MATERNAL AND CHILD HEALTH CARE SERVICE IN NIGERIA: A CASE ANALYSIS OF AKWA IBOM STATE

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Abstract

Unarguably, women and children have been described as an integral part of nation building. They are seen as agent for sustainable development at all levels. Therefore, the overriding importance of effective maternal and child health care delivery system is underscored as it represents one of the drivers of rapid economic, social and political development of any society. This study therefore aims at assessing government policy on maternal and child health care delivery in Akwa Ibom State. The study adopted historical and descriptive methods of enquiry and gathered relevant data from secondary sources. The finding of the study revealed that Akwa Ibom State government has a well-founded policy such as integrated maternal for new born and child health, free medical treatment for pregnant women, children and the elderly. The study also revealed that despite this well-intended policy, a high proportion of women and children, particularly in the rural area lack access to basic health care services. Based on the above findings, the study recommended, among others, that the government should promote prenatal care, skilled care during childbirth and post-natal care and that the government should encourage education and public awareness for the girl child and mothers to help reduce the mortality rate of both mother and child.

(***Keywords:*** *Maternal, Child Health, Nigeria, Akwa Ibom State).*

Introduction

The overriding importance of effective maternal and child health care delivery system is underscored as it represents one of the drivers of rapid socio-economic and political development of any society. Women and children have been described as an integral part of nation building. They are seen as an integral agents for sustainable development at all level. To achieve this, a well-founded healthcare is crucial and strategic which will help reduce maternal and infant mortality rate. However, the important features of reproductive health in most parts of the developing countries are high maternal death and morbidity rates, huge prenatal and childhood losses and high birth rates. Underlying these purely health related matters is the sheer magnitude of the high risk factors operating among women themselves such as early marriage, early teenage pregnancy and high parity combined with high child mortality. These factors are, in turn, manifestations of the low status accorded to the majority of women in most societies in developing countries and of the larger issues of underdevelopment of social, economic and political processes (Harrison and Bergstrom, 2001). One of the most overwhelming misfortunes that have endured throughout history is incessant death of women during pregnancy and labour. This misfortune is one that comes with so much disappointment and carries a huge burden of grief, pain and heartbreak. The scorch of maternal deaths is one that is aggressively destroying numerous households, terminating innocent lives and resulting in alarming unwarranted and preventable deaths. It is a well established fact that the birth process is perhaps one of the most dangerous journeys that majority of women are likely to make. But it is sad as statistics showed that the extent of loss of lives across low and middle income countries resulting from maternal and infant mortality is increasingly becoming high (Ibeh, 2008).

According to a 2015 report from the World Health Organization (WHO), approximately 830 women die from preventable causes related to pregnancy and childbirth everyday and a high percentage of all maternal deaths occur in developing countries, including Nigeria. Further proof by the United Nations Children's Emergency Fund, UNICEF (2016) reports that "every single day, Nigeria loses about 2,300 children under five and 145 women of childbearing age. This makes the country the second largest contributor to the under-five and maternal mortality rate in the world. The United Nation (UN) estimates that one in every six children dies from childhood related illness before age five. Under-five mortality in Nigeria is

estimated at 191 per 1,000 live births. Almost one million children die in Nigeria more than any other country in Africa largely from preventable diseases (Ifijeh, 2016); Onumera, 2010; WHO, 2006).

The deaths of newborn babies in Nigeria represent a quarter of the total number of deaths of children under five. The majority of these occur within the first week of life, mainly due to complications during pregnancy and delivery reflecting the intimate link between newborn survival and the quality of maternal care. The main causes of neonatal deaths are birth asphyxia, severe infection including tetanus and premature death. Also, a woman chance of dying from pregnancy and childbirth in Nigeria is 1 in 3. Although many of these deaths are preventable, the coverage and quality of health care services in Nigeria and by extension Akwa Ibom State continued to fail women and children, (www.unicef.org, 2016; Ogunjimi, *et. al.* 2012; Udofia, 2008). However, the recent trends show that the country is making progress in stemming infant and under-five mortality rate, but the pace still leave much to be desire in achieving the Millennial Development Goals (MDGs) of reducing child and maternal mortality by the year 2015. This study therefore seeks to examine maternal and infant mortality in Akwa Ibom State and the extend to which the government has gone in stemming this ugly situation faced by women and under-five children in the States.

Conceptual Explication

Harrison and Bergstrom (2001) defined maternal death as the death of a woman while pregnant or within 42 days of termination of the pregnancy. The maternal mortality ratio is the number of maternal deaths per 100,000 live births and the maternal mortality rate is the number of maternal deaths per 100,000 in the reproductive age group (14-49 years) in a given period. It is worth noting that the levels of maternal mortality are largely estimates. They are notoriously difficult to measure accurately in the absence of reliable vital statistics. Even where the latter are available, underestimates are still common. Prenatal or infant mortality rate refers to stillbirths plus first-weeks, or births 500g, in weight and heavier, per 1000 live and stillbirths. The estimated annual total of prenatal deaths worldwide is 7.6 million, with 98% of these death taking place in developing countries. Several important features about prenatal mortality rates are common to all areas of the developing world. It is worth-mentioning that the same social, economic, biological and heath determinants that influence levels of maternal mortality also apply to prenatal mortality rates. In addition, fetal

characteristics also determine fetal survival with fetal size being the most influential (Lawson, *et. al.*, 2001; Harrison, 1997).

Similarly, the World Health Organization WHO(2006)sees maternal mortality as the death of women while pregnant or within 42 days of termination of pregnancy irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incident cause. Infant mortality on the other hand refers to the death of infants and children under the age of five. For example in 2011, 6.9 million children under five reportedly died down from 7.6 million in 2010, 5.1 million in 2009 and 12.4 million in 1990. Global statistics on the challenge revealed that child mortality is more prevalent in the sub-Saharan Africa with about half of child deaths. This is supported by the fact that Nigerian is identified as one of the countries in the world with high maternal and infant death rates with a ratio of 545-630 per 100,000 live births, or 75 per 1,000 live births in the infant mortality index. Statistics also revealed that every single day, Nigeria loses about 2,300 under-five year olds and 145 women of childbearing ages. In the whole, it is obvious that maternal mortality is death due to pregnancy or childbearing, the commonest causes which are hypertensive and hemorrhagic disorders. So maternal and child death is one occurring during pregnancy or labour as a consequences of pregnancy within forty-two (42) days after delivery or abortion (www.artidesng.com, 2016; Barron and Thompson, 1983, Harrison 1985).

Theoretical Framework

This study is predicated on Basic Need theory as enunciated by Abraham Maslow hierarchy of needs. Abraham Maslow (1943), a Professor at Brandeis University, seen as the father of humanistic psychology. His theory is based on the idea that individuals work to satisfy human needs such as food and complex psychological needs such as self esteem. He coined the term hierarchy of needs to account for the roots of human motivation. He pointed out that motivation depends on the realization of needs. He stated that if the needs and the desire of individuals are realized, they will be motivated. He however, stated that needs are of hierarchy and priority and went on to classified them into five (5) levels: physiological needs or requirement for human survival. If these requirements are not met, the human body cannot function properly and will ultimately fail. Physiological

needs are thought to be the most important which should be met first such as air, water, food, clothing, shelter, adequate birth rate or health etc. Safety and security needs include: personal security, financial security, health and well being and safety against accident/ illness and their adverse effect

This theory is suitable for this study because in every society women and children are seen as an integral part of nation building, as well as agent for sustainable development. This can only be achieved by the provision of basic needs such as maternal and child health care services for healthy living. This is in line with Akwa Ibom State government determination to provide these basic needs which is clearly seen in the government vision of reducing the morbidity and mortality rates to the barest minimum through policies and actions such as Interpreted Child Survival and Development (ICSD), provision of free medical treatment to pregnant women and under five children, immunization coverage and provision of mosquito nets etc.

Causes of Maternal and Child Mortality

UNICEF observes that child and maternal mortality have many triggers both direct obstetric, indirect obstetric and socio-economic causes. Direct obstetric causes are abortion, eclampsia, obstetric hemorrhage, obstructed labour and puerperal infections. Indirect obstetric deaths result from previous existing disease or disease that developed during pregnancy and was not due to direct obstetric causes but which was aggravated by the physiological effect of pregnancy such as HIV/AIDS, anaemia, malaria, viral hepatitis, pulmonary tuberculosis, infective diarrhoeal diseases, tetanus, heart diseases and sickle cell disease (Harrison and Bergstrom, 2001, UNICEF, 2016). On the other hand, socio-economic causes are non-medical. These includes; illiteracy, poverty, poor nutrition and poor use of available but unpopular maternity services, cultural factors, logistical factors (poor transport and telecommunications) and biological factors (age and parity differentials). More importantly, failures in the transport and communication systems reduce access to healthcare facilities, causes delay in reaching hospital and in starting effective treatment. Delays caused by organizational problems in the health services such as personnel shortage and mal-distribution. Even where personnel are available, shortage in essential materials, supplies, power and water supply interruptions often produce the same effect (Harrison and Bergstrom, 2001).

In Nigeria and by extension Akwa Ibom State, the most important factors responsible for infant and maternal mortality are malnutrition, poor environment hygiene, low access and utilization of quality health care services by women and children. Others are low female literacy level, poor family health care practices, lack of access to safe water, severe maternal bleeding, infections, obstructed or prolonged labour, unsafe abortion, hypertensive disorders of pregnancy especially eclampsia etc. (Marchie and Anyanwu, 2009).

Analysis of Maternal and Infant Health Care in Akwa Ibom State

Akwa Ibom State was created on the 23rd September, 1987, it is one of the36 States in the Nigerian Federation and the tenth largest state in the country with 31 Local Government Areas and Uyo as the state capital. Akwa Ibom State is the third largest oil producing State in Nigeria. The State covers a total area of 7,246. 499 square kilometre and therefore has a population density of about 475 per square kilometre. The life expectancy at birth in Akwa Ibom State is 49 years while the disability adjusted life expectancy at births is 38.3 years. Vaccine-preventable diseases and infectious and parasitic diseases continue to exact their toll on health and survival of women and children, remaining the leading causes of morbidity and mortality in the State (AKS, 2000, Ibok and Ekong, 2013, Ekpo and Umoh, 2007). In Akwa Ibom State, the health sector is broad and is made up of public, private, Non-Governmental Organizations (NGOs), Community-based Organizations (CBOs), Faith-based Organizations (FBOs), and traditional health care providers. The composition of health providers is heterogeneous, which includes unregistered and registered providers ranging from traditional birth attendants and individual medicine sellers to modern hospitals. A total of 232 out of the 615 facilities in Akwa Ibom State presently are owned by the private sector. By implication, private facilities account for one-third of primary care facilities seen as a potentially important partner in expanding coverage of key health services such as maternal and child care service (AKSMH, 2012, NPC, 2008).

The government of Akwa Ibom State vision is to reduce the morbidity and mortality rates due to communicable diseases to the barest minimum; reverse the increasing prevalence of non-communicable diseases; meet global targets on the elimination and eradication of diseases; and significantly increases the life expectancy and quality of life of residents in the state. This vision can only be achieved through a well-articulated policy

environment. For instance, in Akwa Ibom State, child mortality is bedevilled with low immunization coverage and high child mortality. This fall short of meeting the Millennium Development targets of reducing by two-thirds the under-five mortality by 2015. It is also imperative to say that the most vulnerable and unreached children in terms of immunization are the rural children. Despite the efforts put in reducing infant mortality, most of them remain unreachable. On maternal health, the proportion of births attended to by trained health personnel stand at 35% meaning that Akwa Ibom State still has a long way to go in achieving 100% by the year 2015 which has come and gone (Itina, 2005, AKSMH, 2012, Ibok, 2015). Table 1 show case maternal and child health indicators in Akwa Ibom State.

Table 1: Maternal and Child Health Indicators

S/N	Items	% of Population
1	Crude birth rate	32/1000
2	Crude death rate	12/1000
3	Infant mortality rate	84/1000 live births
4	Under 5 mortality	138/1000
5	Maternal mortality rate	545.100,000
6	Total fertility rate	4.6%
7	Skilled attendant at birth	44%
8	Full immunization coverage	32%
9	Children that have no access to immunization	9%
10	Stunting in under 5 children	28%
11	Wasting in under 5 children	14%
12	Diarrhea in children	4.1%

Sources: (NPC, 2008, Akwa Ibom State, 2015)

The above facts call for a more serious efforts in tackling the problem of maternal and infant mortality in the state. No wonder stakeholders in the health sector have continued to search for sustainable solutions to this scourge. In the State, there has been government policies and actions on maternal and child mortality such as: First, Integrated Child Survival and Development (ICSD). This framework and plan of action proves helpful to Akwa Ibom State health sector as a guiding document for the implementation of child survival interventions by the government at the

state level. But sad to say that this programmes though well intentioned is yet to be effective. Second, provision of free medical treatment to pregnant women and under-five children. Third, activation and expansion of eight anti-retroviral centres, 15 prevention of mother to child transmission (PMTCT) centres. Fourth, high immunization coverage to eradicate polio and all other childhood killer diseases. Fifth, provision of mosquito nets across the state especially to pregnant women and children free of charge. Sixth, multiple birth programme as championed by Family Life Enhancement initiative in the state. This serves as a platform for maternal and child health outreach. Since 2008, this programme has benefited more than 4,268 families in the State (Ibok and Ekan, 2013, Williams, 2015).

However, despite the aforementioned policies and programmes of action by the state government in enhancing maternal and child health care in the state, it is clear that the maternal and infant mortality rate is horrendous due to the following reasons: First, insufficient and poor spatial distribution of health infrastructure and facilities; second, limited access to public health services and high cost of accessing the private health care providers; third; high rate of infant, child and maternal mortality; fourth, poor supervision and implementation of health projects by non-functional personnel; fifth, delay in seeking antenatal care. Other factors are, rolonged labour and sequelae, eclampsia, post-partum hemorrhage, retained placenta, septic abortion, anaemia, malaria, HIV, medical complications of pregnancy e.g. hepatitis, TB etc. (Itina, 2005, Ekpo and Umoh, 2007).

Conclusion

It is a well established fact that maternal and child mortality is a common event in many parts of the developing world. Mothers and children are at highest risk of disease and death. So the death of a woman during pregnancy, labour or pueperium is a tragedy that carries a huge burden of grief and pain, and has been described as a major public health problem in Nigeria. This unhealthy trend has become a matter of great concern, calling for concerted approach for all and sundry including Akwa Ibom State government. Although, the huge burden of deaths among Akwa Ibom women is caused by lack of access to proper health care and ignorance among most Akwa Ibom families due to religious or cultural beliefs, experts still believed that if the state's primary health care system is made more robust, effective and functional with proper trained birth attendants,

increased health financing, adequate health facilities and scaled up awareness programmes among every Akwa Ibom women of reproductive age, then maternal and child mortality will reduce drastically in the State.

Recommendations

1. The government should encourage education and public awareness for the girl child and mothers to help reduce the mortality rate of both mother and child.
2. The government should promote prenatal care, skilled care during childbirth and post natal care.
3. The government should ensure an improvement in public health services such as safe water and better sanitation.
4. The government and other stakeholders should encourage delivery under skilled attendants.
5. The government should make provision for emergency obstetric evacuation services.
6. The government should fund community mobilization and enlightenment on maternal mortality issues at state, senatorial district, local government and village levels.
7. The government should be committed to training and retraining of health professionals like doctors, nurses, technologists and mostly obstetricians and gynaecologists.
8. The government should ensure a wider and intensive immunization coverage.
9. The government should ensure that basic health care service such as maternal and child health services be seen as a fundamental human right to be access by all, irrespective of colour, place or location.

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