IMPROVING ACCESS TO QUALITY MATERNAL & CHILD HEALTH CARE IN RURAL COMMUNITIES: ISSUES AND PERSPECTIVES

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INTRODUCTION

Maternal Child Health Care is the health service provided to mothers (women in their child bearing age) and their children. It targets all women in their reproductive age groups (mostly 15-49 years) and children especially those under the age of 5 years.

Over the years, there has been an increase in concern and interest in maternal and child health and this was further strengthened in 1991, after the world summit for children (Unger, 1991).

The World Health Organisation (WHO) has established indices for monitoring the maternal and child health care in every country worldwide. This is correctly based on the premise that the socio-economic wellbeing of any nation is derivable from the rating index of its maternal and child health care. These indices are respectively Maternal Mortality Ratio (MMR) (number of maternal deaths related to pregnancy and deliveries and its complications per 100,000 live births) and both infant

mortality rate (IMR) (Number of infants death within their first one year of life per 1000 live births and under five years infant mortality rate (U5MR). These ratios and rates show the accessibility to **quality maternal and child health care** in which easy and unimpeded access to care will be associated with very low MMR and both IMR and U5MR worldwide but when access is otherwise, the ratio and rate will be high.

The type of care and assistance that women receive during pregnancy and at the time of delivery are key underlying factors influencing maternal and child health services (UNICEF, 2013 and WHO, 2014).

Maternal and child health is of great concern because the group constitutes about 2/3 of the whole world population. In Nigeria, women in reproductive age make up 21%; pregnant women, 4.5%, children under 5 years, make up a highly significant percentage of the total population. Factors such as poverty, inequality, poor attitudes towards women and their health, cultural/traditional practices have been reported to influence the use of maternal and child care facilities in developing countries (UNICEF, 2008). Poverty has been identified as a major barrier to human development as it makes standard health care excessively expensive (Babalola and Fatusi, 2009).

The major result of poor maternal-child health is increased maternal-child morbidity and mortality. The World Health Organisation (WHO) in 2015 reported that nearly 100% global maternal deaths occur in developing countries with more than half of these deaths occurring in Sub-Saharan Africa and Nigeria constituting 20%. WHO concluded that in Nigeria, women have a 1 in 22 life time risk of dying during pregnancy, childbirth or postpartum complication or abortion compared to the life risk of 1 in 4900 in developed countries.

Despite the fact that one of the major objectives of the WHO is to improve maternal child health care, women in the rural communities are still very vulnerable as they are faced with low access to health care and utilisation of maternal health care facilities where they are available. If this continues, it would be difficult to attain the milestone contained in the national health strategic plan as well as the 2030 sustainable Development Goals in this country.

Owumi and Taiwo (2012) and Salami and Taiwo (2012) emphasized that several cultural and socio-economic factors have influence on health care utilization. It is well recognized that a mother's education has positive impact on health care utilization. In other words educated women are more aware of health problems, know more about the availability of health care services and also use the information effectively to maintain good health status. In a study carried out by Becker, Peter, Gray,

Gultianu and Blake (1996) a mother's education was found to be the most consistent and important determinant for use of child and maternal health services.

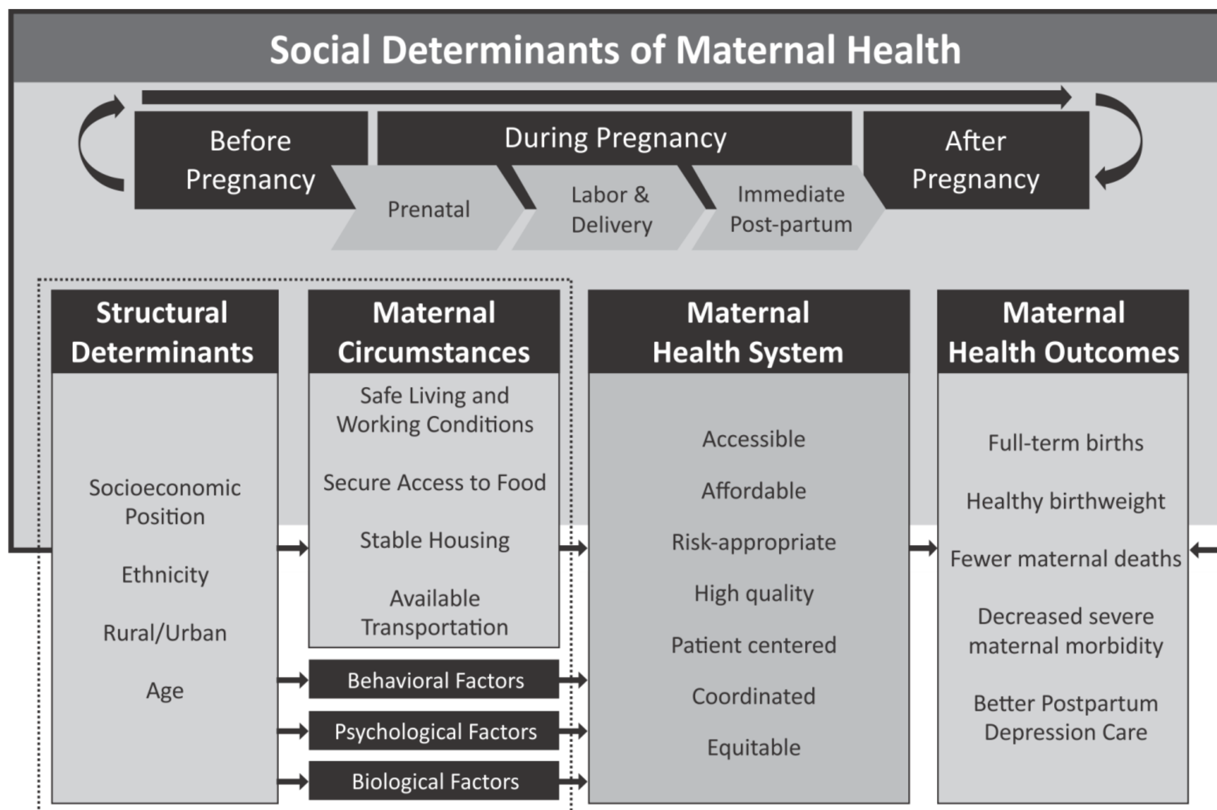
Social factors such as income, housing, food, transportation, social welfare support and health insurance affect a wide range of health functions, quality-of-life outcomes and risks. These factors cannot be easily addressed in rural communities. In 2016, WHO released, standards for Improving Quality of Maternal and Newborn Care in Health Facilities (***1), that includes guidelines to help, "and preventable maternal and newborn morbidity and mortality" and to ensure that, "every pregnant woman and newborn should have skilled care at birth with evidence-based practices" (***2).

Globally, it is estimated that still over 500,000 women die yearly as a result of pregnancy and childbirth event and about 90% of these death occurs in sub-Saharan Africa and Asia; 9% in other developing countries and only about 1% in the developed countries. Nigeria which is the most populous sub-saharan African country with a projected population now of 200 million people has a high MMR which reflect the high range of maternal death as above showing the inequalities between the developed and developing countries. The MMR in Nigeria is still above 800 per 100,000 live birth and this is the second highest MMR for most of the sub-saharan Africa countries. (**See Addendum**). The low

maternal death in the developed countries is so, because, there is wide and unimpeded access by pregnant women to quality maternal and child health care which same access is not available to pregnant women in the developing countries. Therefore, improving access to quality maternal and child health care in especially sub-Saharan Africa Region will substantially reduce the MMR and IMR in this region and consequently also the global MMR and IMR.

Nigeria is characterised by myriads of health issues when her health indicators are compared to those of developed nations. The average maternal mortality rate in Nigeria is 800 per 100,000 women and among the highest worldwide.
The maternal, newborn and child health indices in Nigeria are typically worse within the rural areas, as maternal mortality rate is estimated at 820 deaths per 100,000 live births in contrast to 350 deaths per 100,000 live births in urban area (Abimbola et al., 2012). This is why WHO ranked Nigeria 187 out of 190 member states, Nigeria being ranked much lower than its neighbours viz Benin, Togo, Ghana, Liberia etc.

Social Determinants of Maternal Health



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DEFINITIONS (Maternal and Child Health; Quality Care)

Maternal and child health

The term maternal and child health refers to the promotive, preventive, curative and rehabilitative health care for mothers and children (Annamma, 2012). It encompasses the health aspects of obstetrics, pediatrics, family welfare, nutrition, child development and health education with the main objective of healthy long life.

According to Annamma, (2012) the specific objectives are:

1) Reduction of morbidity and mortality rates for mother and child
2) Promotion of reproductive health
3) Promotion of physical and psychological development of the child with the family
4) Provide information on availability of services for medical termination and refer suitable cases to the approved institution.
5) Supervise the immunization of all pregnant women and children from zero to five years.

Maternal and child health care in clinical practice is made up of the following:

1. Maternal health service before pregnancy for efficient and effective family planning (to postpone, space or even stop pregnancy) so as to reduce case fatality and the life time risk of maternal health.

2. Maternal health care services before pregnancy for upgrading fertility to achieve pregnancy which is what is called infertility management in reproductive medicine clinic. This aspect of infertility management presently enjoys high demand because of several women and men who are postponing marriage and childbirth till advanced age due to educational and professional pursuit. Treatment in people of advanced age often involve the need for Assisted Reproductive Technology (IVF) management.

3. Efficient and effective ante natal care for the pregnant women with emphasis on focused antenatal care content to identify promptly and manage the risks that can complicate pregnancy course and delivery. This is backed up with an antenatal clinic and ward unit.

4. Pregnancy care that must include capacity to treat Abortion related complications that can lead to either severe maternal illness or death.

5. Efficient and effective childbirth (labour and delivery care with such time-tested labour course monitoring tool like the partograph) with deliveries conducted by skill birth attendants with competence for timely surgical interventions in labour ward theatre.

6. Immediate post-delivery care of complication which may cause severe maternal illness or death and extended through over 42 days (six weeks) to handle issue of lactation and other feeding problems, monitor healing of wounds (abdominal, vaginal or perineal) and post-delivery family planning contraception counselling or administration according to choices appropriate for the couple in a post-natal ward.

7. Immediate post-delivery care of the newborn extended for the first one week of life (special care baby unit, SCBU) and first one month of life (Neonatal care unit NNCU).

8. Efficient and effective under five years unit for infants from 29 weeks of life onwards to five years (including immunization). For further efficient child care this is often complemented with children's ward for children 6 years to 17 years.

The Basic Health Unit (BHU) for the provision of effective Maternal and Child Health Care is called the **Primary Health Care (PHC)**. This arrangement was established at the Alma Ata declaration of 1978 and recommended for all nations to adopt. It has been adopted as the best approach to deliver efficient and effective health care system aimed at providing comprehensive health care including emergency obstetric and infant health care with

immunization to the populace where they live, whether rural, semi-urban or urban.

The PHC is to provide curative, preventive and palliative treatment as well as to provide intervention to treat causes of maternal death (**See Addendum**). It should provide effective all year round immunization against killer diseases of children from the time of birth. Each PHC system (Basic Health) is to provide care to a maximum population of 150,000 people.

Quality Care

Quality refers to doing the right thing at the right time for the right people and doing them right first time. There is no universally accepted definition of quality of care. The quality of health care services is also difficult to define. However, Hearly (1988) links the use to the following two aspects;

1) The comparative sense or degree of excellence. Quality care is the process of attainment of the highest degree of excellence in the care of patient.
2) The fitness of the purpose which relates performance to specification.

In this context of health care, quality expresses the degree of excellence of service provided. Its fitness for the purpose it was established and its conformity to planned specification (WHO,1988).

Donabedeen (1980) provides insights into the nature of quality. He perceives quality as having three domains in nature. The first is the technical care, the second is the goodness of interpersonal relationship and the third is the goodness of the amenities of care. He opines that it is important to bring together the views of all concerned, that is, the patient, the public and their representatives, the health care providers and that of the health managers. The expectations of Patients/Communities in relation to the services provided must be considered.

- Does the service address the perceived needs?
- Is delivery on time?
- Is delivery courteous?
- Is there a concern for amenity, effectiveness, accessibility, interpersonal relations and continuity?

What Constitutes Quality Maternal and Child Health care (MCH)?

Quality maternal and child health care is a package of care with an aim to ensure that the decision for and the incident of a pregnancy can end joyfully for the benefit of the couple, family, the community and the nation at large. The package of care consist of the followings:

- Choices in the decision of the woman to get pregnant through family planning methods and infertility management inclusive of assisted reproductive technology (IVF) treatment.

- Ensure appropriate and adequate care in the course of pregnancy and childbirth (labour and delivery) including efficient and immediate post-delivery care for her routinely and when complications occur.
- Immediate post-delivery care of the newborn extended to the first one week and first one month of life.

Benefits of good quality health services

The benefits are numerous but can be summed up as follows.

- Improves wellbeing of women and children and consequently improves productivity and socioeconomic indices.
- Reduces late presentation of patients at health facilities and thus improves outcome
- Reduces mortality, morbidity and disability
- Creates health workers satisfaction and boost morale
- Improves relationship between health worker and patient, client and community
- Increases willingness to pay for care

Reasons why Maternal-Child Health Care access should be improved

1. Improving maternal health is not only a political and social imperative for policy makers, it is also cost-effective as a healthy mother will produce healthy families and societies, strong health systems, and healthy economies.

2. Improved access is very urgent in Nigeria, not only because giving birth should not result in death, but also because women are important economic drivers and their health is critical to long-term, sustainable economic development in Africa.
3. Access will improve health systems overall, which benefits the entire population of a country.

Problems arising from poor Maternal-child Health Care

Every year, globally, over half a million girls and women die from pregnancy-related causes, that is, approximately one girl of reproductive age or woman dies every minute (WHO, 2007). Over 99 per cent of maternal deaths occur in developing countries such as Nigeria. In fact, a woman living in Sub-Saharan Africa is at a higher risk of dying while giving birth than women in any other region of the world. This is especially evident among women aged 15 to 19 years in Africa, for whom giving birth is the leading cause of death. **Due to the weak health systems, maternal and child health status in Nigeria is among the worst in Africa.** With approximately 2.5% of the world's population, Nigeria has more than 10% of all under-5 and maternal deaths – more than 1 million newborn, infant, and child deaths and more than 50,000 maternal deaths every year (**see Addendum**).

Thus Quality is assessed by the following:

- Timeliness of the intervention
- Efficiency of the system
- Effectiveness of the care and humane relationship of the caregiver, and the patient
- Qualification and expertise of the personnel attending to the mothers and children, and the retraining of the workforce.
- Safety of the outcome (mother and child). Does the outcome bring about joy in the end?

Access to Quality care must occur at different times – pre-pregnancy (healthy sex life), during pregnancy (ante-natal), labour and delivery (including caesarian section) and post-natal (mother and newborn including problems of prematurity and neonatal jaundice). For example, are incubators available? It is sad that women still die in labour in Nigeria. The rural community women die mostly from prolonged/obstructed labour, haemorrhage and infection, essentially due to delay in getting to hospitals and other secondary health centres. Even when a woman is saved in labour, sometimes, she goes home without a baby after carrying the baby in her womb for 9 months. She may also be going home with an abdominal scar from a caesarian section consequent upon late presentation or intervention. **This day and age, a woman ought not to die in labour. This is a serious issue of great concern. Also, babies ought not to die, but they do in the first few days because of the circumstances of their birth and the absence of incubator in the maternity centre.**

Annually, an estimated 52,900 Nigerian women die from pregnancy related complications, out of 529,000 global maternal deaths, thus a woman's chance of dying from pregnancy childbirth in Nigeria is 1 in 13. The main causes of maternal mortality in Nigeria are: haemorrhage (23%), infection (17%), unsafe abortion (11%), obstructed labour (11%) and toxaemia/eclampsia/hypertension (11%), Malaria (11%), anaemia (11%) and others including HIV and AIDS contribute about (5%) (**see Addendum**). Other factors underlying maternal mortality include lack of awareness about complications in pregnancy and on the need to seek medical intervention early; lack of transportation to the health facilities where maternal health care can be provided; inability to pay for services, etc.

However, International organizations and individual governments have recognized the severity of the problem and have made and are still making commitments to reduce the number of maternal deaths globally. Countries like Sweden, Finland and Germany record less than 10, sometimes zero death during delivery in a whole year, (**see addendum**). In these countries, if a woman dies during delivery, a major enquiry is set up to unravel the cause of death, but in Nigeria, the death of a woman during labour or delivery is treated with levity and easily explained away.

BARRIERS TO ACCESS OF WOMEN AND CHILDREN TO HEALTH CARE IN RURAL COMMUNITIES

Despite the progress made in many countries on increasing the availability of maternal health care, the majority of women across Africa remain without full access to this care. Countries face a variety of obstacles to improved maternal health: insufficient data prevents Ministries and Agencies from implementing programmes most effectively. Notable barriers include:

1. Funding
2. Access to or lack of it and non-availability of Health Workers.
3. Quality and non-sustainability of health infrastructure
4. Paucity of information and poor statistics
5. Attitudes

All these prevent women in rural communities from using the available resources. Therefore, successful intervention programmes should be aimed at addressing these challenges.

Funding

Although some countries and different states in Nigeria have made efforts to reduce or eliminate maternal and child health services fees in recent years, professional health care remains too expensive for many women. Surveys of West African women found that well over half of those

interviewed listed cost as a reason they did not seek health care (ODI and UN, 2009). In Burkina Faso, Cameroon, Guinea and Niger that proportion was 60 per cent. These costs are both direct and indirect: fees for the use of facilities, services and drugs are high enough on their own. When combined with the cost of transportation to clinics and the possibility of lost wages from work, they are often prohibitive. Furthermore, treatment for obstetric complications is often more expensive, making pregnant women with complications doubly vulnerable. In addition to regular user fees, many rural community health care plans require some registration cost which the poorest of the poor cannot afford.

In spite of Nigeria's poor health indices, current level of funding is grossly inadequate. Consequently, the current funding cannot assure universal health coverage for the targeted health group in this case, mother and child. This is a major issue.

Access and Availability of Health Workers

Even when cost is not a primary obstacle, women are often unable to access quality maternal health care when they need it because health facilities are extremely inadequate or non-existent. Also, manpower is either non-existent, insufficient or inequitably distributed. Africa faces a health-worker crisis: There used to be 36 doctors per 100,000 persons in Nigeria. This figure is getting worse by the day because of mass exodus of medical doctors. Figures as low as 18 per 100,000 are now being

quoted for doctors. This is alarming. On average, there are only 66 nursing and 52 midwifery personnel for every 100,000 people. (**See Addendum**). In the poorest countries, this ratio can be as low as 1 per 100,000 people. Also, this care may not be available where and when it is most needed. A study in Malawi found that only 13 per cent of clinics had 24-hour midwife care, a major hazard for women who face complications from childbirth or neonatal emergencies at night (McCoy et al., 2008). The geographic distribution of health workers further complicates the issue of access. The highest number is concentrated in the cities and significantly in the Teaching Hospitals, Federal Medical Centres and General/Specialist Hospitals. As mentioned earlier, there is still a heavy migration of our health workers to Europe, America and the Arabia. The average number of health-workers in the country does not give a full picture of the shortage in rural areas, where there are far fewer health workers than in urban areas.

Infrastructural Deficit (non-existent, dilapidated, abandoned and lack of sustainability)

There is insufficient data on the quality and sustainability of care provided. The report Countdown to 2015 concludes that not only is more health coverage imperative, but also there must be greater attention paid to “what care is actually provided during antenatal, childbirth and postnatal contacts” (WHO, 2015). One important aspect of the quality of care is its sustainability. While some

improvements in access and coverage have been made through projects financed by international donors and NGOs, only projects that develop health system capacity to ensure sustainability will be able to continue achieving positive health outcomes once the implementing agency has left. Many of these access issues disproportionately affect the poor, causing a problem with equity across health systems. Health care is generally sparser in rural areas; for instance, in Nigeria, rural women are twice as likely as urban women to give birth without a trained health worker present. Sustainability of NGO and Donor programme can only occur if Government invests in it, delivers it counterpart fund and honours any memorandum of agreement.

Poor road infrastructure and transportation present another hurdle to effective care, especially in rural areas, where clinics are often too far away or otherwise inaccessible. Frequently there are no roads to the nearest health facility. Existing roads are often impassable due to road quality, terrain, natural disasters or flooding during the rainy season. The Overseas Development Institute (ODI) reports that in rural Zimbabwe, transportation problems were cited in 28 per cent of maternal deaths, compared with 3 per cent in Harare (ODI and CPSC, 2000). Tunisia has made impressive strides in scaling up maternal care and reducing maternal mortality, but there has been less progress in rural areas. This can be particularly dangerous for women suffering from obstetric complications, where delays in reaching

organised medical care can have permanent negative consequences. Obstetric fistula, a painful and unhygienic consequence of obstructed labour over a long time (compounded by the inability to get medical attention or reach medical facility) disproportionately affects poor and rural women, often resulting in their social isolation. Increasing road access to clinics has a demonstrable impact on care; one study showed that the use of Ghana's public health facilities nearly doubled when distance to clinics or hospitals was halved (Women Delivery, 2010).

Rural communities are mostly bedevilled with dilapidated or abandoned Primary Health Centres with no facilities or obsolete equipment making it difficult to get qualified health workers to be posted to such centres. Women in such communities would therefore have serious challenges accessing quality health care service and are exposed to high risks.

Information Paucity

Most governments in Africa lack accurate data on maternal health and existing funding. This makes it difficult to determine accurately how much funding is needed and what programmes are most effective. Presently, most health project funding from outside a country's ministry of health, such as money from Foundation grants and NGO projects, is distributed independently of the host government. NGO health interventions are not often coordinated or monitored at the national level, and many

organizations do not publish their individual project finances. When some do, their accounts are doctored. As a result, African governments do not have accurate data on total spending on maternal health in their countries. Women are not aware of what government is doing for them and how they can benefit from such provisions. Where information does exist, the lack of a commonly held definition of funding for maternal health prevents effective data use. For example, the Bill and Melinda Gates Foundation gives grants in a category called "Maternal, Neonatal and Child Health", which includes technology, treatment development and also advocacy for government policies related to maternal health. In other cases, an allocation for maternal health is captured under the heading of HIV/AIDS prevention and treatment. Africa has the highest maternal mortality rate in the world, and the lowest proportion of births attended by skilled health workers. The poorest women are more likely to die in pregnancy and childbirth.

The Abuja Health Commitment made by the African Union in April 2001 was to allocate a minimum of 15% of the national budget to addressing health issues. Only 4% of Nigeria's national budget is allocated to health, and until recently, a quarter of this went to HIV Aids. At the moment, COVID-19 is taking all the attention and funding. The money spent on maternal health is not known but is clearly negligible. In other words, funding names and destinations are disparate. Most African health ministries, with limited

human resources, cannot fully monitor and coordinate all the varied streams of funding towards maternal health. The multitude of players in each country makes it very difficult for ministries to coordinate efforts and create economies of scale to benefit more people. As a result, projects and financing are determined by the preferences of the donor or implementing organization, not the priorities and strategy of the government. The lack of accurate, up-to-date statistics on maternal deaths also prevents governments from allocating resources most efficiently.

The World Health Organization reports that 40 million people worldwide die unregistered and 40 million babies are born without record each year. Of the 30 countries in the world with the highest maternal death rates, only Botswana and South Africa have country-wide civil registration systems. In most other countries in this group, data collectors rely on crude measures from imprecise surveys such as polling women about their sisters' experiences with childbirth. Because governments recognize that they cannot improve maternal health without accurate information on the levels and causes of maternal death, countries are working with partners to develop new, cost-effective tools to collect and analyze data efficiently. WHO has discussed the consequences of this lack of information: "Without these fundamental health data, we are working in the dark. We may also be shooting in the dark. Without these data, we have no reliable way of

knowing whether interventions are working, and whether development aid is producing the desired health outcomes. In any case where there is a will, there is a way. Governments must take the bull by the horn.

Attitudes

Pervasive attitudes about women in many areas frequently stop them from accessing existing health care resources – maternal or others. In many parts of Africa, women must seek permission from their husband or family to visit a clinic for care. Even when permission is nominally given, women's lack of autonomy in their families can still prevent them from seeking care. Other family members may consider childbirth as strictly a woman's affair and not that of the household. As a result, women may find it difficult to get the money to pay for services or to obtain transport to get medical care. This may lead to incomplete treatment if husbands or family members do not appreciate the need for long-term care. For example, in Sub-Saharan Africa, 73 per cent of women receive at least one antenatal care visit, but only 44 per cent receive four or more (WHO, 2010). Lack of education for women also prevents them from making informed decisions about their own health and, sometimes, from knowing when to seek care.

Ignorance, it is said, is a disease, but many uneducated women in developing countries regard ignorance as a bliss. In other words they prefer not to

know because that means they don't have to worry about anything including something as fundamental as their health. Because of convenience and cost, a pregnant lady will consult and obtain medicines from a Drug/Medicine store attendant next door and not a medical doctor or better still a specialist obstetrician.

It is not unusual to find a pregnant woman who registers for antenatal care in a standard hospital going for delivery in an unapproved clinic where she may eventually lose her baby or her own life (in a worst case scenario).

Politicization and Provider bias are very important reasons why access to quality health services are not delivered to rural communities. Basically there is no willingness on the part of policy makers to focus on MCHC.

PERSPECTIVES

These relate to the policies and strategies to ensure quality health care which contribute to a significant reduction in maternal and child morbidity and mortality.

What is the way forward and how do we overcome the barriers to quality health care?

If Maternal and Child Health challenges are to be adequately addressed, Special Units or Directorates should be set up in the Ministry of Health to implement and monitor all policies in this regard. The policies must get down the line to reach the mother and child in the rural communities. The barriers enumerated above, can be addressed by:

1. increasing national budget allocations for (maternal and child) health
2. improving infrastructure, and support for community health workers
3. enacting health insurance schemes
4. harnessing the power of the private sector
5. political partnership
6. providing staff training and retraining

Firstly, funding is central to the provision of quality Maternal and Child Health Care especially in rural communities. Special Health Care Provision fund should be set up to increase, expand or scale up the programme and execute it at various levels of governance. This has become imperative because Rural Health Care Centres are non-existent in many communities in Nigeria, and where they existed, they have become dilapidated. Where Health Centres exist, they are located mostly in Local Government Headquarters while, clusters of villages or hamlets that make up the rural communities are neglected. Therefore, Maternal and Child Health programmes should be set up not just in Local Government headquarters, but in large villages or at the centre of hamlets (a cluster of small villages).

Adesokan (2019) identified some enablers to maternal and child care to include;

1. Government placing the clinic within the community.
2. Fixing clinic hours that are flexible to accommodate the community schedule and activities like market days.

Special Funding from WHO, International Finance Corporation (IFC) and other liberal international funding agencies are still needed. However, developing nations must become less and less dependent on Foreign Aids so that they can extricate themselves from the traps that go with such aids.

Increasing National Budget Allocations For (Maternal and Child) Health

Some countries have implemented increased budget for Health which led to drastic improvement in Maternal and child health. For instance, in 2009, Kenya, Ghana and Rwanda made significant allocations in their budgets towards improving maternal health (Kenyatta, 2009). The Kenyan Government allocated KSh4 billion ($49.6 million) to improve health infrastructure and hire 4,200 additional nurses (Duffour, 2009). Ghana's National Health Insurance currently covers 54 per cent of the Ghanaian population and provides a comprehensive health care package, including free care for all pregnant women. This includes childbirth in public, mission and private health facilities.

Furthermore, in recent years Ghana has been consistently increasing its health workers and facilities. In 2009, Ghana increased the number of health-assistant training centres countrywide. In 2008, 530 midwives and 105 medical assistants were trained and integrated into the Maternal and Child Health system, with extended funding for existing free maternal services and midwife training (GHS, 2007). **Rwanda's 2009 budget statement provided for new maternal centres to be constructed, plus enhanced transportation systems, particularly to service pregnant women in rural areas. Fund was also provided for purchase of ambulances for districts** (Hogan et al., 2010). These types of specific actions are needed to improve maternal and child health care in Nigeria. It is important that specific allocations or extra budgetary allocation be made for rural communities (budget within budget for women and children). All African countries must move to the agreed allocation of 15% of National budget on Health. If the situation in Nigeria is to change, the nation's budget for Health must move from 4 or 5% to more than 10% of the National Budget. This increase in budget notwithstanding, **Maternal and Child Health programme delivery must be FREE as a matter of policy.** This will imply removal of registration fee at the point of service and removal of pay for all basic and emergency obstetric and infant health services including caesarian delivery and other operations and ancillary support services for pregnancy related

complications. It is the pay for services that drive women to quacks.

Providing and Improving Infrastructure and Support for Health Workers

Inadequate infrastructure, lack of equipment and a shortfall in manpower remain the bane of poor health services.

In Eastern Africa, only 34 per cent of women giving birth have a skilled attendant present, which is a major cause of maternal mortality. In response, most African governments are working to mobilize health personnel to well equipped centres to provide health care. According to the United Nations, Tunisia's 80 per cent reduction in maternal deaths was due largely to the country's emphasis on skilled attendance at delivery (Thompson, 2009). Community Health Workers (CHWs) are instrumental in providing health care to underserved populations and can be vital in reducing maternal mortality. A study in the Upper East Region of Ghana found that increased training and mobilization of community health nurses reduced mortality rates among women and children. There are several examples of effective strategies for utilizing CHWs to extend health care to underserved populations – appropriate selection, including by gender, continuing education, involvement and reorientation of health-service staff, appropriate curricula, supervision and support. Most studies say that CHW programmes cannot be sustained on a

voluntary basis. Since CHWs are generally poor and need an income, CHW programmes are not cheap or easy, but are a good investment. The alternative is no care for the poor living in peripheral areas. The key to effective programmes is political will and a steady source of funding.

Using trained Community health workers can improve maternal health more cost-effectively and reach more of the population if given the proper tools. Communication system and power/electricity should be extended to the rural areas. Providing means of communication to health personnel can improve access for those in need of care. Phones allow pregnant women to ask health workers questions and alert them when they are going into labour. Additionally, phones allow health workers to communicate information to health facilities. Regular consultations and visits must be available, together with quick transfer system facilitated by the availability of ambulance service. Mobile clinics are advised where enough ambulances are available. Also, Blood Transfusion Service is a sine-qua-non of quality Health care. Over and above these, the distribution of amenities must be well thought of and planned so that the distance travelled by mother and child should not hinder access.

Bicycles or motorcycles can help community health workers to reach more women in rural areas, increasing distances covered fourfold and saving time compared to walking.

In a study in Pakistan, traditional birth attendants were trained and issued with disposable clean-delivery kits. In accordance with WHO principles of cleanliness at birth, clean-delivery kits must include: soap, a plastic sheet, a sterile string for tying the umbilical cord, a sterile razor blade for cutting the cord, and pictorial instructions explaining how to use each item in the kit. The result was a significant reduction in prenatal and maternal deaths. Risk rates dropped from 0.70 and 0.79 to 0.59 and 0.45, respectively (Bhutta et al., 2008).

Training of Health Workers

Training and retraining of health workers namely, doctors, midwives, traditional birth attendants are a vital part of any programme to improve rural Community Health Care. Emergency obstetrics care training (for the Nurses/Midwives which should be at least every 2 years) must encompass all areas of the lifesaving skills (LSS) consisting of prevention and treatment of eclampsia, haemorrhage, shock and infections and the technique of suction aspiration treatment for abortion complications. Others are monitoring of the progress of labout with the partograph, resuscitation of the newborn and management of the complication of abortion and post-abortion care. For the doctor, this should be expanded to include the technique of surgical deliveries, blood transfusion and anesthesia. For the lower cardre like the CHW, the LSS training can be modified to include easier techniques like vacuum

extraction (or vacuum aspiration) for incomplete abortion. Standardization, training protocol and service aids should be developed to assist with the provision of these services in all PHCS. These already exists in Lesotho, Zimbabwe, and Ghana for CHW who mann the health clinics/posts in these countries.

Residency training in Obs and Gynae should include experience in and rotation through rural communities (Rural Residency Training), but with adequate supervision and monitoring. This should also apply to midwives and other health workers. It is important to incentivise Maternal and Child Health Care Providers to enable them practice in the rural area. Giving incentives to doctors and other workers who go to the rural communities will encourage them greatly. If the place is made cosy, they will always feel needed and may begin to confess that the rural community is where they want to be. Training and retraining should be rewarded with up-grading and increase in salaries and special allowances. The tradition whereby universities and medical schools have rural training centres (in Community and Maternal Health) for their students should be retained and expanded.

Community Involvement

Government through its Ministry of Health and Information Agencies must penetrate the rural communities creating awareness on the availability of Healthy Services/Maternity Centres, insurance schemes or free services. However, it is important

that right from the planning stage to the stage of implementation of new programmes, policy makers must involve the community. Their actions will included preliminary visits and courtesy calls on important stake holders and then to the beneficiaries through existing community structures.

Information agents and town criers should be despatched regularly to preach the advantages of using available health services. Traditional rulers and chiefs should lead in health information dissemination in rural communities. It is also appropriate to involve Religious Leaders in community mobilization to ensure that the services provided are taken up by the target group – the pregnant women and children.

Enacting Health Insurance Schemes or Expanding them where they already exist

In recent years, a number of governments have implemented or sought to implement health insurance schemes to finance health care efficiently and reduce the cost burden for the population. Insurance schemes are typically funded by taxes paid to national governments, community assets, or premiums charged to beneficiaries. Coverage and target populations vary depending on the size and scope of the programme just like we have the National Health Insurance Scheme (NHIS) in Nigeria. A major drawback of most large schemes, however, is that they are largely city based and unknown among the very poor; people cannot use

programmes they are not aware of and cannot pay for. In Nigeria, only the Federal Government workers and some private company workers are involved in the NHIS and they pay a little health premium deducted from their salary for the service. The scheme must be reworked to cover the poor and those who live in rural communities.

Affordability is a primary barrier to accessing quality health care even in advance nations for those who are uninsured and those who have insurance plans with high premiums or high deductibles. Although laws and regulations have expanded access to health insurance and coverage of maternal health and family planning related services, in 2017, 11% of women in the USA were still uninsured. In other words, insurance coverage is a global problem. (Gunja, M. Z. et al 2018 and WHICH, Henry Kaiser Foundation, 2018).

Support For Women, Post-Delivery

Women who deliver should not be left on their own so quickly. Social services should be rendered especially after pregnancy and delivery, services like family support, economic or financial services, ill-treatment and violence prevention and nutrition support. On the medical side, there should be follow up and regular check-ups, support for conditions that emerged during the pregnancy or those exacerbated by pregnancy such as hypertension or diabetes. Mental state should be assessed especially following a traumatic delivery, for example

prolonged labour, post-partum haemorrhage or death of the new born. Puerperal psychosis and post-partum depression could follow such delivery. Oral hygiene should be encouraged to improve oral health. Family planning is needed for appropriate birth spacing and prevention of unwanted pregnancies. Breastfeeding should be encouraged. The woman should be persuaded to carry on with breastfeeding for as long as possible since breastfeeding provides health benefits for both mothers and babies in whom the immunity is boosted (Schreck P. K. et al 2017).

Harnessing the Power of the Private Sector

Governments must analyze the best ways to utilize the private sector to improve maternal and child health in their countries. The private sector plays an increasingly important role in health care provision in Africa; some 60 per cent of health expenditure is financed by private entities. WHO estimates that in Sub-Saharan Africa 32 per cent of pregnant women used public facilities, while the remaining 68 per cent used a variety of private facilities (including home deliveries) (IFC, 2005). In rural communities, 18 per cent delivered babies in a public facility while 78 per cent delivered by themselves or in a local private facility. Private services are generally more expensive for the consumer as they receive little or no support from government. Public– private collaboration is therefore imperative to ensuring an efficient and affordable health care delivery system, particularly for pregnant women and children.

Financial institutions are developing new mechanisms to invest in private-sector health care facilities in Africa. The International Finance Corporation (IFC) recently announced the launch of the Health in Africa Fund, which will invest in socially responsible and financially sustainable private health Small and Medium sized enterprises (SMEs), such as clinics and diagnostic centres, to help low-income Africans gain access to affordable, high-quality health services.

Political Partnership

Political will and strong leadership enable innovative, cost-efficient interventions. Investing in and improving maternal and child health builds political support for leaders among diverse national constituencies. Strong leadership at high levels promotes accountability within ministries and enables them to find reliable partners to drive and champion progress in maternal health. Because women are often marginalized economically, politically and socially in Africa, strong and sustained leadership who will place value on the health of women is required to improve maternal health. Attitudes about women in rural areas have been particularly negative. According to an official at the Ministry of Health in Nigeria, men sometimes "think it's cheaper to take another wife than to save a life". This is wicked and evil thought.

Investing in girls and women, particularly in education for girls, can be an effective measure to

reduce maternal mortality in the longer term. It is no longer true that the place of a woman is in the kitchen. Such thinking is now outrageous and totally unacceptable. Education for women helps them to appreciate access to quality health care. Educated girls tend to marry later and have fewer, healthier and better-nourished children. Mothers with little or no education are less likely to receive skilled support during pregnancy and childbirth. Therefore, governments should prioritize women in overall development strategies. Our women of reproductive age need not die during labour or delivery.

Sustained political will has been instrumental in reducing maternal and child mortality and improving the lives of women in rural communities. As it is said, where there is a will, there is a way.

SUMMARY AND RECOMMENDATIONS

1. Increased funding is central to what now appears to be a timeless discussion on improving access to Health. While increasing the National Budget allocation for Health, Special mention with designated amount must be reserved for Maternal and Child Health. **Free services for Maternal and Child Health care is the desired ultimate goal**.

2. Provision of adequate infrastructure is vital for quality health care. In addition to physical

structures like Health Centre buildings and passable roads that are well maintained, provision should be made for Ambulances and Blood Transfusion Service if the Health Care system is to benefit our target group. For a start, each local government should have 1 or 2 functional ambulances to help transfer women and children (and of course the elderly) to higher centres. Extension of Communication System and power/electricity to the rural communities will create the desired positive effect on MCHC.

3. Following the above, a Comprehensive Health Centre (CHC) should be established to serve 4 PHCs in a large community. The Comprehensive Health Centre should be upgraded with a step up of the equipment and staffing over what is available in the PHC. The CHC must have a doctor, a blood bank and the capacity for operation, including caesarian delivery by the doctor who has been trained in the desired skills. In effect, the point here is that there should be an overhaul of PHC and the misdistribution as it stands now.

4. The obvious lack of institutionalized referral linkage between the PHC/CHC, secondary and tertiary health institutions in our present health care is the worst weakness of the system. It is therefore important and urgent to install referral linkage in the system. This requires good

vehicular transportation and road network, communication and constant electricity.

5. Training and retraining of health workers, doctors, midwives and traditional birth attendants, and all who take deliveries. Emergency obstetrics care training for the nurses and midwives should be done regularly and must encompass all areas of the life saving skills. Training of workers should also include rotation of trainees through rural communities. Accommodation and other facilities plus rural allowances should be made attractive to retain the staff.

6. Allowances or some form of incentives should be provided for apparently less critical, but important stakeholders including mobilizers and those who manage and pass information from governments and higher Health Institutions to the Community.

7. At the moment the health insurance scheme in Nigeria covers only Federal Government and some private company workers. This is not satisfactory. Although ignorance and affordability constitute primary barriers to Health Insurance, a modified insurance scheme must be worked out for the poor and vulnerable in the rural community, especially the women and children. Obviously, this cannot be contributory!

Finally, while the nation works for "Universal Health Coverage", attention should never shift from women and children. Like some advanced nations, we must work towards zero maternal mortality. No woman should die in labour and all babies must be safely delivered: No still birth and no neonatal death.

CONCLUSION

Maternal and child health are vital components of healthy societies, economies and nations. The future of nations depends upon healthy women and mothers giving birth to healthy children. Women are the sole income-earners in one-third of households globally, and comprise 70 per cent of agricultural workers in Sub-Saharan Africa (WHO, 2010). Women are very important in any community, contributing significantly to the overall development of their society. Women's unpaid work, including farming, managing homes and caring for family members equals approximately one-third of the world's Gross National Product (GNP). It is important these days to establish "Well Women Care" to take care of women before pregnancy and after pregnancy is over. Smart improvement in maternal-child health strengthen health systems overall, and increase the cost-effectiveness of resources allocated to the health sector. Failure to improve access to quality maternal and child health care is not only irresponsible and immoral but also deeply

counterproductive, injurious to the economy and undermining national growth and development. Pregnancy-related deaths of women and newborns cost about $15 billion in lost productivity annually. These deaths and economic losses are nearly 100 per cent preventable. While women face a plethora of problems when pregnant in Africa, the barriers to maternal health enumerated earlier remain particularly problematic and must be addressed to stop preventable deaths. Successful maternal and child health interventions should be aimed at addressing these challenges which include access to and availability of health care, addressing the cost of health care, adequate infrastructure (transportation and electricity), and manpower. Also, information on health should get to the women and attitudes of women to health care must change. The key to successful programmes is political will (and commitment), accompanied by a steady source of funding, to support gender equality and maternal health. Steady sources of funding ensure the sustainability of programmes while political will ensures the sustainability of steady funding. Improving the education and socio-economic status of the populace are absolutely essential. Whatever, the policy put in place, ultimately the goal of quality care is to ensure that all women and newborns have skilled care and excellent service with perfect outcome (safe mother, safe birth and healthy baby). We do not have more time to waste as every minute we waste,

leads to the death of another woman and/or a child during childbirth. Now is the time to act.

I thank you most sincerely for your attention. God bless you all.

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ADDENDUM (Tables 1 – 7)

Table 1: Some Selected Maternal Mortality Ratio: Comparison with other Countries

Country	MMR (Maternal Death/100,000 live birth
Mozambique	980
Nigeria	800
Zimbabwe	610
Botswana	480
South Africa	340
Britain	9
Sweden	7
U.S.A.	12

Table 2: Zonal Variation of MMR within Nigeria

Comparison with other Countries

Zone	MMR
North East	1500
North West	1000
South East	250
South West	200
Urban	350
Rural	820
National	800

Table 3: Under Five Mortality Rates/1000 Live (U5MR)- Nigeria and its Neighbours

Country	U5MR in 1960	U5MR in 1998	Percentage Reduction	WHO Ranking
Benin	310	144	54	97
Cameron	264	113	57	164
Ghana	216	170	21	135
Ivory Coast	300	150	50	137
Niger	320	280	13	170
Nigeria	204	187	6	187
Togo	264	144	49	152

Table 4: WHO's Estimate of Health Personnel: Number of Health Personnel per 100,000 population.

Country	Physician	Nurse	Midwives	Dentist
Benin	5.7	20.4	7.9	0.3
Cameron	7.4	36.7	0.5	0.4
Ghana	6.2	72.0	53.2	0.2

Ivory Coast	9.0	31.2	15.0	N/A
Niger	3.4	22.9	5.5	0.2
Nigeria	18.5	66.1	52.4	2.6
Togo	7.6	10.4	10.4	0.7

Table 5: Medical Cause of Maternal Mortality

Post-Partum Hemorrhage	25%
Puerperal Sepsis	15%
Unsafe Abortion	13%
Eclampsia	11%
Obstructed Labour	11%
Others (ectopic pregnancy etc)	5%
Anaemia Malaria Anesthesia Hepatitis in Pregnancy HIV/AIDS in pregnancy	20%

Table 6: Non-Medical Causes of Maternal Mortality

Socio-cultural		
	Early age of marriage	- 10% pregnant at 15 years of age
		- 35% pregnant at 18 years
	High premium on child bearing	- High fertility rate of 5.1%
		- 4% still pregnant after 34 years
		- 6.9% of births are less than two years spacing
		- 24.3% of births are in grand multiple
		- Low contraceptive prevalence rate of 8.9%
	Low Status of Women	- High illiteracy rate of 59%
		- 36% women in adult work force
		- Poor nutrition in childhood and consequent poor development from childhood
	Lack of decision making power	- Require male authority

		to access medical treatment
		- Reason for poor maternity care
	Poor access to Resources hence unable to afford cost of access to facility	- High rate of non-facility delivery
		- 60% of women deliver at home
	Lack of knowledge	- Poor appreciation of risks signs of signs of pregnancy and delivery complication
	Poor citing of health facility	- Few and not centrally located - Poor road network
		- Poor transportation
	Poor health facilities functioning capacity	- Low staff morale
		- Low supplies of consumables
		- Poorly maintained equipment
		- Poor training of staff
		- Poor staff attitude to clients

Table 7: Causes of Maternal Death and Principal Interventions Required at PHC.

	Causes of Maternal Death	%	Proven Interventions
1	Bleeding after delivery (postpartum Haemorrhage)	25	Treat anaemia in pregnancy. Skilled attendant at birth with the partograph: prevent/treat bleeding with correct drugs, replace fluid loss by intravenous drip/transfusions if severe, manual removal of placenta.
2	Infection after delivery	15	Skilled attendant at birth with the partograph: clean practices at delivery Antibiotics if infection arises
3	Unsafe abortion	13	Skilled attendant: give antibiotics, empty uterus, replace fluids if needed, counsel, and provide family planning; managed abortion complication. Access to safe abortion where not against the law.

4	High blood pressure (hypertension) during pregnancy: most dangerous when severe (eclampsia)	12	Detect in pregnancy; after to doctor in hospital. Treat emclampsia with appropriate anticonvulsive (magnesium sulfate) Refer unconscious woman (eclampsia) for expert urgent assistance.
5	Obstructed labour/ruptured uterus	8	Detection in time with the partograph and referral for operative delivery to prevent ruptured uterus
6	Other direct causes the ectopic pregnancy etc	8	Refer ectopic pregnancy for operation to prevent death
7	Indirect causes	19	Disease-specific interventions (malaria, HIV, Hepatitis etc).

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