services should also target men so that they can support their wives in getting the services provided in the PHC centres.
4. Efforts should be made by the state government to site PHC centres in localities where PHCs are very far from the users. The government should also desist from interfering in the siting of facilities. Merit should be used in siting new facilities.
5. Women should be empowered by the various arms of government especially the local government. Also, the women should not fold their arms and think that manner would fall from heaven. Women should be sensitized to realize that they need to work with their hands to earn income or wages no matter how small it is.
6. Roads leading to PHCs should be put in good conditions. This will improve accessibility to the PHC centres.
7. Drugs should be made available by the government and accessible at the PHC centres so that the mothers and the children will receive all their prescriptions at once. Also, this will help reduce the overall cost incurred by mothers at the PHCs.
8. The national drugs policies and essential drugs list need to be reviewed, making them more responsive to patients' needs and improving availability.
9. Adequate staff should be provided in the PHC centres to enable it to start operating 24 hours a day in centres where this is not the case. Also, security should be provided for those in night shift to encourage the skilled personnel to avail themselves for services at night.
10. The coordinator of PHC in the local government should as a matter of urgency put monitoring and supervisory machinery in motion to checkmate the excesses of the health workers in theses PHC centres.

Conclusion

This policy brief demonstrates that the use of maternal health services by expectant mothers in Nigeria is influenced majorly by their socioeconomic status in the society. Factors identified in this study that influence the use of maternal health care by Nigerian women in rural areas are: getting permission to go for treatment, getting money for treatment, distance to health facility, transport cost, concern about the availability of health providers and drugs in the facilities. Money for treatment is the major barrier that hinders women from accessing maternal health care service. However, transportation and distance to PHC location also pose challenge to accessing maternal healthcare services by women in the rural areas of Nigeria.

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ABOUT CPED

The Centre for Population and Environmental Development (CPED) is an independent Think Tank organization dedicated to promoting sustainable development and reducing poverty and inequality through policy oriented research and active engagement on development issues. CPED is located in Benin City, Edo State, Nigeria. The Organisation was formally registered in Nigeria by the Corporate Affairs Commission (CAC) in 1999. CPED is a member of different Think Tank Networks including the "West Africa Think Tanks Network (WATTNet)", and also a beneficiary of the Think Tank Initiative (TTI), a multi-donor program of the *International Development Research Centre (IDRC),* Canada. The Centre's Executive Director is ***Professor Emeritus Andrew Godwin Onokerhoraye***, vice chancellor University of Benin (1992-1998).

CPED core programme areas can be broadly categorized into: Action Research; Policy Engagement, Communications and Advocacy; Intervention Programme and Capacity Building for Policy makers, CSOs and Mentees from allied institutions. CPED research agenda covers (1) Climate change with particular reference to the wetland and coaster regions (2) Gender and development (3) Health Systems and Health Care Service Delivery (4) Research on Governance and Development (5) Peace Building and Development in Niger Delta Region (6) Growth, Development and Equity.

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