

Understanding Maternal Healthcare in the Contexts of Culture, Infrastructure and Development in Pluralistic Nigerian Society

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Abstract

Background: Culture, poverty and maternal health risk occasioned by paucity of necessary maternal health infrastructures are detrimental factors to the health of both mother and child in Nigeria pluralistic society. While cultural tendencies perpetuate seemingly negative practices, culture contours and lack of political will act as the primary cause for high mortality rates among mothers and babies in their first five year of life. **Objectives:** The main reasons are low utilization of quality of maternal healthcare services, negative opinion of important referents, social, cultural, physical and economic barriers such as patriarchy, long distances, high transport and other indirect costs. Therefore, an epistemological understanding of healthcare consumption and process of care depends on these factors: the genetic, social, environment and culture. Others are poverty, bad hygienic conditions, limited access to treatment and underdevelopment of infrastructures. **Methodology:** The review examined the existing level of maternal and child mortality/morbidity within the extant literature and statistics. **Conclusion:** It is therefore suggested that government should make available functional primary health care facilities including maternity centres equipped with up to date infrastructures which would be funded equitably to encourage patronage and easy access to both rural and urban residents. Effort should be made to retain trained professionals.

Keywords: Maternal health, Culture contour, Development, Poverty, Infrastructure

Introduction

The Millennium Development Goals (MDG5) on maternal health was established by the United Nations in 2000 to improve on maternal health in general and specifically to drive maternal and child deaths down by 2015. Improvements in key health indicators have been slow and Nigeria ranks second in the world among the countries with the highest child and maternal mortality: the under-five mortality rate is 201 per 1,000 live births (NHRHSP, 2012); maternal mortality ratio is estimated at 800 per 100,000 live births ((NHRHSP, 2012; Akiyode-Afolabi (2014) ⁽¹⁾). Achieving the Fifth Millennium Development Goal (MDG 5) will require political will on the part of the government and enthusiastic participation of the people in pulling resources together for the needed development and suitable strategies for sustained implementation. In Nigeria alone, maternal mortality rate reaches up to 3,200 women (number of mothers per 100,000 births dying within 42 days after the childbirth). The case is more worrisome in Northern Nigeria, where the rate is even higher.

Maternal healthcare is the total health cares for pregnant mother and under five year's baby. It encompasses educational, social, and nutritional services and medical care during and post pregnancy. It is however, to be noted that, there are a variety of reasons while maternal women and those of reproductive ages choose not to engage in proper pre-natal and post-natal cares. Among these reasons are factors of culture, genetic and the levels of social, economic and political developments. That is, the nature (biology) and nurture (environment) play strong and decisive roles in maternal healthcare consumption of women in any society. Culture therefore, is critical for the establishment of social order and health stability in every society.

This is in coterminous with every aspect of human behaviours – including the means and methods of deployment of knowledge and technological knowhow to correct every form of health discontinuities – for instance maternal ill-health/disease. Cultural practices may be, in some cases, the albatross against orthodox health care but culture in this respect can be censured with sustained improved medical interventions to engender modern health practices to assuage any health problem including maternal ones and at the same time bring about development in social and economic terms. Mother's health in this context determines the health and survival of children. Development in this sense is a state of growth or advancement in maternal health care utilization and accessibility. It may also mean an epoch which constitutes a new stage in changing situation. It is noted that human resources development and management pose a major challenge to the implementation of health sector reforms and achievement of the health related Millennium Development Goals in Nigeria (NHRHSP, 2012).

Maternal health when viewed *vis-à-vis* the level of technology and health system in Nigeria, and elsewhere in developing countries, studies revealed that there is a positive relationship between the numbers of pregnancies a woman has had before, the total number of her children she is having presently and overall development of such children. Not less number of these children die before age five (Tella, 2014; UNFPA 2010a).

Many of these pregnancies and babies may not be necessary if there is high priority on overall socio-economic development and maternal health in term of adequate budgetary allocation to grow primary health in its entire ramifications. Each year over 162,000 women die from causes related to pregnancy and childbirth within sub-Saharan Africa countries (AbouZahr & Wardlaw, 2003). Neonatal deaths in developing countries account for 98% of world incidences yearly. These rates of incidence are precariously larger than any region of the world (WHO, 2006). Pregnancy also affects women's health because for each maternal death in Nigeria and elsewhere in developing world, more than 100 women suffer illnesses related to pregnancy and childbirth (Safe Motherhood, 2000). Nigeria and other countries of Sub-Saharan Africa (SSA) are still reputed to have high maternal morbidity and mortality rates in the world (United Nations -UN 2003). The World Health Organization's (WHO) in 1992, on the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) defines maternal mortality as retrieved in February, 2012:

...the death of a woman while pregnant or within 42 days of termination of pregnancy irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes

Morbidity is the disease/illness suffered by the pregnant women during the period of pregnancy. Sometimes it may lead to disabilities and in some cases it affects the victims economic, social and fertility roles (World Health Organization-WHO, 2003). The risk for maternal death (during pregnancy or childbirth) in sub-Saharan Africa is 175 times higher than developed countries, and risk for pregnancy-related illnesses and negative consequences after birth is even higher (UNICEF, 2006). Literally, every minute a woman dies from avoidable complications caused by pregnancy; this adds up to approximately half a million fatalities per year (UNICEF, 2006). In Nigeria alone, maternal mortality rate reaches up to 3,200 women (number of mothers per 100,000 births dying within 42 days after the childbirth). Maternal deaths result from a wide range of indirect and direct causes. The case is more worrisome in Northern Nigeria, where the rate is even higher. The main reasons for the low utilization were the low perceived quality of maternal healthcare services in clinics, negative opinion of important referents, physical and economic barriers such as long distances, high transport and other indirect costs. Indirect causes represent 20% of the total incidence of mortality - they are pre-existing or concurrent diseases that are not complications of pregnancy, but that are complicated during pregnancy or aggravated by it (WHO, 2006). Major direct causes however, in Africa are haemorrhage (34%), infection (10%), hypertensive disorders (9%) and obstructed labour (4%) (WHO, 2006). Added to these, in Nigeria especially are anemia, malaria, placenta retention, premature labor, prolonged/complicated labor, and pre-eclampsia.

The rate of maternal mortality of 500/10,000 along with high rate of morbidity in Nigeria is one of the highest in the world worst incidences (Anate, 2006; Harrison, 1997). Studied have shown repeatedly that women in Nigeria and elsewhere in SSA suffer from twins these problems of maternal mortality and morbidity due to low socio-economic status (SES) and cultural practices which place women at a disadvantage ((Nwokocha & Okakwu, 2012; Nwokocha, 2004, Chiwuzie, & Okolocha, 2001; Ashford 2001). Stressing the foregoing further, Roberts (1996) quoting from the work of Fathala (1995) observed:

.... a woman does not die as a result of post- partum hemorrhage, she died because she is suffocating from chronic under nutrition and anemia, lack of cheap and convenient transportation to take her to the tertiary health centre which may be miles away. Lack of communication to inform the centre of the pending emergency, lack of available compatible blood transfusion and because she has born several children before and she is unaware of family planning (p.62)

However, a large number of women facing maternal death or morbidity are lowly placed within and between the social hierarchies due to poverty occasioned, especially by lack of sufficient income (Aluko-Arowolo, 2012, Jegede, 2010; Erinosh, 2006).

Maternal Health, Culture and Development

Interpreting what is development in Nigeria and elsewhere in Sub-Saharan Africa (SSA) countries regarding the quality of maternal health care which is available to individual pregnant and nursing mother could be gleaned from the level of development and socio- cultural inputs by the government and society respectively. Cultural and ethnic preferences often act as the unseen hands in acceptability of health worker services or posting outside their cultural domain. Government's inputs are in forms of infrastructures, progressive budgetary allocation and overall political will for monitoring and evaluation to encourage compliance to technological innovation and other medical advances, such as vaccine and drug innovations. But society's contributions would be seen from core value and norms attached to overall health of the mothers and children through cultural prescriptions (Feyisetan, Asa & Ebigbola, 1997).

This may be multidimensional and multifaceted, because what constitute health development as it were, in a plural society like Nigeria is relative and highly contentious. Not uncommon is the auspicious roles culture is playing, especially when religious practice is juxtaposed with culture to bring about value judgments on what constitute quality and unfettered health care for mothers. Of a particular interest is the conundrum of husband-wife relationship as defined by culture and the way the community perceive this relationship and especially Islamic injunction that forbids male doctors from treating female patients – this is particularly rife in the northern states of Nigeria - where majority are Muslims (Walker, 2001; Orubuloye & Ajakaiye, 2000; Jejeebhoy, 1998). Because of this, in SSA alone, more than 250,000 mothers are dying yearly with many sustaining health impairment leading to disability as a result of unbooked (unregistered) pregnancy, inefficient and/or lack of maternity care (Harrion, 1997; Arkutu, 1995).

The foregoing underscores the structural inputs, process and outcomes of care available to women seeking for maternal health care. Structural inputs in health care provision are classified as building, medical equipments, drugs, medical supplies and vehicles (Efe, 2013; Ogundele & Olafimihan, 2009; Ademiluyi & Aluko-Arowolo, 2009, Erinosh, 1989). Others are personnel, money, organizational arrangements or bureaucratic apparatus (Efe, 2013, Erinosh, 2006; Geyndt, 1995). These inputs are not only complimentary to health care consumption of mothers specifically and other family health in general; but it is highly instructive for all round quality health for all. But often they are not always sufficient and available (Salami & Taiwo, 2012; Ademiluyi and Aluko-Arowolo, 2009; Jegede, 2002). Where these are available, the technological know-how to harness the resources together is inadequate or may be lacking (Grange, 2012; Jegede, 2012).

The process, as the second of the tripod upon which quality health stands encapsulates the actual effort done to and for the patients in giving and receiving care. This entails accessibility and health care workers relationship with health care consumers. Process in this sense is the key element to ensure quality and adequate minimal supply of inputs (Owumi, 2002; Geyndt, 1995). It is also assumed that a correct process has a high probability of a satisfactory health improving outcome including maternal ones. However, the outcomes, which is the last but, not the least of the tripod may be uneventful if the process is well managed or otherwise eventful – such as maternal complications, disability or loss of life if the process was encumbered and shoddy (Geyndt, 1995; Eschen, 1992). Outcomes are therefore the end result of the correct process of, and for patient care and the timely availability of the necessary inputs.

Outcome may be measured using indicators of mortality, morbidity and functional impairment (Geyndt, 1995). Favourable outcome however can be affected by factors not under the direct control of the health workers. These factors can be enumerated thus: Culture, housing, diet, environment, genetics, etc. All have impact on the process and outcomes of any intervention. Several cultural practices are noted to have influence on maternal and child mortality occurrences in Nigeria and elsewhere in sub-Sahara African societies (Salami & Taiwo, 2012).

However, maternal and infant mortality rates in Nigeria are worrisome and of great concern to health managers within and without Nigeria. These challenges involved infrastructure, economic, social and cultural factors (Owumi, 2002; Erinosh, Osotimehin & Olawoye, 1996). Apart from inadequate and inefficient healthcare services in Nigeria (Tella, 2014) institutional arrangements, cultural beliefs and practices have contributed to the rise of maternal and infant mortality rates in Nigeria. Structural inputs will lead to strong health system, correct application of process will bring about skilled delivery attendance and all point to an outcome where the women's rights for maternal health are not compromised. However, this is not always the case. A cursory look at institutional variables and arrangements- such as budgetary allocation, spatial distribution, beliefs and practices would suffice to explain the predicaments:

Budgetary Allocation, Spatial Distribution of Health Workers and Facilities

Health care facilities and infrastructures allocation in any society are influenced by different institutional, local and regional factors (UNFPA, 2010a). Poor work environment including dilapidated structures, inadequate and outdated equipment and cumbersome work flows, lack of protective, safety equipment and logistics for staff and misalignment of pre-service production and training programmes to health priorities are all too common challenges. These challenges in distribution impact on the quality, quantity, effectiveness and efficiency of medical personnel and all round hospital management. It will also affect accessibility to the patients who may like to patronize the centre. It is a common knowledge that the location and what a health officer practices with would have impacts on his mien and subsequently affects his relationship with the patients and his productivity (Maguire 2010; Lupton, 2000). It is not unthinkable that health worker without the necessary equipments and facilities to work with may behave offhandedly and negative behaviour towards his patients. This assertion is supported by inequity in which Nigerian ministry of health spends 70% of her budgetary allocation in the urban areas with only 30% of the population and the remaining 30% of the budget on 70% large and burgeon rural population (Ademiluyi & Aluko-Arowolo, 2009).

There are great disparities in health status and access to health care among different population groups in Nigeria. For instance, the under-five mortality rate in rural areas is estimated at 243 per 1,000 live births, compared to 153 per 1,000 in urban areas (UNICEF, 2006). While 59 percent of women in urban areas deliver with a doctor, nurse, or midwife, only 26 percent of women in rural areas do so (NHRHSP, 2012; Ogun State Health Bulletin, 2009). Furthermore, there are wide variations in health status and access to care among the six geo-political regions of the country, with indicators generally worse in the North than in the South (MDG Report 2004 in NHRHSP, 2012). In 2014 budget allocation to health sector was six percent or N262 billion (or, 1.7billion USD), this is against N279billion allocated in 2013. The usual template of allocation between rural and urban areas was still in place. The urban areas benefitted more to the detriment of rural areas and little effort was on primary health including maternal health. Following from forgoing, healthcare system in Nigeria is replete with spatial variations in terms of availability, quantity and quality of facilities which often may not be apt to the needs of health care consumers, in this regards, the pregnant and nursing mothers. The health sector in Nigeria is noted to be facing financial and human resources crisis (NHRHSP, 2012)⁽²⁾. The Human Development Index (HDI) as a composite index that measures the achievement of countries in three basic dimensions of human development in the areas of: a long and healthy life, knowledge, and a decent standard of living have poor rating for Nigeria. There are also systemic deficiencies in the planning, management and administration of available personnel. The intensity of human resource challenges vary from one location and level to the other. The common outlooks are: shortage of professional staff in the north and over supply in the south. Distribution of health workers is also skewed toward urban centres with acute shortages in rural locations. Coupled with these are staff recruitment regulations in some states with shortages of critically needed health staff that discriminate against non-indigenes (Efe, 2013; NHRHSP, 2012). Attrition of health professionals is becoming excessive due to brain drains. Brain drain is whereby professionals from the country of origin are "pushed away" due to unfavourable conditions of service to another country with alluring scenario that are "pull factors". Migration of health care personnel to other countries is a current and serious issue in the health care system of the country, from a supply push factor, a resulting rise in exodus of health care personnel may be due to the unbearable working condition among other things. Furthermore, there are low level and discrepancies in salaries and other conditions of service for health professionals working at different levels, locations and between states/provinces.

The health work force available was unevenly distributed (Efe, 2013; Ogundele, & Olufimihan, 2009, Aluko-Arowolo, 2005) with urban areas of 30 percent inhabitants having the larger concentration of health workers and facilities, as against the rural areas with preponderance percentage of 70 percent having to do with lesser health workers and facilities (NHRHSP, 2012; Aluko-Arowolo, 2005). In Nigeria of more than 160 million people; there are about 39,210 doctors and 124,629 nurses (This would translate to a doctor's ratio of 1: 4103; or, about 30 doctors per 100,000 populations and 1: 1284 or about 100 nurses per 100,000 populations respectively) registered in the country, currently working (or not working/practicing at all).

Household Structure and Decision Making

Apart from the level of development which is one of the factors that determines health seeking behaviour of maternal women, culture, gender roles and maternal health are inseparable. These roles are serving as constraints to maternal healthcare of pregnant women. This is because in most cases, women have no right of their own to determine when to have sex for instance, or when to prepare for the next baby. In any case, this is one of the leading factors of unwanted pregnancies and unsafe abortion which also heightens incidences of mortality, morbidity, child loss due to the problem of several pregnancies. There is invidious intra power play within the family set up with wife's rights subjugated under the husband's own. In consequence of this, it sometimes leads to poor health communication between husband and wife (Salami & Taiwo, 2012). Sometimes these rights are abrogated out rightly. The Gender Inequality Index (GDI) ranking in Africa as a composite measure that reflects inequality in achievements between women and men in the categories of reproductive health, empowerment, and the labour market did not favour Nigeria and other sub-Saharan Africa countries (WHO, 2012).

The political process and procedure in this sense undermines the rights of women in taking decisions on reproductive issues including family planning (Gage and Njoku, 1994). This process alone has been traced to be one of the causes of low utilization of health services in Nigeria societies. While the foregoing represents a more or less general understanding in the society, studies have examined low utilization of formal health services vis-à-vis health of pregnant women as worst scenario of poor decision making (Samba, 1999). It has been discovered however, that the consequence of women's lack of autonomy in decision making is having related results in poorer child health and survival, including inadequate reproductive health education and outright infant, foetal and mother's death (Jejeehboy, 1998). Household power structure at home alone in a way is an inhibition/hindrance to redressing unmet reproductive needs among women in Nigeria and Africa at large (Samba, 1999).

In a study by the Prevention of Maternal Mortality Network (PMMN) (1992) in Erinsho (2006), which covers Nigeria, Ghana and Sierra-Leone, it was discovered that the patriarchal family system is impinging precariously on the health of the pregnant women. This is because women are made to be subjects and subordinates to their men. This affects the extent to which women can make independent decisions in case of complication during labour and delivery period. Not only this, complications may be cumulative effects of religious practices, belief system, nutrition dos and don'ts during pregnancy and other cultural practices.

Religion and Health Seeking Behaviour of Pregnant Women

Pregnant is regarded as a mystery in all societies of Africa and Nigeria is not an exception to this belief. Despite the illumination and understanding brought about by science and liberal art, this belief still persists. In this respect, religion tends to influence the belief system more especially reproductive ones are affected by religious affiliation in African societies (Akintan, 2001). In this sense what is known as religion in Yoruba land is constructed through what is explicable within the environment to explain the inexplicable. Thus, religion is devised to counteract environment problems, and as a response to certain diseases and life hazards, included in these are the ones associated with pregnancy.

This is contrasted to the belief system in western societies on which their concept of disease, reproductive issues and maternal ill health is based on scientific interpretation with particular reference to germ theory. Because of this, patients and physicians in western societies perceive disease in whatever form, in terms of organic malfunctioning of the system and it is diagnosed and treated by using clinical methods and techniques (Erinsho, 2006). However, the incidence of disease, illness and sickness in non-western societies of Africa is often traceable to magic and religion. It is usually attributed to witchcraft, sorcery and other mystical forces. Therefore the nature of pregnancy itself is perceived as a spiritual exercise and a part of destiny and it must be guided spiritually.

And this entails adhering strictly to certain religious prescriptions. For instance, pregnant women are made to abstain from taking salt in some societies in Nigeria. This could be because of belief that salt is found in the sea, and sea is regarded as abode of spirits, including the “born to die child” or *Abiku* therefore, anybody that takes salt may likely end up having an *Abiku* child. Belief in *Abiku* is so rife that when a pregnant woman is moving around, may, be to the market, or other important places she is advised to always tie a pebble or a piece of iron at the edge of her wrapper. This is believed to ward off the *Abiku* spirit which may enter into her womb and displace the foetus in the womb. This practice is particularly rife among the not-so educated and illiterate women in this province. Although historians of Christianity or Islam in Africa depict traditional religion as static, unchanging and evil; experience in some areas shows that, belief in the traditional religion is shared even among the Christians and Muslims alike. Isichei (1983) recorded that; belief in *egungun* (masquerade) and its worship has helped to ward off witches that are killing children in the time past. Thus, pregnant women in Yoruba land and other places in West Africa do protect their yet unborn babies by using *egungun* as anti-witchcraft severally and collectively on the religious pedestal to ward off unseen hands of witches and from the manipulation of the unborn babies by *Abiku spirit*. For this reason, it is not uncommon seeing an expectant mother who is going through complication during delivery period consulting with herbalist cum traditional birth attendants (TBAs) to know the “leg” or the “destiny” of the baby and why the complication or prolong labour. And when this is done, it is not unexpected that the baby would be delivered. For instance, Chiwuzie and Okolocha (2001) saw a correlation between traditional beliefs (and practices) and poor health status for pregnant women due to prescription of dos and don'ts/ foods taboo where food intake that would help the pregnant woman to be well off would be excused on the basis of religion. Islam on the other hand frowns at the practice of male physicians/Doctors attending to female patients (see SMHFS, 2000). This idea without prejudices is counterproductive, to pregnant women especially where female doctors are not in adequate supply.

Concluding Remarks

Mother and child mortality and incidences of disease show that lack of maternal education, cultural practices, un even development and poor income have a significant impact in exacerbating mother and child deaths. In addition, there is a strong trend in poor countries that appears to be antagonism to development in technological and other advances, such as bio-technology, vaccine and drug innovations. The points therefore, that suffice from this review are thus: Pregnant women are directed and affected by certain socio-cultural and environmental factors, values and norms: such as long distances hindering accessibility to timely booking and other inhibitions like decision making, food taboos and gender inequality. However, with an extensive health education, sufficient budgetary allocation, moderation of some cultural elements/taboo which is contrary to maternal health consumption; the inhibitions would be mitigated. Therefore, to attain the expected and robust health seeking behaviour, pregnant women are expected to act individually and collectively too in response to their health issues and adhere strictly to the ante-natal, delivery and post-natal matters. Also, the husband/partner should collaborate with his wife/partner in order to achieve better health/pregnant status for the woman.

Notes

1. Dr. Abiola Akiyode-Afolabi (2014) of Women Advocates and Documentation centre (WARDC) was particularly specific that in every day 2300 under five year olds and 145 women of child bearing age die. And that a woman dies every 90 seconds from complications related to pregnancy and child birth. Maternal death to her is 630/ 100,000, the new figure as against 800/100,000 quoted by National Human Resources for Health Strategic Plan; in 2012 is still far and grossly unacceptable (The Nation - A Nigerian Newspaper - on Sunday June, 22).
2. National Human Resources for Health Strategic Plan, was Nigeria's effort at revamping health care services in the areas of resources allocation from 2008 – 2012.

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