RESEARCH ARTICLE

Perceived Challenges of Using Maternal Healthcare Services in Nigeria

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Okechukwu O Ajaegbu
Department of Sociology, University of Ibadan, Ibadan, Nigeria.

Correspondence: ajaegbuodina@yahoo.com

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Abstract
Motherhood is a thing cherished by most women; yet this valued and precious part of life is among the most hazardous experiences that women often engage in without being aware of the risk or danger they are in. Health Belief Model was used in this study to explain how perceived barriers affect the use of maternal health care services by expectant mothers. The data for this study came from 2008 Nigeria Demographic and Health Survey. Three-quarters of women reported they have at least one problem in accessing health care. Fifty-six percent of women said that getting money for treatment was a serious problem in accessing health care. The study concludes that money for treatment is the major barrier that hinders women from accessing maternal health care services. However transportation and distance to hospitals poses great challenge to accessing maternal health care services in rural areas of Nigeria.

Keywords: Maternal healthcare; maternal mortality; problems; access; perception.

1. Introduction

Maternal health refers to the health of women during pregnancy, childbirth, and the postpartum period. It encompasses the health care dimensions of family planning, preconception, prenatal, and postnatal care in order to reduce maternal morbidity and mortality [1]. Motherhood is a thing cherished by most women; yet this valued and precious part of life is among the most hazardous experience that women often engage in without being aware of the risk or danger they are in [2]. Pregnancy and childbirth complications are leading causes of death and disability among woman of reproductive age, especially in developing countries. One thousand girls and women die in pregnancy or childbirth every day. It is estimated that about 529000 women died from the complications of pregnancy in 2000. Of this figure, Africa and Asia accounted for about 95% (502550 deaths), with each contributing half of this figure. About four percent occurred in Latin America, while less than one percent occurred in developed regions [3]. In 2008, an estimated 358,000 women died due to complications developed during pregnancy and childbirth [4]. One out of every 31 women dies during pregnancy or childbirth in sub-Saharan Africa, compared with just one in 4,200 in Europe [4]. For every woman who dies, at least 20 more suffer injury, infection or disability from maternal causes; approximately seven million women every year [3].

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 [5]. Nigeria loses about 145 women of childbearing age every day. 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 [6]. 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 [7].

High-quality accessible health care has made maternal death a rare event in developed countries, where only 1% of maternal deaths occur; these complications are often fatal in developing world [1]. It is projected that providing skilled health care workers at delivery and emergency obstetrics care could save nearly three-fourths of mothers' lives. Yet each year, 50 million women give birth in their homes without any professional help [8]. Therefore, this study examines perceived challenges that deter women from using available maternal healthcare services in Nigeria.

1.1. Health belief model

This study is anchored on Health Belief Model which suggests that individuals weigh the potential benefit of the recommended action against the psychological, physical and financial cost of the action. Rosentock noted that the combination of perceived susceptibility and severity provide motivation for action [9]. The comparison of perceived benefit to perceived barriers provides the pathway to action. Thus, the stronger the perception of severity, susceptibility and benefit, the weaker the perception of barriers the greater the likelihood that health protective action would be taken.

Perceived challenges of using maternal healthcare services in Nigeria could be explained using Health Belief Model. Rosentock argued that the combination of perceived susceptibility and severity provide motivation for action [9]. The knowledge of the susceptibility of a woman to lose her life during child delivery if not properly taken good care of by health practitioners and the severity of delivery complications motivate people to consult health practitioners during pregnancy. Rosentock noted that there are challenges (money, proximity, and environment) that influence people's decisions. He indicated that these perceived challenges could be suppressed when the knowledge of the severity of not complying outweighs the benefit. This may account for why many women in the rural areas do not access modern maternal healthcare services in Nigeria. Illiteracy and low awareness of its benefits in most rural areas of Nigeria could account for the low usage of maternal health services in Nigeria. Most women are unaware of the benefit of using modern maternal health services and even when they are aware, money to access maternal health services become another challenge. Thus the inability of most Nigerian women to pay for maternal health services (challenges) and the knowledge of the severity of not using these services, push these women to use other remedies (herbs). This may be why about 50% of Nigerian women deliver at home [10], where they use traditional and other home remedies and might have accounted for high rate of maternal deaths in Nigeria.

Finally, Karsl and Cobb noted that exposure to factors that prompt action and the confidence in their ability to successfully perform an action influences people's decision [11]. Therefore, due to lack of or almost absence of quality formal healthcare providers (challenges) in most rural communities in Nigeria, people tend to be unaware of the need to receive maternal health care services from skilled providers during pregnancy. This may account for why the numbers of people that use such services are higher in urban areas when compared to rural areas of the country.

1.2. Challenges of using maternal healthcare services in Nigeria

The use of modern health care such as maternal health services can be influenced by the socio-demographic characteristics of women, the cultural context, and the accessibility of these services [12, 13]. The major and consistent determinant of using maternal health care is the level of education of expectant mothers. Maternal education has been shown repeatedly to be positively associated with the utilization of maternity care services [12, 14]. In a study of maternal mortality in Addis Ababa, women who did not receive maternity care were often poor, illiterate, and unmarried, with limited knowledge of maternity care services [14]. A woman that is not educated is likely not to be aware of the benefit of using maternal health services. 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. According to Addai, cultural perspective on the use of maternal health services suggest that medical need is determined not only by the presence of physical disease but also by cultural perception of illness [14]. In most African rural communities, maternal health services coexist with indigenous health care services; therefore, women must choose between the options [14]. 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 [15]. Moreover, in many parts of Africa, women's decision making power is extremely limited, particularly in matters of reproduction and sexuality. In this regard, decisions about maternal care are often made by husbands or other family members [16].

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 [17]. Many communities in Nigeria do not have hospitals and when they do, they do not have qualified medical practitioners that take care of patients. This may account why only 35% of 2008 delivery in Nigeria took place in health facility [10]. Furthermore, Ibekwe revealed that in most countries, roads are inaccessible and transportation systems are chaotic [17]. 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 urban area through bad roads. This is one of the major factors that deter women from accessing maternal healthcare services because after such long journey, one may even develop health problems due to stress.

Economic situation of the woman is another factor that hinders access to maternal healthcare in Nigeria. Fees reduce women's use of maternal health services and keep millions of women from having hospital-based deliveries or from seeking care even when complications arise [18]. A situation where more than half of Nigerians live on less than one dollar a day, maternity healthcare service which is financially demanding may be seen as secondary need.

2. Methods

The data for this study come from the 2008 Nigeria Demographic and Health Survey. The sampling frame used for the 2008 NDHS was the 2006 Population and Housing Census of the Federal Republic of Nigeria conducted in 2006, provided by the National Population Commission (NPC). The survey collected information from a nationally representative sample of 33,385 women age 15-49, who had given birth in the five years preceding the survey. Mothers were asked whether they had obtained antenatal care during the pregnancy for their most recent live birth in the past five years and factors that deter them from accessing maternal healthcare. Questionnaire was administered and was analyzed using percentage Table.

3. Results

3.1. Antenatal care

Table 1 presents information on the type of provider from whom antenatal care services were received for the most recent birth among women who had a live birth in the five years preceding the survey, by background characteristics. According to the World Health Organization (WHO), a skilled health worker is "an accredited health professional—such as a midwife, doctor, or nurse—who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate post-partum period, and in the identification, management, and referral of complications in women and newborns" [19].

Table 1 shows that 58 percent of women age 15-49 received antenatal care (ANC) from a skilled provider (doctor, nurse/midwife, or auxiliary nurse/midwife) during their last pregnancy. Three percent of women received ANC services from a traditional birth attendant, and 36 percent did not receive ANC services at all. Mother's age at birth is related to use of professional antenatal care services, increasing from 45 percent among women under age 20 at the time of the birth to 61 percent among women age 20-34, and then declining to 55 percent among older mothers age 35-49. Child's birth order is inversely related to the use of antenatal care. Women with higher order births are less likely to receive antenatal care from a skilled professional. Table 1 indicates that 64 percent of women pregnant with their first child received antenatal care from a skilled health worker, compared with 47 percent of women with births of order six or higher. The proportion who obtained ANC services from a skilled health worker is higher among women residing in urban areas (84 percent) than among women who reside in rural areas (46 percent). The percentage of women receiving antenatal care from a skilled provider varies substantially among the zones, from 31 percent of women in North West to 87 percent in South East and South West. Mother's education is directly associated with increased use of a skilled health worker for ANC services. Almost all women (97 percent) with more than secondary education received ANC from a skilled health worker, compared with 31 percent of women with no education.

Perceived problems of accessing health care

In the 2008 NDHS, women were asked whether each of the following factors would be a big problem in seeking medical care: getting permission to go for treatment, getting money for treatment, distance to health facility, transport cost, not wanting to go alone, concern there may not be a female provider or any health provider, and concern that drugs may not be available.

Table 1: Antenatal care.

Percent distribution of women age 15-49 that had a live birth in the five years preceding the survey by antenatal care (ANC) provider during pregnancy for the most recent birth and the percentage receiving antenatal care from a skilled provider for the most recent birth, according to background characteristics, Nigeria 2008.

Background characteristics	Traditional/community health attendant/Others	Percentage receiving antenatal care from a skilled provider	No one	Missing	Number of women
Mother's age at birth					
>20	6.6	43.0	50.2	0.2	2,368
20-34	5.4	61.3	33.0	0.4	12,005
35-49	5.5	55.2	38.3	0.8	3,263
Birth order					
1	6.3	64.2	29.5	0.1	3,053
2-3	5.3	62.1	32.5	0.4	5,632
4-5	5.7	59.1	34.8	0.4	4,264
6+	5.4	47.0	47.0	0.6	4,687
Residence					
Urban	3.9	83.8	11.8	0.4	5,330
Rural	6.2	46.4	46.9	0.4	12,305
Zone					
North Central	8.4	65.1	26.2	0.4	2,525
North East	5.7	43.0	51.2	0.2	2,751
North West	1.1	31.1	67.1	0.7	5,372
South East	5.3	87.0	7.4	0.2	1,603
South South	3.0	69.8	18.8	0.3	2,310
South West	5.8	87.1	5.7	0.4	3,075
Mother's education					
No education	4.9	30.8	63.7	0.6	8,017
Primary	7.7	68.9	23.1	0.2	4,012
Secondary	5.8	86.0	7.9	0.3	4,557
More than secondary	1.0	97.4	1.2	0.4	1,050
Total	5.6	57.7	36.3	0.4	17,635

Three-quarters of women reported that they have at least one serious problem in accessing health care. The leading barrier to health care for Nigerian women is getting money for treatment. Fifty-six percent of women said that getting money for treatment was a serious problem in accessing health care. Forty-one percent of women said they were concerned that there would be no drugs available at the health facility. About one in three women reported that transportation, distance to the health facility, and not having a provider to attend to them are big problems. Twenty-one percent of women were concerned that there would be no female provider to attend to them. Not wanting to go alone (17 percent) and problems getting permission to go for treatment (14 percent) were less likely to be reported as a hindrance to seeking health care.

4. Discussion

Discuss on maternity care is necessary in order to provide information on planning, implementation and monitoring of programs designed to reduce maternal morbidity and mortality. Available information from 2008 NDHS shows that number of women that use maternity health care service is still low, with more than 42% of pregnant women not receiving antenatal care from a skilled provider and about 36% not receiving maternity care at all. This situation is the major issue that is responsible for high maternal mortality in Nigeria. The reasons may not be farfetched; 56.4% of the respondents noted that money to access maternal healthcare service is the major barrier that hinders them from accessing maternal healthcare service even when they have health complications. Nigeria is a country where majority of the citizens live below one dollar per day. Therefore as long as needs concerning feeding are not met, money to access good maternal healthcare service remains secondary need.

Table 2: Problems in accessing health care.

Percentage of women age 15-49 who reported that they have serious problems in accessing health care for themselves when they are sick, by type of problem and background characteristics, Nigeria 2008.

Background Characteristic	Problems in accessing health care									
	Getting permission to go for treatment	Getting money for treatment	Distance to health facility	Having to take transport	Not wanting to go alone	Concerned no female provider available	Concerned no provider available	Concerned no drugs available	At least one problem accessing health care	Number of women
Age										
15-19	16.2	56.6	36.8	33.8	23.6	20.5	33.2	40.5	73.2	6,493
20-34	13.3	55.2	35.3	33.1	25.7	20.3	33.5	41.4	73.0	17,076
35-49	12.4	58.6	37.4	35.6	15.4	20.8	33.4	41.7	75.1	9,816
Number of living children										
0	12.5	51.8	32.3	29.6	19.1	17.1	30.6	37.7	68.8	10,392
1-2	14.6	56.0	37.1	35.0	16.6	21.6	34.0	41.9	73.7	8,352
3-4	13.5	59.4	37.0	34.6	15.8	21.1	32.9	41.2	75.8	7,591
5+	14.2	60.6	40.0	38.5	16.3	23.5	37.5	45.9	78.7	7,049
Marital status										
Never married	10.6	52.8	31.0	28.2	18.0	13.7	28.1	35.2	67.4	8,397
Married or living together	15.0	57.4	37.9	35.9	17.1	23.0	35.3	43.4	75.7	23,579
Divorced/separated/widowed	7.6	65.1	38.0	37.3	13.6	19.1	34.4	42.2	78.5	1,409
Residence										
Urban	9.8	44.1	21.1	18.9	10.4	14.1	26.0	32.4	61.4	11,934
Rural	15.7	63.3	44.6	42.4	20.9	24.1	37.6	46.2	80.5	21,451
Zone										
North Central	14.3	65.4	40.6	36.5	19.5	15.2	25.8	35.2	75.8	4,748
North East	20.5	63.2	47.8	47.6	31.6	26.1	47.4	58.4	87.3	4,262
North West	20.4	57.8	37.7	37.4	18.7	39.4	48.6	57.0	80.3	8,091
South East	16.0	65.0	42.3	42.6	16.3	13.0	30.2	40.1	74.5	4,091
South South	6.9	50.7	32.2	26.8	10.7	11.7	31.6	37.6	69.1	5,473
South West	4.8	43.8	23.8	23.8	10.4	10.4	15.5	19.9	59.1	6,789
Education										
No education	21.5	64.6	45.9	45.0	24.0	32.7	44.0	52.9	84.3	11,942
Primary	11.9	62.3	39.9	36.6	16.5	17.3	32.0	39.8	77.4	6,566
Secondary	8.6	50.3	28.8	26.0	13.1	12.9	26.4	33.6	66.2	11,904
More than secondary	5.9	35.1	18.4	16.0	7.9	9.4	22.3	28.6	52.8	2, 974
Total	13.6	56.4	36.2	34.0	17.2	20.5	33.4	41.3	73.7	33,385

Scholarly works have shown that education is significant to the type of antenatal health care provider during pregnancy. Women who have completed secondary or higher education are most likely to be attended by skilled workers during childbirth [6]. From 2008 NDHS, 97% of those that have more than secondary school education received antenatal care from skilled health providers while about 31% of those that do not have any formal education received antenatal care from skilled health provide. To receive antenatal care from a qualified health practitioner involves finance and since education could be associated to financial status of an individual, money could be the major barrier that hindered these uneducated women from accessing antenatal care from qualified health practitioner. In order to further stress the relationship between money and education to accessing maternal health care service, Table 2, reveals that while 64% of women that have no education said that money is the major barrier that hinders them from access maternal health care, only 35% of those that have more than secondary school education noted that money is the major problem that hinders them from accessing maternal health care.

Worldwide, women giving birth in urban areas are twice more likely to be attended by skilled health workers than those in rural areas [20]. From the data, about 84% of respondents that live in urban area received antenatal care from skilled practitioner while 46% of respondents that live in the rural area received antenatal care from skilled practitioner. From Table 2, about 40% of women that live in urban area revealed that transportation and distance to hospital are among major barriers that hinder them from accessing maternal health care service, 87% of the respondents that live in rural area noted that transportation and distance to hospital are among major barriers that hinder them from accessing maternal healthcare service. Most rural areas in Nigeria do not have hospitals and therefore women have to go long distance through dilapidated roads to the city in order to access maternal healthcare service. This is one of the major barriers that alienate rural women from receiving maternal healthcare service. In order to avoid stress of travelling long distance through bad roads and due to lack of hospitals in many rural communities, pregnant women in rural areas use local remedies or do not use at all. This may be the reason 6.2% of women that live in rural area used home or traditional remedies during pregnancy while 46.9% of them did not use any maternal health service at all [10].

5. Conclusion

This study demonstrates that use of maternal health services by expectant mothers in Nigeria is influenced by their socioeconomic status in the society. Factors identified in this study that influence the use of maternal health care by Nigerian women are: getting permission to go for treatment, getting money for treatment, distance to health facility, transport cost, not wanting to go alone, concern there may not be a female provider or any health provider, and concern that drugs may not be available. The study concludes that money for treatment is the major barrier that hinders women from accessing maternal health care service. However, transportation and distance to hospital poses great challenge to accessing maternal healthcare services by women in the rural areas of Nigeria.

Competing Interests

None declared.

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