

# Maternal Health and the Implications for Sustainable Transformation in Nigeria

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## Abstract

Transformation is the major goal of the present democratic administration in Nigeria. No country ever achieves sustainable transformation without achieving maternal health. Maternal health is a major concern of all countries, especially in developing countries. This explains why Millennium Development Goals (MDGs) made maternal health one of the cardinal goals to be achieved by 2015. This paper examines the factors that brought about poor maternal health by critically identifying and discussing such factors as poverty, low level of education, inaccessibility of health care services, unbooked emergencies, hypertensive disorder of pregnancy, obstructed labour, anaemia, haemorrhage and infection. Guided by functionalist and political economy theories, the paper argued that the present maternal health is incapable of ensuring sustainable transformation in Nigeria owing to massive corruption, misplacement of priority, neo-liberal policies of government, leading to social and economic dislocation of families and widespread poverty. The paper concludes by arguing that, for there to be real sustainable transformation of Nigeria, the issue of maternal health should be accorded priority through reducing maternal mortality rate by government and other stakeholders. This could be achieved through massive enlightenment, sustainable education, poverty reduction, and adequate provision and funding of healthcare facilities in Nigeria.

**Keywords:** Maternal health, MDGs, Maternal Mortality, Sustainable transformation, Poverty

## Introduction

Sustainable transformation is a major target of every country that intends to achieve human development. Maternal mortality is a key indicator of a society's level of development and the performance of the health care delivery system. The majority of the causes of these deaths are preventable (Pittrof and Johanson, 1997; Ransom and Yinger, 2002; Bankole et al., 2009; Harrison, 2009). As cited by Archibong and Agan (2000), the World Bank Statistics indicated that at least 144 women die each day from pregnancy-related complications in Nigeria, placing the country among one of the worst in the world for women to deliver babies. There also exists marked urban-rural variation in maternal mortality rates: 135/100,000 in the urban as compared to 828/100,000 in the rural parts of the country (NPHCD, 2009).

Maternal mortality is one of the major challenges to health systems in the world and sub-Saharan Africa, in particular. In order to encourage the international community to address this challenge, maternal mortality reduction was included as one of the Millennium Development Goal (MDG) 5. The target of MDG 5 is to reduce maternal mortality ratio (MMR) by 75%, from 1990 to 2015 (UNGA, 2000). Although several studies have highlighted the slow progress in reducing maternal mortality, global reduction in maternal deaths with variations across countries has been reported elsewhere (Hogan et al., 2010). Global maternal deaths reduced by 35% from 526,300 in 1980 to 342,900 in 2010. In Nigeria, the maternal mortality ratio (MMR) in 2008 was reported to be 608 deaths per 100,000 live births (95% confidence interval (CI): 372-946). This was an increase from an MMR of 473 (95% CI: 306-703) in 1990 (Hogan et al., 2010). Despite challenges of measuring maternal mortality, the need for monitoring of maternal mortality is a priority for many countries including Nigeria. Estimates of maternal mortality are indispensable for planning and monitoring the outcome or impact of interventions. Recently, Nigeria expressed reservation about accuracy and methods used to obtain figures quoted and the bases for such estimates (NFMOH, 2011).

Maternal mortality is the single most important health issue facing obstetricians, gynaecologists, and Nigerians. Most Nigerians, especially women who are poor, are very vulnerable to illness, disability and even death owing to lack of access to comprehensive health services, particularly reproductive health services. These women need quality reproductive health services, such as medical care, planned family, family size, safe pregnancy, delivery care and treatment and prevention of sexually transmitted infections like HIV/AIDS. With accessibility to comprehensive reproductive health services, women are less likely to die in pregnancy, more likely to have healthier children and better able to balance their family and work life. Against this background, this paper examines factors affecting maternal health using Nigeria as a focal point.

## 1.2 Brief Review of the State of Maternal Health in Nigeria

Globally, the estimated number of deaths worldwide in 2005 was 536,000 as against 529,000 in 2000. According to the WHO Factsheet (2008), 1500 women die from pregnancy or pregnancy-related complications every day. Most of these deaths occur in developing countries, and most are avoidable. Of all the health statistics compiled by the World Health Organization, the largest discrepancy between developed and developing countries occurred in maternal mortality. Ujah et al. (2005) note that 25% of females of reproductive age who lived in developed countries contributed only 1% to maternal deaths worldwide. A total of 99% of all maternal deaths occur in developing countries. More than half of these deaths occur in sub-Saharan Africa and one-third in South Asia. The maternal mortality ratio in developing countries is 450 maternal deaths per 100,000 live births versus nine in developed countries. Fifteen countries have maternal mortality ratios of at least 1000 per 100,000 live births, of which all but Afghanistan and India are in sub-Saharan Africa: Afghanistan, Angola, Burundi, Cameroon, Chad, the Democratic Republic of the Congo, Guinea-Bissau, India, Liberia, Malawi, Niger, Nigeria, Rwanda, Sierra Leone and Somalia (WHO, 2008). Nigeria has one of the highest maternal mortality rates in the world, second only to India, whose population is eight times larger than that of Nigeria (Mojekwu and Ibekwu, 2012).

However, Mairiga et al. (2008) assert that the world's maternal mortality ratio (the number of maternal deaths per 100,000 live births) is declining too slowly to meet Millennium Development Goal (MDG) 5 target, which aims to reduce the number of women who die in pregnancy and childbirth by three-quarters by the year 2015. While an annual decline of 5.5% 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%. Gains in reducing maternal mortality has been modest overall, while average global infant mortality and under-five mortality have been reduced by more than half in the past 40 years, and average global life expectancy at birth has increased enormously during the same period but there have been no visible progress in maternal mortality ratio (MMR) reduction at the global level. Shah and Say (2007) note that the trend in developing countries is much worse, as studies from various countries of sub-Saharan Africa indicated that maternal mortality has not only continued to be high, but is also increasing after the launch of the Safe Motherhood Initiative (SMI) in Kenya in 1987 (Mojekwu and Ibekwu, 2012).

Nigeria at present has one of the highest rates of maternal mortality in the developing world. A recent report (Hogan et al., 2010) listed Nigeria as one of six countries that account for 50% of global estimates of maternal deaths. There exist wide variations in rates of maternal mortality between the six geo-political zones of Nigeria: the North East Zone has the highest rate of 1,549/100,000 live births, while the South West Zone has the lowest rate of 165/100,000 live births (SOGN, 2004). Indeed, the country has been ranked as the second country after India with the highest absolute number of maternal deaths in the world. Consequently, there is a growing concern that the country may not achieve the maternal mortality reduction aim of the Millennium Development Goals (MDGs), if the present trend continues. This consternation has created an emergency need for programmes and policies aimed at accelerating progress towards addressing the problem (Okonofua, 2010). Maternal mortality is one of the key indices of the state of health and quality of healthcare in any society. The death of a woman has devastating effect on the whole family.

Maternal mortality remains unacceptably high. New data showed signs of progress in improving maternal health — the health of women during pregnancy and childbirth — with some countries achieving significant declines in maternal mortality ratios. But progress is still well short of the 5.5% annual decline needed to meet the MDG target of reducing by three-quarters the maternal ratio by 2015. Progress has been made in sub-Saharan Africa, with some countries having maternal mortality levels between 1990 and 2008, though maternal mortality reductions has long been a challenge in low-income countries despite the data on levels of maternal mortality. Other regions, including Asia and Northern Africa, have made even greater headway (UNS, 2010). Haemorrhage, sepsis, unsafe abortion, obstructed labour, and hypertensive diseases of pregnancy have caused more than 80% of maternal deaths. Most of these deaths are preventable when there is access to adequate reproductive health services, equipment, supplies and skilled healthcare workers. More women are receiving antenatal care and skilled assistance during delivery. In all regions, progress is being made in providing pregnant women with antenatal care. In North Africa, the percentage of women seeing a skilled health worker at least once during pregnancy increased by 70%. Southern Asia and Western Asia reported increases of almost 50%, with coverage increasing to 70% of pregnant women in Southern Asia and 79% in Western Asia. In 2008, skilled health workers attended 63% of births in the developing world, increase from 53% in 1990. Progress was made in all regions, but was especially dramatic in North Africa and South-eastern Asia, with increases of 74% and 63%, respectively (UNS, 2010). Although wide disparity still exists between providing pregnant women with antenatal care and skilled assistance during delivery. Poor women in rural and remote areas are least likely to receive adequate care. This is especially true for regions where the number of skilled health workers remains low and maternal mortality high particularly sub-Saharan Africa, Southern Asia and Oceania. HIV is also curtailing progress, contributing significantly to maternal mortality in some countries (UNS, 2010).

Nigeria has been mentioned by the United Nations as having one of the highest rates of maternal mortality in the world. Reducing high maternal mortality ratio is not just a technical and medical challenge but also largely a political one which requires the attention and commitment of political leaders (Mojekwu and Ibekwe, 2012). According to WHO (2007) as cited by Mojekwu and Ibekwe (2012), maternal mortality, also known as maternal death, continues to be the major cause of death among women of reproductive age in many countries and remains a serious public health issues, especially in developing countries (Mojekwu and Ibekwe, 2012). Shah and Say (2007) define maternal death as death of a woman 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 (Mojekwu and Ibekwe, 2012).

Nigeria is the tenth most populous country in the world and the largest in sub-Saharan Africa, with an estimated population of 174,507,539 (CIA, 2013). Nigeria's population growth rate has been driven by high fertility which has fallen in the last few decades but not as rapidly as the fall of the crude death rate (Toure, 1996; Kolawole, 2006). The Total Fertility Rate (TFR) declined modestly from 6.3 children per woman in 1981-1982 to 5.7 children per woman in 2008. Understanding fertility desires and behaviour requires a careful examination of women's and men's attitudes and behaviours about reproduction within their economic, social, and cultural context (Akinfeleye et al., 1994; Smith, 2004).

High population growth is related to the socio-economic development of any nation (Daniel, 2009). The effects of rapid population growth include reduced per capita income; high rural-urban migration; heavy pressure on social services, such as health care and education; high unemployment rates; poverty; land fragmentation and degradation; and communal clashes over arable land (Akinfeleye et al., 1994). Within families, elevated risks of maternal and child mortality and a higher risk of being trapped in poverty are areas of concerns as family increases (Olukoya and Ferguson, 2002). High fertility is one of the primary determinants of rapid population growth, which can hinder socio-economic development. Thus, efforts to reduce poverty and promote sustainable development have included an emphasis on strengthening family planning programmes (Adiri et al., 2010).

The Nigerian health system as a whole has been plagued by problems of service quality, including unfriendly staff attitudes to patients, inadequate skills, decaying infrastructures and chronic shortages of essential drugs. Electricity and water supply are irregular and the health sector as a whole is in a dismal state (Mojekwu and Ibekwu, 2012). In 2000, the World Health Organization ranked the performance of Nigeria's healthcare system 187th among 191 United Nations member states. A 2003 study revealed that only 4.2% of public facilities met internationally accepted standards for essential obstetric care (Harrison, 2009). Approximately, two-thirds of all Nigerian women deliver outside of health facilities and without medically skilled attendants present. The state of well-being performance of the health system must be understood in the context of the country's long-standing problems with governance. Corruption in the political system is endemic, while social development, including the promotion of the health of Nigerian citizens, has been more a rhetorical than a real aim of the state (Mojekwu and Ibekwu, 2012).

Also, Nigeria has one of the worst records of maternal deaths in the world and this situation is worsening with time. The problem of poor organization and access to maternal health services has always been a major challenge in Nigeria (Mojekwu and Ibekwe, 2012). Omo-Aghoja et al. (2010) assert that maternal care in Nigeria is organized around three tiers: primary, secondary, and tertiary health care levels. Primary health centres are located in all the 774 local government councils in the country. Pregnant women are to receive antenatal care, delivery and postnatal care in the primary health centres nearest to them. In case of complications, they are referred to secondary care centres, managed by states, or tertiary centres, managed by the Federal Government (Mojekwu and Ibekwe, 2012). According to the 2008 Nigeria Demographic Health Survey (NDHS), Nigeria's maternal mortality ratio over the past five years ranged from 475 to 615 per 100,000 live births, with an average of 545/100,000 live births (NDHS, 2008). The United Nations, in 2010, reported that, although substantial progress has been made globally towards meeting the MDGs, the two goals relating to maternal and child health have lagged behind (Countdown, 2010). Data from the United Nations and the World Bank identified Nigeria as one of the worst countries for a woman to give birth, with women having one in thirteen chances of dying during pregnancy and child birth (United Nations MDG Report, 2008). It is estimated that about 59,000 women die each year in Nigeria owing to pregnancy-related complications, which translates into 144 maternal deaths on a daily basis. In 2003, the average maternal mortality ratio for Nigeria was put at 704/100,000 live births, with a range of 165/100,000 live births in the southwest to 1,549/100,000 live births in the northeast of the country (NDHS, 2003).

As part of its effort to meet the MDGs, the Nigerian government has formulated and approved several policies and programmes in the health sector (Bankole et al., 2009) and has increased the health budget from 1.7% in 1999 to 5.6% of the total budget in 2006 (Integrated Maternal and Child Health Strategy, 2007). This is still a far cry from the 15% budgetary allocation to health agreed to by Africa nations in the Abuja declaration of

2001 (The Maternal Newborn Roadmap, 2005). Five years to the target of the MDGs, Nigeria is still among the 38 African nations that made no significant progress in achieving the MDGs (Countdown, 2010). According to NDHS (2008), there were some regional variations in the maternal mortality ratios with the north-western and north-eastern regions having the worst figures (Chama et al., 2010).

Poor quality and coverage of maternal healthcare has long been identified as leading causes of high maternal mortality in developing countries, such as Nigeria (Oguntunde et al., 2010). Existing evidence indicates that inability to access high-quality ANC and skilled providers at birth are likely to result in adverse outcomes for mothers and infants (Villar et al., 2001; Saha and Kabir, 2006; Ezechi et al., 2004; Ogunlesi, 2005; Okunola et al., 2006). In addition, concerns about women's health related to maternal morbidity and mortality have made discussions on fertility intentions and contraceptive preferences paramount. Nearly half of pregnancies worldwide are unintended, and much scope remains to improve contraceptive coverage (Cleland, 2009). The goal is to avert health outcomes associated with unintended pregnancies in order to increase chances of attaining the fifth Millennium Development Goal (MDG) of reducing maternal mortality by three-quarters by the year 2015 (Avidime, 2010). Across the globe, fertility rates have fallen largely owing to the widespread and increasing use of modern methods of contraception. However, in some developing countries, the uptake of contraception remains low as a result of cultural, economical, and political barriers (Konge and Oladipo, 1999). Today, sub-Saharan Africa is the region with the lowest levels of contraceptive use and the high levels of fertility rates. A study of six ethnic groups in Nigeria (Yoruba, Hausa, Fulani, Ibo, Kanuri, Efik, and Ibibio) found that all placed a high premium on large family size (Avidime, 2010).

Socio-cultural factors also play a key role in influencing men and women's knowledge and practices related to maternal health. For instance, people in the northern part of Nigeria, are mostly Fulani/Hausa Muslims. Since men hold the primary decision-making power in the society, the decision to go to a health facility in an emergency must wait until the husband (or in-laws) give consent (Wyss et al., 1996). In addition, the low value placed on girl's education leads to low rates of girl's primary school enrolment. Even though knowledge about maternal health is not taught in school, the very fact of having attended school seems to increase overall awareness and ability to obtain new knowledge, as has been seen in Nepal, Venezuela and south-western Nigeria (Kane, 2004; Hyacinth et al. 2006).

Place of delivery is another important factor. The 2008 Nigerian Demographic and Health Survey (NDHS) reported that 90.2% of deliveries in the northeast region took place without a skilled birth attendant (SBA). The report also reveals that north-western Nigeria women who gave birth without a skilled attendant were perfectly divided. For example, 44% were assisted by relative or a traditional birth attendant and the other 44% delivered completely alone (NDHS, 2008). Although delivering alone is quite rare in other countries, it is a routine among women in Hausa-Fulani society because it is considered shameful to be heard crying out during child birth (Yusuf, 2005). Rates of home deliveries exceed 90% in rural areas. Adamu et al. (2002), in a study based in rural Kano, found that 96.3% of women delivered or planned to deliver at home (Yusuf, 2005).

### **1.3 Theoretical Framework**

This research was guided by functionalist and political economy theories. The theories support the fact that present maternal health is incapable of ensuring sustainable transformation in Nigeria owing to massive corruption, misplacement of priority, neo-liberal policies of government leading to social and economic dislocation of families and widespread poverty.

#### **1.3.1 Functionalist Approach to the Health Care System of Nigeria**

Functionalists generally adhere to the view that society can be understood in its totality as an entity unto itself. Among the earlier functionalist thinkers, it was not common to view society as an organism with differentiated parts that function together in order for it to adapt and survive in its environment. Although contemporary functionalists are not as crude, they tend to look at society as an integrated system of functionally interrelated structures, at times suggesting that societies have a life of their own and that their survival demands that particular needs of the system have to be met.

The contributions of Talcott Parsons to the theory of functionalism are the record of a life time of writing in the area of social theory (Farganis, 2003). Parsons attempted, in his several works, to develop concepts that would help organize our perceptions of social reality. In recasting the functional imperatives of a social system, Parsons developed a fourfold classification scheme with the acronym AGIL (Adaptation, Goal attainment, Integration and Latency). Adaptation refers to the fact that systems are embedded in physical and socio-political environments to which they must adapt if they are to survive. Goal attainment refers to the need to define the primary goals of any system and the methods by which individuals accept those goals as their own and strive to achieve them. Integration refers to the need to coordinate the component parts of the system so that they contribute to the maintenance of the whole. Latency refers to those structures that serve to maintain and revitalize the motivation of individuals to perform their roles according to social expectations (Farganis, 2003).

Parsons further elaborated his conceptual scheme to a four-fold system. Each of the action systems,



namely social, cultural, personality and the behavioural organism, is tied to the functional imperatives of a total system. Thus, the complex of institutions that we group under the rubric of socialization and social control perform the integrative functions of the system, whereas the values and norms that serve to motivate social action are grouped as part of the cultural system (Farganis, 2003). The personality system functions to attain the goals of the system and the behavioural organism which provides the energy for adaptation and transformation of the system in relation to its environment.

In Nigeria, the most pressing emergency in the health sector is the health of mothers, during pregnancy and after birth. How can the system work in a different and better way to deliver better health outcomes when government spend about 70-80% of the country resources available for healthcare at the point of need of the masses. It can make a huge difference, especially in the issue of maternal mortality rate, if such funds that are available are spent for health care delivery (NAS, 2009). Primary health care is the key indicators of maternal health issues. The epidemiology of disease for women in Nigeria is haemorrhage, or complications of childbirth, like postpartum infections. Science is not needed in to handle these but the system of the health care delivery for women, should be organized to do things better in a more effective and efficient way. There should be replication of primary health care in Nigeria, most especially in the rural areas of Nigeria where pregnant mothers can have free health care services. The investment government has made in the health system in Nigeria over the years is so little compared to what obtains in developed countries. Communities having well-organized health insurance schemes can raise significant resources to deliver health care to women.

### **1.3.2 The Political Economy of the Maternal Health Care Delivery in Nigeria**

Political economy has undergone a process of dramatic change over the years. This process, which spans over more than two centuries, has helped to define the boundaries of the field's domain, organize its subject matter, and establish an identity for modern political economy (Merlo, 2006).

Nevertheless, the forces surrounding the economies of underdeveloped world, especially Africa, has practically stifled its economic progress, growth, development, and sustainability. This economic condition brings to the fore the massive onslaught of rural/urban poverty which the African continent has been grappling with since the post-world war II era. Is there any chance of imperialism initiating and championing industrialization in the Third World? (Onimode, 1982). This question has been at the root of a growing debate between the Underdeveloped/Dependency Theorists (UDTS) and Marxist critics. The UDTS, who arose primarily as critics of bourgeois modernization theories, argued that there has always been a link between underdevelopment in the Third World and development in the West and that imperialism cannot industrialize the Third World in any serious way (Onimode, 1982). Marxist critics, on the other hand, have argued that there is no reason to believe that capitalist industrialization is impossible in the Third World, given that expansion is the primary force of the capitalist mode of production. Onimode, following classical UDTSs, avers that Nigeria's underdevelopment had its origins in the 15th century, with the European slave trade, and was entrenched through colonisation. Today, underdevelopment is sustained through neo-colonialism. Onimode's prime objective is to debunk the distortion of the Nigerian reality by bourgeois modernization theories (Onimode, 1982).

The rising tides of post-World-War II experiences and the shocks arising from poor socio-economic fortunes of African states are a major impediment to growth, socio-economic and political development in the region. Africa suffers an ugly trend of colonial domination, exploitation and manipulation to the extent that the capitalist traits have literally been transferred to the African domestic elite who, in turn, are constrained by the very nature of their imperial grand masters to so little or nothing to stimulate economic growth as well as alleviate mass poverty (Erunke and Uchem, 2013). The foregoing is a demonstration of the ideological and philosophical questions of the spirit of primitive accumulation (Luxemburg, 1913; Goulbourne, 1979; Onimode and Synge, 1995; Onimode, 1993), the attitude which was handed down to African leadership from their superior masters. The inability to allow for social and home-grown economic designs that could ultimately transform the economies of backward nation-states constitutes a fundamental setback to the road to progress of less developed countries, especially on the African continent. Situations such as this propel underdevelopment, backwardness, lack of focus and vision for strategic development plans, deterioration in living conditions of the African people, unemployment, famine, disease pandemics, illiteracy, terrorism, malnutrition, violence, war and, ultimately, entrenchment of poverty in the socio-economic landscape.

The medical profession of the underdeveloped countries, like those of the advanced industrialized nations, obstructs programme reforms in health care as they try to protect their control over medical practices, and their status and income. Placing the profession and its members' interests above those of the people's needs for accessibility to health services, the medical practice in Nigeria has generally remained small elite right, thus the priority for curative than preventative health care (Jegade, 2002). For instance, the medical system, which the Nigerian government inherited from the colonial administration, had the hospital, as opposed to rural health centres, as the cornerstone. Curative health care, compared with public health, was associated with hospital work. The government continued the same policies. In 1962, while ₦125,000 and ₦150,000 were allocated to the expansion of public health laboratories and the national institutions for social and preventive medicine, over ₦4

million was earmarked for just three hospitals in Lagos and Ibadan. During the 1970-74 development plan, ₦29.1 Million was allocated for curative services and ₦8.05 million for preventive services (Pearce, 1986). While the trend still continues, hospitals today have remained “mere consulting clinics” because of poor funding (Jegede, 2002).

According to Soyibo (1998), only 1.5% of the total expenditure was allocated for health between 1985 and 1996 compared, with an average of 8.8% allocated for defence and security during the same period. This is about six times the share of health. Currently, about 1% of the annual budget is allocated for health compared with 3% allocated for defence and security. Nigeria, unlike other African countries, allocated less than 5% as recommended by the World Health Organization (WHO). For instance, between 1992 and 1998, Ghana allocated 7% for health, Kenya allocated 6%, Tanzania allocated 6%, and Zambia 8% (UNICEF, 2000). The determinant of government responsiveness to its citizens is a key issue in political economy. The problem of health care delivery in Nigeria is, therefore, rooted in the political economy of the nation. Although the health care system of the country has witnessed tremendous growth since independence, there is still a number of problems that prevail which hinder corresponding improvement or progress in the health of the people. These factors include inadequate supply of physicians, poor distribution of health facilities, lack of adequate access to safe water and sanitation, shortage of drugs, attitude of health workers, cost, poor infrastructure facilities, and poor health education strategy. The National Health and Population Policy have identified most of these problems, but they still dominate health agenda today.

The genesis of health care delivery problem in Nigeria is its capitalist-oriented economy. The process of capital accumulation determines the growth of social needs. Today, there are additional health problems, which are as a result of technological development, such as accidents and occupational diseases. As a result of technological development, there is differentiation of labour, which fragments the process of production in healing business. This means centralization within the medical sectors and domination within the echelon of the medical hierarchy. The medical sector is one of the very few sectors of the economy which is favoured by capitalism. Medicine in Nigeria grew from being a civil servant employment to what Cooper and Schatzkin (1982) call “the last hope of man on earth,” thus operating as cult system. Medical schools became the property of the bourgeoisie as the admission and finance of trainee physicians became a class issue. The health problems in Nigeria are likely to remain the same and even more endemic in the future, taking into consideration the present political economy of the nation, leadership style which is adamant to progress, and high degree of political instability. There cannot be proper implementation of programmes of equity in a society faced with class-consciousness, corrupt leadership, and democratic abortion. To alleviate these problems, there is first of all the need for Nigeria to separate the political economy from foreign influence. Second, the economic exploitation and political ineffectiveness by Nigeria’s ruling class should be replaced by economic equality of the population and leadership. Nigeria should have welfare programmes for her citizens and make health care delivery a national priority (Jegede, 2002).

### **1.3 Discussion on Factors Affecting Maternal Health in Nigeria**

Everywhere in the world, pregnancy and birth pose a risk to the life and health of women and newborns, regardless of whether a pregnancy was intended. The level of risk depends on a woman’s health before she is pregnant, her living conditions, and the care she receives during pregnancy and delivery (Singh et al., 2009).

One of the major development and health challenges facing developing countries, particularly those countries in Africa has the unacceptably high levels of maternal deaths arising from complications related to pregnancy and child birth. An estimated half a million women die every year in child birth or owing to pregnancy-related causes. As a result, more than one million children are left motherless and vulnerable. Also, for every woman who dies, an estimated 20 or more other women experience serious complications such as obstetric fistula. In Nigeria, an estimated 30,000 women die yearly from complications related to pregnancy and child birth, a majority of them in north-west and north-east regions of the country. This does not have to be the case: these lives could be saved if all women had access to reproductive health (RH) services, care during pregnancy and skilled medical attendance, and emergency obstetric care to handle complications.

Increasing the survival of mothers is a crucial international development challenge. Mothers are the cornerstone of families, their health and well-being is fundamental to the health of the newborn babies and children. The health of mothers is inseparable from the health of newborns (Lawn, Cousens and Zupan, 2005). Newborns whose mothers die of any cause are three to 10 times more likely to die within two years than those whose mothers survive.

However, in the international statistical classification of diseases and related health problems, 10th revision (ICD-10) (9), WHO defines maternal death as the death of a woman 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 (WHO, 2012). This definition allows identification of maternal deaths, based on their causes, as either direct or indirect. Direct

maternal deaths are those resulting from obstetric complications of the pregnant state (pregnancy, delivery and postpartum), interventions, omissions, incorrect treatment, or a chain of events resulting from any of the above (WHO, 2012). Deaths arising from obstetric haemorrhage or hypertensive disorders in pregnancy, or those arising from complications of anaesthesia or caesarean section are classified as direct maternal deaths. Indirect maternal deaths are those resulting from previously existing diseases, or from diseases that developed during pregnancy and that were not due to direct obstetric causes but aggravated by physiological effects of pregnancy. For example, deaths owing to aggravation of an existing cardiac or renal disease are considered indirect maternal deaths. The concept of “death during pregnancy, childbirth and the puerperium” is included in the ICD-10 and is defined as any death temporal to pregnancy, childbirth or the postpartum period, even if it is due to accidental or incidental causes. This alternative definition allows measurement of deaths that are related to pregnancy, even though they do not strictly conform to the standard “maternal death” concept, in settings where accurate information about causes of deaths based on medical certificates is unavailable (WHO, 2012).

New estimates show that leading causes of maternal deaths are haemorrhage and hypertension, which together account for more than half of maternal deaths. Indirect causes, which include deaths due to conditions such as malaria, HIV/AIDS and cardiac diseases, account for about one-fifth of maternal deaths (WHO and UNICEF, 2010). Regional estimates show that haemorrhage and hypertension are among the top three causes of death in both South Asia and sub-Saharan Africa, where the majority of maternal deaths occur. This is in contrast to developed countries where other direct causes, for example, those related to complications of anaesthesia and caesarean sections — are the leading cause of death, reflecting global disparities in access to needed obstetrical care (WHO and UNICEF, 2010). The categories of maternal deaths are based on a new classification system developed by WHO that considers obstructed labour and anaemia to be contributing conditions rather than direct causes. Deaths related to these two conditions are now classified within the categories of haemorrhage or sepsis.

There are several factors identified in maternal mortality which are categorized into four: reproductive factors, obstetric complications, health service factors, and socio-cultural factors. Teenage pregnancy and maternal mortality, heavy domestic duties, religion, attitudinal issues, environment infrastructure and socio-economic factors are also contributing factors for maternal mortality during pregnancy and after childbirth (Adetoro, [ND]).

1. Reproductive factors, including early age at menarche, early age at first birth, low parity and frequent birth intervals are associated with increased risk of maternal mortality, for instance, in maternal age, where age 10-14 years has five times higher risk than age 20-24 years. The parity is higher and more dangerous; parity 5th to 9th is at 43% more likely to die, highest level of women in their first birth. Also, the proportion of women with unwanted pregnancy that are saying that they do not want more children rises sharply with age and parity (Adetoro, [ND]).
2. Obstetric complications are difficulty or abnormality that arises during pregnancy and childbirth. These include haemorrhage, spontaneous abortion (which consist of ectopic, ante-partum, postpartum, multiple pregnancies), puerperal infection, toxemia, obstructed labour and induced abortion (Adetoro, [ND]).
3. Health service factors point to the lack of access to maternity services, poor medical care during unbooked emergencies, inadequate trained personnel, and lack of essential supplies, drugs and instruments (Adetoro, [ND]).
4. Socio-cultural factors which operate before the pregnancy or arrival of the baby: these include:
  - i. Status of women (low status, gender discrimination) and unequal opportunity for nutrition, health and education.
  - ii. Cultural practice (cultural acceptance of large family and pro-natalists, social status and number of children, traditional preference for boys, celebration after the birth of the tenth child and traditional food taboos (forbidden proteinous food)).
  - iii. Polygamous marriage, which encourages competition for more children over stretched resources and deprivation.
  - iv. Requirement of permission to visit health institution
  - v. Cultural belief that a woman in labour must endure suffering (just like in the Northern part of Nigeria).
    1. Teenage pregnancy, which includes cultural practice in many developing nations, physical immaturity, high parity and high fertility rate (Adetoro, [ND]).
    2. Teenagers and maternal mortality include heavy workload, look after young siblings, house cleaning, hawking, cooking, fetching water, and gathering firewood.
    3. Do other domestic duties during pregnancy and after childbirth, trading, farming, working and doing heavy work even when pregnant. The effect of all these is overwork, tiredness and malnourished.
    4. Religion is a major factor associated with maternal mortality. Certain religions do not accept blood transfusion (such as the Jehovah’s Witnesses). Practice of purdah may isolate women, which encourages subjugation and over-dependence on man. Some religions encourage fatalism, attributing all misfortune to

the Almighty God, making them unnecessarily resigning to fate instead of taking positive steps to help themselves. Some prayer houses have been converted to all-purpose healing and maternity centres in an attempt to exploit their followers. There are also harmful traditional practices, such as female genital mutilation, female circumcision and very hot bath at delivery believed by some to prevent ill health (Adetoro, [ND]).

5. Attitudinal issues of health workers to maternal patients point to aversion to surgical deliveries, unfriendly and uncompassionate attitude of health workers during pregnancy and after childbirth that creates a social and psychological distance between maternal population and the health institution limiting accessibility.
6. Environmental infrastructure, which includes poor infrastructural development, bad roads and poor transportation, especially in the rural areas of Nigeria.
7. Socio-economic factors, which include maternal mortality, which is linked with the economic status of women, lack of access to wealth and resources and difficulty in securing gainful employment. The money the women make is spent on the family rather than themselves. Also, global economic downturn compound the plight of the masses, the cost of medical escalates and is unavoidable, coupled with government underfunding of health (WHO recommends that 5% of government funding should be for health) but most nations spend 1.5-4% (Adetoro, [ND]).

Many pregnant women in Nigeria do not receive the care they need either because there are no services where they live, or they cannot afford the services because they are too expensive or reaching them is too costly. Some women do not use services because they do not like how care is provided or because the health services are not delivering high-quality care. Further, cultural beliefs or a woman's low status in society can prevent a pregnant woman from getting the care she needs. To improve maternal health, gaps in the capacity and quality of health systems and barriers to accessing health services must be identified and tackled at all levels.

#### **Implications for sustainable development**

The MDGs have been one of the successful attempts ever to encourage global collective action around a limited set of goals with one core objective of a significant reduction of maternal mortality. MDGs have also contributed to mobilizing international efforts for development and have significantly influenced the policy discourse. In particular, they have had some impact on international policies and, in some cases, on national development strategies. Implications for the post-2015 framework of the MDGs have provided a unique common and comprehensive framework to track global progress in several areas of human development, such as maternal health-related issues and maternal mortality reduction. This has become a key reference point in policy debates, highlighting the intrinsic value in maternal health as one of the vital tool for sustainable transformation of any country's development.

In developing countries, maternal mortality still remains a core focus of transformation agenda but its aim to tackle its causes by adopting a model of development that is more inclusive for sustainable transformation and development, has been unsuccessful. In Nigeria, the present maternal health is incapable of ensuring sustainable transformation in Nigeria owing to massive corruption, misplacement of priority, neo-liberal policies of government, leading to social and economic dislocation of families and widespread poverty. With regard to combating high maternal mortality in Nigeria, government and relevant stakeholders need development strategies to transform maternal health and social structures, by eradicating poverty amongst disadvantaged groups in the rural areas, and incorporate sustainability considerations. No country ever achieves sustainable transformation without achieving maternal health. Maternal health is a major concern of all countries, especially in developing countries. Maternal mortality is a key indicator of a society's level of development and the performance of the health care delivery system.

In order to protect and promote maternal health, it is essential to consider the health implications of policies and programmes in all sectors, for example energy, transport, agriculture, and as part of broader policies concerning labour rights, trade liberalization, intellectual property and environmental protection, among others. Health can, therefore, serve as an indicator (Council of the European Union, 2012; United Nations, 2012) of whether development and sector policies benefit individuals and their families in ways that are tangible and easily understood. Careful selection of health indicators can also help identify and strengthen synergies among sector policies, human rights protection, and human development investments. The achievement of health goals requires policy coherence and shared solutions across multiple sectors: that is, a whole-of-government or health in all policy approaches (The World We Want, 2013; World Health Organization, 2013).

Prioritizing a global maternal health as a goal is essential for sustainable development. It is imperative that the health sector address its weaknesses, not least of which are poor governance and weak accountability mechanisms; low status compared to other sectors in the view of finance and planning ministries; serious shortages of well-trained, motivated and supported health workers and unfair distribution of them within and across countries; and lack of knowledge or capability in many key areas, such as quality assurance. In the face of such challenges, continuing progress depends, to a great extent, on empowering communities and people as the



agents for their own health and as advocates with government. Long-term, predictable, and sustainable financing for health, from domestic as well as international resources, is required just to provide an irreducible minimum of preventive and curative health services and capacity-building in the sector. Further progress in improving health and well-being will require reducing health inequities not only through health system strengthening and financial protection, but also through integrated approaches for health and other millennium development goals.

From all indications, the state of maternal health in Nigeria is very dismal as a result of a number of factors which range from reproductive factors, obstetric complications, health service factors, socio-cultural factors to socio-economic factors. Thus, the state of maternal health in Nigeria is incapable of delivering sustainable transformation. Global maternal deaths reduced by 35% from 526, 3000 in 1980 to 342,900 in 2010. In Nigeria, the MMR in 2008 was reported to be 608 deaths per 100,000 live births (95% confidence interval (CI): 372-946). The majority of Nigeria people, especially women, who are poor are very vulnerable to illness, disability and even death owing to lack of access to comprehensive health services, especially reproductive health services. Nigeria currently has one of the highest rates of maternal mortality in the developing world (Hogan et al. 2010; Mojekwu and Ibekwu, 2012).

The following are the listed implications of poor maternal health and high maternal mortality:

- Nigeria's inability to meet up with MDGs by 2015 in the sustainable and transformation agenda.
- When there is high maternal death or maternal health related issues, women's inability to participate fully in the labor force that will enhance sustainable development.
- High maternal mortality will be a basis for low life expectancy in the population pyramid for women in the reproductive age (15-49 years) who are the main drivers of sustainable development in any country.
- Constant yearly cluster of budgetary allocation to combat maternal health rather than diversifying resources to other sectors for developmental purpose.
- With the high incidence and prevalence of maternal mortality, there will be high incidence of single parents and orphaned children, which is a threat to sustainable development.

#### **1.4 Recommendation and Conclusion**

The main factors affecting maternal mortality ratio, as determined by this study, is subdivided into direct maternal death and indirect maternal death. Direct maternal deaths are complications of the pregnancy itself; that is, complications of pregnancy, labour, delivery and complications that may arise within six weeks after the delivery period (postpartum). Direct cause accounts for about 80% of all maternal deaths and cannot be predicted. These direct causes include haemorrhage (uncontrolled bleeding), sepsis (infections), hypertensive disorders (complications of high blood pressures), prolonged or obstructed labour, and unsafe abortion. Direct maternal deaths are those related to medical illness before the outset of pregnancy. These medical conditions are usually aggravated by the body changes associated with pregnancy or because of the demand of the pregnancy. These include malaria, anaemia (shortage of blood), HIV/AIDS, heart diseases, and hepatitis. Among the direct causes, haemorrhage accounts for about 25%, of all deaths in developing countries. Other factors such as reproductive factors, obstetric complications, health service factors and socio-cultural factors, are associated with high maternal mortality. Other underlying factors related to maternal deaths include maternal age, socio-economic factors, cultural practices, teenage pregnancy, heavy domestic duties during pregnancy and after childbirth, religion, attitudinal issues of health workers and environmental infrastructures.

Most maternal deaths are avoidable. If a woman has access to antenatal care during pregnancy, has trained (skilled care) at labour, and both the baby and the mother are under standard medical care during and after delivery, and continue till the first two weeks after delivery, excess bleeding will be identified at the right time. Also, underlying causes of any abnormal bleeding will be identified and necessary intervention will be provided, with blood transfusion, if necessary. Surgery may also be performed to stop the bleeding, or the womb may be removed outright if the bleeding refuses to respond to all conservative methods of controlling blood loss. If all maternity centres are well equipped with facilities and manpower, controlling excessive bleeding during labour and, especially after childbirth, will reduce a quarter of all maternal deaths worldwide.

The high number of maternal deaths in developing countries reflects the inequalities in access to health services – a signal to the gap between the rich and the poor, even in the same developing countries. The rate of maternal health in the urban cities cannot be compared to that of a remote village or town in the rural areas of Nigeria across the geo-political zones, where access to standard health care is far from the reach of the citizens. The extremely high rates of maternal mortality and pregnancy-related disabilities in Nigeria have lasting social and economic consequences on both individual families and the nation as a whole. Children who are left without their mothers are more likely to suffer from illness or malnutrition and are at an increased risk for early death. Even women who survive severe complications from pregnancy and childbirth often face long recovery times, and their ill health and loss of productivity may have social and economic consequences within their families and society. Long-term health problems, such as obstetric fistula, anaemia and uterine prolapsed, can limit a woman's mobility and her ability to contribute to the household. Often times, these problems drive families into

poverty, put children at risk of malnutrition and illness, and cause marital problems.

However, to combat maternal mortality in Nigeria, it is imperative to immediately implement programmes that target the lack of access to contraception and obstetric care, concentrating particularly on rural areas in the North with high populations of poor and uneducated women. In order to decrease fertility rate, the nation must implement contraception education programmes that target high-risk areas and make modern contraceptives more affordable. The delays caused by medical professionals, which prevents women from receiving obstetric care, must also be addressed and delays in the decision making to receive care by women must be addressed through dissemination of birthing-practice educational programmes. Eliminating fees from primary health centres would also encourage women to seek medical care rather than attempt in-home delivery or unsafe abortions. In order to address delays in receiving care, some organizations in Nigeria have begun partnering with local communities to improve their emergency transport systems to hospitals. These programmes should be expanded and should target high-risk communities in the rural areas of Nigeria.

In addition, in ensuring sustainable transformation, reduction of maternal mortality to elimination of massive corruption in the health sectors and relevant parastatals is important. The enforcement of the rule of law is a key concern in dealing with massive corruption in the health sector. Participation and inclusiveness of government and health stakeholders is vital, so as to fight against massive corruption in the health sector at national and local levels. Also, improving governance with neo-liberal policies and effective political philosophy of government and relevant stakeholders is crucial to eradicating social and economic dislocation of families and widespread poverty. It is equally necessary to enhance effective development cooperation to eliminate misplacement of priority in relation to commitment and timely delivery of maternal health development interventions to ensure effectiveness of such facilities and interventions of women of reproductive age (15-49 years). There should be emphasis on transparency and accountability in the implementation of maternal health bill priority strategies. Similarly, providing quality service delivery in the area of health, education, water and sanitation to women will improve maternal health. Access to quality health services by women is vital for reduction of maternal mortality and ensuring sustainable transformation and development of women in the country.

Furthermore, the federal and the state governments have a role to play in the reduction of maternal mortality by providing facilities and ensuring that the information coming from the facilities is used to plan for the states. Health institutions should be refurbished and have up-to-date facilities. Drugs should be provided and medical professionals should be mobilized and retained in rural communities for the populace to access these good services and extend them to women during pregnancy and after child birth. Traditional institutions have a major role, just like the government. They should ensure that when a woman is pregnant, she gets the services available at the hospital. Nigeria should implement these training programmes so that the health centres may be better equipped to handle life-threatening complications that arise during childbirth and pregnancy. It is necessary to improve both access to and quality of care, so that women can receive the help they need and benefit from the services provided by the health centres.

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