GLOBAL JOURNAL OF MEDICAL SCIENCES VOL. 2, NO. 2: 2003: 177 - 186
COPYRIGHT(C) BACHUDO SCIENCE CO. LTD. ISSN 1596 - 2911. PRINTED IN NIGERIA

REPRODUCTIVE HEALTH CARE AND MATERNAL MORTALITY: STRATEGIES FOR IMPROVEMENT IN NIGERIA.

P. O. OGUNJUYIGBE

(Received 13 December 2001; Revision accepted 30 March 2002)

ABSTRACT

Available evidence shows that developing countries account for significantly higher proportion of maternal mortality in the world. Nigeria is not an exception. Reproductive health care in these countries has also been identified to be at a very low level.

This paper therefore attempts to investigate the perception and health-seeking behaviour of Nigerian women as well as their opinion about pregnancy-related risks. Data used for the study were obtained from a survey of 320 women in the age range 15-49 using two rural communities and one urban location in South Western Nigeria as the study areas.

The Results of the study indicate that, some of the serious pregnancy-related risks were differently perceived by Nigerian women. Many of the women would not perceive these risks as being too serious as they were regarded as normal and to be expected during pregnancy. The need to improve reproductive health care in Nigeria was recognised and suggestions on how to prevent this high incidence of maternal mortality in Nigeria are proffered

KEY WORDS: Health-seeking Mortality; Reproductive health; Pregnancy risks

INTRODUCTION

The health situation of women of childbearing age in Nigeria remains unacceptable. The maternal mortality rate stood at above 15 per 1000 livebirths (NDHS, 1990). This is as a result of widespread ignorance, harmful cultural practices and limited access to health services. The negative impact of all these have been greatest on women and children who constitute the most vulnerable groups of the population.

The developing world accounts for 76 percent of the global population, 86 percent of the world's birth, 96 percent of the infant mortality and 99 percent of the maternal mortality (Potts, 1986). The risks involved in having children are numerous. The likelihood of developing a given risk factor is also high. In Africa, particularly Nigeria, a major cause of reproductive morbidity and mortality is obstructed labour. Several well-documented risk factors include young age, short stature and first pregnancy. These risk factors often lead to cephalopelvic disproportion (the woman's pelvis is too small for easy passage of the foetal head) caused by pelvic contraction from rickets, infection, malnutrition or cervical and vaginal scarring from female circumcision (Liskin, 1988). Thus though short, young and primigravid women become pregnant worldwide, many African women have additional risk factors increasing their chances of developing complications.

It is estimated that 500,000 women die each year as a result of pregnancy and childbirth. Almost ninety-nine percent of the worlds maternal mortality is contributed by the developing countries, particularly Africa, where deaths frequently occur in the home and never become recorded in the health care system (Potts, 1987). The World Health Organisation through monitoring deaths on various parts of the globe estimate that 500,000 women die annually as a direct result of child-bearing, and that most of these deaths are preventable (WHO, 1991). The fact that great majority of the deaths are preventable with low to moderate technology and education adds to the tragedy.

Most of the mortality and morbidity occur in women aged less than 15 years, women aged over 39 years and women who have more than four births. The average maternal mortality ratio for developing countries has been calculated as roughly 400 per 100,000 and less than 25 for the developed world. These estimates however are based on incomplete and defective data. In countries with the highest rates, a majority of deaths go unreported (Bullough, 1981). The true

P. O. OGUNJUYIGBE, Dept. of Demography and Social Statistics, Obafemi Awolowo University, Ile-Ife, Nigeria.

incidence of maternal morbidity, that is, complication suffered during the reproductive period, in the developing world is unknown. One study estimates that for every maternal death, there are sixteen episodes of maternal morbidity (Liskin, 1992). As recognised by World Health Organisation (WHO) (1987), the difficulty of measuring maternal mortality has long proved to be a barrier to progress in alerting health planners and others to the magnitude and causes of this problem and hence to effective interventions on an appropriate scale. Therefore, there is an urgent need to address the problem of maternal mortality with effective programmes to reduce the unacceptable number of deaths that occur in the world's poorest countries through pregnancy and childbirth.

Data and Method

The data used in this study were derived from a study carried out among 320 women in two rural communities (Akinlalu and Asipa) in Ife North Local Government area of Osun State, Nigeria and one urban location (Osogbo, the state capital). As already described in a paper (Ogunjuyigbe, 2000), the people occupying these areas are predominantly Yorubas, although we have other people from virtually all ethnic groups in the areas. The people are predominantly farmers, weavers, traders and artists. While Akinlalu can only boast of one health facility, Asipa on its part has none. Therefore, ailing people in both areas have to go to the State General Hospital in Ipetumodu, the headquarters of the local government area. In Osogbo there are Government Hospitals, maternity and dispensaries, and many approved fee paying private hospitals and maternity centres. In both urban and rural locations, there are people of diverse religious affiliations.

Osogbo was divided into four zones to reflect the residential patterns. The residential zones are the elite area (consisting mainly of high income individuals); the migrant zone (consisting mainly medium and low income migrant workers); the mixed zone (consisting of medium and low income migrants and non-migrants); and the traditional area (consisting mainly of the indigenes). The streets in each zone were identified and a systematic selection of households on randomly selected streets was undertaken until the quota for that zone was exhausted. Women of reproductive age (15-49 years) in the selected households were interviewed. Selection of houses in the rural areas was based on a simple random sampling of odd and even number selection until the required number of respondents was obtained. At the end of the survey 301 eligible women were successfully interviewed.

Information was collected through formal interviews and focus group discussions. The interview schedule contains direct questions on women's attitude towards last pregnancy, pregnancies and their outcome, perceptions of motherhood, experiences and recognition of reproductive risks, marriage, religion, occupation and other socio-economic characteristics.

Field supervisors were employed to do on the spot-checking of questionnaires. Interviewers were asked to revisit households for which they had inadequately completed schedules. Internal consistency checks and other methods of evaluating the consistency of demographic data show that the data are of good quality. In addition to quantitative survey, four focus group discussions were held (two sessions in each of the areas) for women less than 30 years and those older than 30 years. Statistical analysis was performed at both univariate and bivariate levels.

Perception and Health-seeking Behaviour

The distribution in Tables 1 and 2 show that the main reproductive conditions respondents experienced were massive bleeding, long labour and high fever. We found out from Table 1 that more people (26%) in the rural area experienced massive bleeding during delivery than their urban counterparts (24.5%). When respondents were asked about their perception of this complication at delivery, about six out of every ten women, irrespective of place of residence claimed that they recognised it as a serious occurrence that could have fatal outcomes. It is most alarming to note that about one out of every ten women said that they attached no seriousness to incidences of vaginal bleeding. In fact, this set of respondents claimed that any type of bleeding (massive or not) was to be expected during delivery. A woman participant from Asipa even said: "Bleeding before and after delivery is good as this would clear the womb of all necessary remnants of pregnancy". It is unfortunate that few respondents were treated for this bleeding especially when it occurred after birth. Only 27% of affected respondents in the urban area went for treatment while more respondents in the rural area (53.8%) got treated. The larger turnout of rural women for treatment was linked to the availability of a maternity hospital for rural women in Akinlalu, and the General Hospital in Ipetumodu, which is situated within walking

distance for residents in Asipa.

Regarding long labour (that was more than 12 hours), more respondents from the urban area had this difficulty, and received treatment for it even though more of them did not regard it as a serious disorder.

It was found that close to three-fifths of these women regarded the issue of prolonged labour with levity. This was apparently why most of the women discussants from Osogbo claimed that long labour was normal, although there was a condition attached to this opinion as expressed by one of the women participants in focus group discussion. She said: "A woman experiencing prolonged labour is not facing any extraordinary risks especially when it is her first delivery".

In the urban area, a relatively high proportion (76.3%) sought help, and this was in spite of the fact that they usually regard the complication as a normal one. We found that most of the respondents had initially planned to deliver their babies at home or in churches but changed their decisions when complications set in. Respondents said when labour became prolonged, they eventually had to seek help in the hospitals because they believed their lives were endangered.

Most cases of babies in bad or unsuitable positions went hand in hand with cases of prolonged labour. However, these were few as only 7.9% (urban) and 4.7% (rural) went through this experience. The recognition of this disorder was encouraging because about four-fifths of all respondents agreed that there could be serious consequences for mother and child, if a baby remained in a bad position for long. Health-seeking behaviour was particularly encouraging in the urban area as about four out of every five women at risk were attended to. Respondents in the rural area also sought help, about two-fifths of the women who experienced this complication.

There were very few cases of women with retained placentas in both areas. In spite of this, awareness about the reproductive condition could be regarded as high because about four-fifths of all the women interviewed, agreed that this was a serious risk to face in pregnancy. This was probably why all affected urban respondents went for help, and close to three out of every five women who experienced it did so in the rural area. It was surprising to find that more urban respondents (10.6%) than rural respondents (2%) regarded retained placental as not serious (Table 2). These set of respondents were found to be Christians who claimed to believe that 'nothing was too serious or dangerous for God to put right'. This opinion was echoed by a woman discussant in Osogbo in the group for women above thirty years. She said:

> "Although I agree that pregnancy complications may arise especially at delivery, I still believe in God's supremacy over all problems and difficulties. There is no bad situation He cannot put right".

About one out of every five women suffered from very high fever during delivery. However, this type of condition was regarded as normal by these respondents. Even though some respondents believed it is not a serious problem, some said it is quite serious. They believed that it could endanger the lives of mother and child since it could result in convulsions, if the high body temperature as a result of the fever is not lowered.

Although not indicated in the table, we found out that in both urban and rural areas, close to half of the respondents had their deliveries in hospitals. Out of the other deliveries not in hospitals, more urban respondents delivered in churches while more respondents in the rural area delivered at home. Some respondents were also found to have delivered on their way to hospitals.

Considering the fact that quite a number of women experienced long labours and the unsuitable positioning of their babies before delivery, very few caesarean operations were performed. In fact, there was none in the rural area while only 9.9% of the urban respondents had these operations. Also, regarding women who had to seek help during delivery because of complications, it was found that more urban respondents (46.9%) jointly decided with their spouses on the treatment made. This was not so in the rural area where 32.4% of the couples decided on the type of treatment together. As a result, more of them were subject to their husband's decision on the choice of treatment. In both areas, it was found that relations had little contributions to make about the treatment choice. However, relations in the rural areas influenced treatment more than they did in the urban area. It was found that in the rural area, whenever a problem arose at delivery, the spouse usually informed relations especially the parents of the woman, and together, decisions on the next line of action were taken. This was common for incidences of prolonged labour. In the urban area, this was not the case as the spouse usually took the decision on treatment

Table 1: Percentage Distribution of Respondents By Risks Experienced and Health-seeking Behaviour during Delivery

VARIABLES	URBAN	RURAL	BOTH
Conditions experienced:			
Massive bleeding	24.5(37)	26.0(39)	25.2(76)
Long labour (more than 12 hours)	25.2(38)	14.0(21)	19.6(59)
Baby in bad position	7.9(12)	4.7(7)	6.3(19)
Retained placenta	4.0 (6)	4.7(7)	4.3(13)
Very high fever	20.5(31)	20.0(30)	20.3(61)
% Seeking treatment for:			
Massive bleeding	27.0(10)	53.8(21)	40.8(76)
Long labour (more than 12 hours)	76.3(29)	42.9(9)	64.4(59)
Baby in bad position	83.3(10)	42.9(3)	68.4(19)
Retained placenta	100.0(6)	57.1(4)	76.9(13)
Very high fever	71.0(22)	56.7(17)	63.9(61)

Table 2: Percentage Distribution of Respondents by Risks Recognition and Treatment Sought

VARIABLES	URBAN		RURAL		BOTH	
Recognition of Risks:						
(a) Massive bleeding						
Normal	12.6	(19)	8.0	(12)	10.3	(31)
Serious	60.9	(92)	66.7	(100)	63.8	(192)
Very serious	26.5	(40)	22.7	(34)	24.6	(74)
Don't know	-	-	2.7	(4)	1.3	(4)
(b) Long labour (more than 12 hours)						
Normal	55.6	(84)	30.7	(46)	43.2	(130)
Serious	43.0	(65)	59.3	(89)	51.2	(154)
Very serious	1.3	(2)	2.7	(4)	2.0	(6)
Don't know	-	-	7.4	(4)	3.7	(11)
(c) Baby in bad position						
Normal	17.2	(26)	6.0	(9)	11.6	(35)
Serious	80.1	(121)	80.0	(120)	80.1	(241)
Very serious	2.6	(4)	12.0	(18)	7.3	(22)
Don't know	-	-	2.0	(3)	1.0	(3)
(d) Retained placenta						
Normal	10.6	(16)	2.0	(3)	6.3	(19)
Serious	87.4	(132)	80.7	(121)	84.1	(253)
Very serious	2.0	(3)	13.3	(20)	7.6	(23)
Don't know	-	-	4.0	(6)	2.0	(6)
(e) Very high fever						
Normal	55.0	(83)	46.0	(69)	50.5	(152)
Serious	45.0	(68)	35.3	(53)	40.2	(121)
Very serious	-	-	2.7	(4)	1.3	(4)
Don't know	-	-	16.0	(24)	8.0	(24)
Total	**100.0**	**(151)**	**100.0**	**(150)**	**100.0**	**(301)**
Type of Treatment Sought:						
Formal	63.2	(31)	70.2	(26)	66.3	(57)
Religious	32.7	(16)	16.2	(6)	25.6	(22)
Traditional	4.1	(2)	13.5	(5)	8.1	(7)
Total	100.0	(49)	100.0	(37)	100.0	(86)

with or without the woman's consent.

Some women did not seek help despite complications they experienced at delivery. For those urban women who experienced some form of complications during delivery and who did not seek help, it was found that about one-third of them felt that the conditions they experienced were normal and did not therefore need special attention. A few respondents also complained about the long distance of their treatment location to their homes. This they said hindered their movements and prevented them from seeking treatment. Other reasons given were transportation problems, ignorance about where to find appropriate help, and husband's decision against the need for health care.

In the rural area, the reasons for not seeking help were similar to those found in the urban area. There were fewer women (13.5%) who said that they did not seek help because they believed the conditions they experienced were normal. We also found that there were more rural women who said that they decided for no particular reason not to find help, and those that said that even if they had wanted to go for treatment, they did not know where to find it.

Women's opinions on the risks that are likely to occur during delivery are also shown in Table 3. A few respondents reflect the view that these risks are normal and to be expected during delivery. About one out of every ten women interviewed believed that complications may be fear induced. This is believed to occur more among younger women or first-time mothers because stories they heard prior to delivery, instilled psychological fears that left them exposed to complications they had imagined before. A few others claimed that complications can be more fatal. As put by a woman discussant from Osogbo, she said:

> "Complications at delivery can easily be regarded as the most serious. Imagine a woman who loses a lot of blood, and yet has a prolonged labour, if care is not taken, she and her child may die because she would be too weak and tired to deliver the baby. Left to me, complications at this point in a woman's reproductive years are the most serious".

We also found that there were more respondents in the urban area who claimed that pregnancy risks were due to spiritual or supernatural activities of evil persons. Similarly, some more of these urban women were of the opinion that these risks were acts of God showing His supremacy over mankind. Opinions such as these, which have religious undertones were found to be due to the fact that there were more Christians in the urban area who had religious sentiments about pregnancy and childbirth.

Opinions About Pregnancy Risks

Table 4 contains information about women's opinion of pregnancy risks. It shows variations in opinions by ages, levels of education and religious affiliations.

The table shows that inspite of the difference in the place of residence, the respondents in the different age groups have similarly represented opinions about pregnancy risks that occur to women of childbearing ages. The most popular opinion expressed by both urban and rural women is that pregnancy-related problems are normal. They believe that problems are usually prevalent among first-time mothers or young women/mothers who are in their early twenties; that as soon as a woman gets older and/or has had more pregnancy experiences then conditions hitherto regarded as risky are regarded as usual or regular, and can then be dealt with accordingly from experience. About two out of every five women in age group 20 - 29 said that they believed that most reproductive conditions like oedema, vaginal discharges and high fevers do not have serious or fatal outcomes.

The study revealed that about one out of every five women believed that pregnancy related problems had supernatural roots or causes. Examples given were illnesses due to witchcraft and traditional black magic (Juju). This finding was supported by the views of women discussants mostly from the rural areas. They laid a lot of emphasis on this, saying that supernatural/spiritual activities were a major route for pregnancy risks. A woman discussant in Asipa had this to say in support of supernatural causes of pregnancy-related risk:

> "In this area, a pregnant woman tries very hard not to offend people. She has to avoid situations that can lead to a quarrel or misunderstanding. This is because past experiences show that some wicked individuals take out their revenge on these women and their innocent babies. They either cause the pregnancy to be unnecessarily delayed and/or cause the woman to have a stillbirth or a deformed baby. Even without offending some people they behave wickedly. Such individuals have

Table 3: Percentage Distribution of Respondents According to Personal Opinion of Risks Occurring during Delivery

Personal opinion of risks occurring during pregnancy		Urban	Rural	Both
(i)	Complications are due to inadequate care	19.2 (29)	14.0 (21)	16.6 (50)
(ii)	Complications are due to poverty-induced malnutrition	6.0 (9)	8.7 (13)	7.3 (22)
(iii)	Complications are due to spiritual attacks	11.9 (18)	8.7 (13)	10.3 (31)
(iv)	Complications are normal	4.6 (7)	14.0 (21)	9.3 (28)
(v)	Complications may be fear-induced	13.2 (20)	14.0 (21)	13.6 (41)
(vi)	Complication is an act of God	9.9 (15)	5.3 (8)	7.6 (23)
(vii)	Different individuals face different complications	17.2 (26)	6.7 (10)	12.0 (36)
(viii)	Complications may be fatal	11.9 (18)	2.0 (3)	7.0 (21)
(ix)	Don't know/ No opinion	6.0 (9)	26.7 (40)	16.3 (49)
	Total	100.0 (150)	100.0 (150)	100.0 (301)

Table 4: Percentage Distribution of Respondents Opinions About Pregnancy Risks by Selected Variables.

Variable	Opinions About Pregnancy Risks									
	Normal		God's Desire		Supernatural		Advanced Age Risky		Ignorant of causes	
	U	R	U	R	U	R	U	R	U	R
Age										
16-19	1.5	3.1	-	1.0	-	2.1	0.8	-	-	-
20-29	29.2	26.8	6.9	6.2	15.4	14.4	3.1	4.1	1.5	2.1
30-39	13.8	16.5	6.9	3.1	4.6	10.3	0.8	3.1	1.5	-
40-49	3.8	3.1	9.2	2.1	-	2.1	0.8	-	-	-
Education										
None	3.1	13.4	0.8	1.0	0.8	1.0	-	-	-	-
Primary	22.3	23.7	10.8	9.3	2.3	18.6	2.3	3.1	-	-
Secondary	15.4	12.4	8.5	2.1	16.9	9.3	3.1	4.1	3.1	1.0
Tertiary	7.7	-	3.1	-	-	-	-	-	-	1.0
Religion										
Christian	22.3	23.7	9.2	5.2	14.6	18.6	3.1	1.0	1.5	2.1
Muslim	26.2	24.7	13.8	7.2	5.4	10.3	2.3	6.2	1.5	-
Traditional	-	1.0	-	-	-	-	-	-	-	-

Note: U - Urban (130); R - Rural (97)

> to be avoided, and sometimes it is necessary to pray hard so that you do not have the misfortune of dealing with them".

Opinions bordering on the spiritual or supernatural were found to be more among rural women, and this was attributed to the fact that more residents still believe the traditional practices or beliefs held by their ancestors in settling disputes. Generally, opinions about pregnancy risks even among the educated were disappointing. Urban women who by virtue of their higher level of education and exposure to enlightenment especially through the media were even found to harbour uninformed notions about these risks. It was found that close to two out of every ten of these women either believed that pregnancy risks were normal, and to be expected or that they had supernatural origins. A few also said that it was sometimes God's desire or wish to punish erring followers by it.

Only a few respondents had the opinion that an advanced maternal age has its associated pregnancy-related risks. These women believed that an advanced age especially coupled with a high parity made childbearing very risky.

It was found that most women reacted faster and attached more importance to some risks than to others. Vaginal bleeding and high blood pressure for example were amongst the most dreaded conditions. Others like vaginal discharges, backaches and stomach cramps were only regarded as serious problems when they impaired women's ability to attend to their daily chores. Excerpts from focus group discussion with some discussants are as follows:

A Woman discussant from Akinlalu:

"Sometimes, some problems get better without being treated or attended to. Most of the time, when I experience serious stomach cramps, all I do is drink some warm water and rest for a few hours. After this, I am okay and I never bother to seek medical help. Pregnancy is a normal stage in a woman's life and if she takes care of herself well she will have no serious problem at all".

A woman discussant from Osogbo had a different opinion as she says that:

"Pregnancy is a delicate state in a woman's life. A pregnant woman needs to be vigilant about changes that may occur in her body. Any unusual signs need to be reported to the appropriate health care provider which happens to be the doctors and nurses in hospitals".

Another woman discussant from Osogbo:

"Although pregnancy can be regarded as a normal process, the delivery period is a delicate time for a pregnant woman. If appropriate help is not provided during delivery, some deliveries may prove fatal for mother and child. It is necessary then to have doctors close to the woman in labour in case of a complication like prolonged labour".

A woman discussant from Asipa:

"Only pregnancy-related problems like vaginal bleeding or high blood pressure need to be tackled swiftly otherwise the consequences maybe fatal. Other

Table 5: Percentage Distribution of Respondents' Health-seeking Behaviour by Selected Variables.

Variable	Health-seeking Behaviour			
	Formal		Religious	
	U	R	U	R
Age				
16-19	1.1	2.4	-	36
20-29	41.1	42.9	5.6	20.2
30-39	33.3	19.0	4.4	3.6
40-49	2.2	4.8	12.2	3.6
Education				
None	14.4	11.8	1.1	3.5
Primary	23.3	28.2	13.3	18.8
Secondary	28.9	29.4	6.7	8.2
Tertiary	11.1	-	1.1	-
Religion				
Christian	42.2	37.6	8.9	17.6
Muslim	35.6	31.8	13.3	12.9
Marital Union				
Monogamy	70.0	43.6	20.0	16.7
Polygyny	7.8	26.9	2.2	12.8
Parity				
1	26.7	17.6	2.2	7.1
2	20.0	16.5	3.3	9.4
3	8.9	8.2	2.2	4.7
4 and above	22.2	27.1	14.4	9.4
Opinions	U**	R**	U**	R**
Normal	50.0	41.1	4.2	10.7
God's Desire	12.5	5.4	16.7	5.4
Supernatural Causes	6.9	19.6	4.2	14.3
Advanced Age Risky	4.2	3.6	1.4	

Note: U - Urban (96) ; R – Rural (84)
U** - Urban (72); R** - Rural (56)

disorders like fever and vaginal discharges hardly show immediate dysfunctions in mother or child, and so they may be regarded as less serious".

On the whole, women's perception of the prevalent reproductive conditions in terms of their ability to recognise the severity of these risks was not impressive. Apart from the reproductive conditions of vaginal bleeding, all other three risks were treated with levity. Only among a few women was there some seriousness notably attached to the occurrence of high fever in pregnancy.

In the focus group discussions, the views of the participants were expressed in a similar vein. Their opinions about these risks also give cause for concern. Results show that a large number of women (those interviewed and those who were participants in the focus group discussions) are not aware that some conditions, which they have experienced before were pregnancy-related problems. Generally, recognition of these risks as the risks they actually were, and opinions about them, was low.

Health-seeking Behaviour by Selected Variables

Table 5 shows that respondents either made formal or religious treatment decisions; although the most popular choice was the formal health care. About eight out of every ten urban women and seven out of every ten rural women, claimed that their preferred choice of treatment was that which they received from hospitals or clinics. We found that more rural women between the ages of twenty and twenty-nine claimed to have received treatment from hospitals or clinics while more of the older urban women (in the next older age group) received similar health care. In addition, more rural women in the age group twenty and twenty-nine who received treatment from churches or spiritual houses did so because they believed that formal treatment by inefficient personnel cause complications unlike 'God' who they believe cannot make mistakes like human beings. Urban women in the oldest age group preferred to receive spiritual treatment. A woman discussant from Osogbo had this to say about late pregnancies and childbirth:

> "Most women do not want to have children when they are in their forties but whenever such a pregnancy occurs, the woman accepts it in good faith believing that God has a purpose for sending a child late in her reproductive years when childbearing is believed to be fraught with more risks. Personally, from previous experience, I believe that women must move closer to God and the church, submitting everything to Him with the hope that the pregnancy and delivery would go smoothly. Only God is able to guarantee such safety".

It was found that the educational level of the respondents in both urban and rural area influenced their preference for formal treatment (Table 5). The number of women who chose formal health care in both areas increased as educational level advanced from the none category to the primary, and finally to the secondary level. All but one of the respondents who have tertiary education preferred formal health care. A few respondents out of whom there were more rural respondents who had either primary or secondary education claimed to prefer religious health care. They mentioned their trust in God's unfailing help as the reason why they preferred this type of health care.

Table 5 which also contains the distribution of the type of health-seeking behaviour by the number of pregnancy experiences shows that as the experiences of pregnancy and childbirth increased from the first to the third, the number of women who made formal treatment choices decreased. After the third experience, the number rose again suggesting that women attach more importance and care to their first pregnancies than they do to their second or third. Thereafter, the increase in the number of women who seek formal and religious health care when they have had more than three pregnancy experiences also suggests that women treat such later births with care and attention.

Concerning respondents opinion about pregnancy risks and how this affects their health-seeking behaviour, Table 5 shows that majority of the respondents claimed that pregnancy-related problems are normal, and yet they still went ahead to seek formal or religious health care when the need arose. This may be attributed to the reason that even though these women believed in the normalcy of pregnancy, the fact that it is not an every day affair prompted them to take advantage of treatment available for these special occasions.

The belief that some risks have supernatural causes encouraged more rural women to seek religious health care even though more of them who believed in the supernatural opted for formal treatment. Respondents in the latter group said they believed that formal treatment could counteract

the effect of supernatural risks.

Those factors that women felt influenced their health-seeking behaviours, as well as their opinion of the suitable places to seek help were examined in focus group discussions. Women mentioned the economy as a major factor deciding a woman's health-seeking behaviour. The dominance of a male partner over his female counterpart, communication problems and reproductive education are other deciding factors mentioned. Women discussants from both urban and rural areas had similar opinions of how the economy influenced the type of health behaviour made. The contribution of a woman discussant from Akinlalu presented below summarises the opinion of women about the economic factor influencing types of health care decision made:

> "Usually, the finances of a family determine what type of health care a woman would receive. Most of the time, formal treatment from hospitals is made especially where this is subsidized by the government. In most cases, complete treatment and cure is found for reproductive conditions because government health personnel do not have selfish or personal motives unlike those in private establishments. It has been observed in private hospitals or traditional health care centres that much emphasis is placed on profit margins rather than the health of patients".

Regarding the low status of women whereby health care decisions were hinged on the husband, a woman discussant from Asipa had this to say:

> "Women have to inform their husbands about any problems they have in pregnancy. It is now left for the husband to determine within the means of his pocket the type of health care he can afford. It is according to this that a man makes health decisions on behalf of the wife, and which she has to abide with".

Sometimes, communication hinders the effort made to seek help, and this may influence the type of health decisions finally made. A woman from Akinlalu said:

> "Sometimes long distance between the health facility and a woman's residence may affect health-seeking behaviour. A woman who has to travel several kilometres to see a doctor may decide affer a while to find an alternative source of treatment close to her home. In most cases, this alternatives are in form of traditional health care which is not always the best option in the event of an unexpected complication".

A woman discussant from Asipa further said:

> "Whenever there are frequent disruptions in treatment as a result of language barriers between health personnel and patient, a change of treatment source may occur because the woman would like to communicate with health care personnel. This is common in this area, and it affects women's health-seeking behaviour".

Women participants also agreed that a woman's knowledge about reproductive health matters was of great importance. A woman discussant from Osogbo had this to say about this subject:

> "A woman who takes her pregnancy seriously from the start would be encouraged to register at a hospital for the close monitoring of her health and her child's. The awareness that anything can go wrong suddenly, and which may require treatment usually encourages women to play it safe from the start, and this is where prior knowledge about the risks in pregnancy comes in handy".

DISCUSSION AND CONCLUSION

Nigeria as a member of the United Nations is a signatory to all the conventions and declarations on health issues and human rights. This is an expression of our national commitment to the recognition of women and children in particular as very vulnerable groups. The national objective is to ensure that all infants have a healthy start in life and enhancing the health of their mothers is among the highest priorities by preventing disease and promoting health through pre-conception counselling, early prenatal care, and access to high quality delivery and postpartum services (Ogunjuyigbe, 2000). Pregnancy is a dynamic process in which a woman's risk status can change at any point. Therefore comprehensive programme must be established to ensure the provision of care appropriate to the status of the pregnant woman and her child.

The disparities in the available health care service for mothers and children in various population groups in the country are of particular concern (Lucas, 1997). Government is committed to the promotion of equity in the access to high quality, preventive and promotive services for all mothers and children in Nigeria.

The provision of maternal and child health care (MCH) for reproductive services is therefore the responsibility of all levels of government. MCH services are an essential component of Primary Health Care and are administered by the Local Government Areas; secondary referrals and acute care services are administered by State Government and tertiary referral services are the responsibilities of the Federal Government.

While problems on maternal and child health are currently being addressed by various programmes both within and outside the health sector, the impact on the overall maternal morbidity and mortality has been minimal. There is therefore, an urgent need to properly integrate, expand and strengthen appropriate functional strategies for an accelerated attainment of the goals and objectives of this policy in Nigeria and these include:

- Advocacy: through mobilization of the policy makers and key government official, opinion leaders and non-governmental organisations (NGOs) through the medium information, education and communication by print and electronic media and interpersonal correspondence.

- Develop virile information, education and communication system or package that is sensitive and culturally acceptable as well as community mobilization and involvement.

- Improved and expanded services on maternal and child health services referral by accessing the prevailing situation to identify shortfalls and areas of need; develop plans of action; mobilize resources; implement planned activities; and establish referral system.

- Provide finance, manpower and equipments, which are the resources needed to translate the maternal and child health policy into programmed activities.

All these can be achieved through (a) provision of adequate funding and mobilization of resources from donor agencies and philanthropists for running programmes as well as providing appropriate funding through community participation for sustainability; (b) making available adequate human resources through manpower rationalization, employment, continuing education and involvement of NGOs and professional bodies; (c) functional equipments and materials should be procured, developed, maintained and regularly supplied; (d) seen to the logistics by ensuring efficient supplies and distribution of services and commodities; procure adequate materials; having regular supply, equitable distribution of necessary equipments and maintenance of these equipments; (e) provide appropriate training and development of health manpower; identify training needs for Neonatologists, Paediatricians, Nurse/Midwife, Private health staff, community health workers, VHW and traditional birth attendants (TBA); conduct training programmes and develop staff to the appropriate units; (f) provide monitoring formats and re-orientates on the use of formats; (g) strengthening intra- and inter-sectoral collaboration at each service delivery point. There is need for an integrated approach in order to provide minimal service package, provide preventive, curative and rehabilitative services as may be required through the involvement of all related units in the health sector in the planning and implementation of programmes; involvement of all relevant sectors outside the health sector such as agric, works and housing, water resources, National Women Commission and involvement of NGOs and professional bodies; (h) there is a need for the provision of health service for inmates of remand homes, street children, motherless babies and the handicapped.

Finally, reproductive health has become the centre piece of development and among other things, it encompasses safe motherhood. So necessary strategies must be adopted to improve reproductive health status of the populace and reduce the incidence of maternal mortality in the country.

REFERENCES

Bullough, C.H.W., 1981. Analysis of maternal deaths in the central region of Malawi, East African Medical Journal 58(1): 25 - 36.

Liskin, L.S., 1992. Maternal morbidities in developing countries: A review and comments. International Journal of Gynaecology and Obstetrics, Feb.; 1. 37(2): 77-87.

Lucas A.O., 1997. History of the Prevention of Maternal Mortality Network, International Journal of Gynecology and Obstetrics, Nov. 59 Supplement 2: S11-3

Nigeria Demographic and Health Survey, 1990.

Ogunjuyigbe, P.O., 2000. Pregnancy Risks, Women's Health Status and Safe Motherhood in Nigeria, African Journal of Development Studies, 2(1 & 2): 8-17.

Potts; M., 1987. AIDS: The most presumptuous pox. Network Special Issue, Spring, pp.1-7.

World Health Organisation, 1987. Studying maternal mortality in developing countries: Rates and causes, Division of Family Health Geneva, WHO (WHO/FHE/87.7): 5.