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BRIDGING THE GAP BETWEEN CONCEPT AND REALITY IN THE NIGERIAN MIDWIVES SERVICE SCHEME

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ABSTRACT

Health programs are often instituted to prevent diseases and to restore or promote health. In many cases, there are gaps between anticipated and attained goals. A case in point is the Nigerian Midwives Service Scheme, where the concept of providing 24 hour coverage of the primary health centers by skilled birth attendants is currently failing to meet the desired targets in certain parts of Nigeria, predominantly the North Eastern and North Western Zones. This is in spite of adequate funding and organization. This article discusses the barriers to effective implementation of the program and suggests that the gap between goals anticipated during program conceptualization and goals attained after program implementation can be bridged by optimizing innovative health communications to the target audience and applying social marketing techniques to health care delivery in the affected zones. This is in addition to inter-sectoral coordination and collaboration between relevant government ministries and stakeholders.

Key words: ***Bridging gaps, Concepts, Reality, Nigerian, Midwives Service Scheme***

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INTRODUCTION

The main problems affecting the health of mother and child in developing countries revolve around the triad of malnutrition, infection and consequences of unregulated fertility. Associated with these problems, is the scarcity of health and other social services in vast areas of these countries together with poor socioeconomic conditions (Park, 2007). Though the Nigerian government established at least a primary health center in the 10 to 12 wards that constitute each of the 774 local government areas in Nigeria, Inegbenebor (2007) observed however, that there was no 24-hour coverage by skilled birth attendants in these facilities. This concept became the basis for the Nigerian Midwives Service Scheme, which commenced in 2009.

The rationale was that maternal, newborn, and child health indices in Nigeria vary widely across geopolitical zones and between urban and rural areas, mostly due to variations in the availability of skilled attendance at birth (Harrison, 1997). The program was expected to reduce maternal mortality ratio to acceptable levels in Nigeria. At the outset of the program in 2009, the maternal mortality ratio was 1,549/100,000 live births in Northeast zone as against 165/100,000 live births in South West Zone and 351/100,000 live births in urban areas as against 828/100,000 in rural areas. However, the under-5 mortality rate was 171/1,000 live births which ranged from 87/1000 to 219/1000 live births (Abimbola et al., 2012). Although the rates are lower in the South East and South West, indices in these regions still fall short of global development targets (Abimbola et al., 2012) when compared to the developed countries with average maternal mortality of less than 13 per 100,000 (Hogan et al., 2010). These indices, without doubt, illustrate the dismal state of health care delivery in Nigeria.

The introduction of the Midwives Service Scheme in 2009 resulted in the reduction of maternal mortality ratio from 1100/100,000 to 608/100,000, though with zonal variations. The over 40% reduction in the maternal mortality ratio in Nigeria at a rate of 1.4% per year indicates an attempt by the Federal Government of Nigeria to halt and reverse the trend of escalating maternal mortality ratio. However, this has not taken Nigeria close to the target of reducing the maternal mortality ratio by three quarters in 2015 (UNFPA, WHO, World Bank and UNICEF, 2012).

Four years after the inauguration of the Midwives Service Scheme, there is evidence that the program is not meeting the expected targets (Abimbola et al., 2012). Thus the target of reducing the maternal mortality ratio by three quarters by 2015 may be an illusion. This may be due to the presence of several

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barriers, which may have been overlooked at the outset of the program. These barriers include socio-economic, political, religious, cultural and educational barriers.

BARRIERS TOWARD THE REALIZATION OF THE CONCEPT OF MIDWIVES SERVICE SCHEME

1. Political Barriers

The quest for power and recognition is making certain political gladiators to propose and promote bills, which seem to protect certain cultural heritage that can jeopardize the progress being made by relevant governmental agencies towards reducing adverse high health indices in the northern zones of Nigeria. Recently, a bill was deliberated upon to amend Section 29(4) of the Nigerian constitution. Section 29(4) (a) and (b) provides, *'For the purposes of subsection 1 of this section: (a) "full age" means the age of 18 years and above; (b) any woman who is married shall be deemed to be of full age'* The Senate initially voted to remove section 29(4) (b). In spite of the monumental problems of escalating maternal mortality and morbidity resulting from prolonged obstructed labor and obstetric fistulae, secondary to under-developed female pelvis due to child marriage and malnutrition, and high divorce rates and social ostracism resulting from complications of pregnancy and child birth from such marriages, 35 Nigerian Senators, mainly from the North Western and North Eastern Zones formed a formidable opposition, which voted successfully to retain section 29(4) (b) under the guise that it was un-Islamic to vote otherwise (Ajumobi, 2013). Their action favored child marriage, which allows girls to be married at the age of 13 years, sometimes before their first menstrual periods. Such policies can only aggravate the already bad situation.

2. Religious Barriers

In many parts of Nigeria, it is common to find pregnant women attempting to deliver in churches under supervision of unskilled birth attendants whose only qualification for the purpose is that they are wives of pastors and prophets. Many of these people brainwash their converts into believing that demons can obstruct child birth and that such deliveries are only possible with spiritual intervention in the church. In addition, they encourage women who have been advised to have cesarean section to deliver in the church. While a few women have successful childbirth, most women develop devastating and debilitating injuries leading to obstetric fistulae, ruptured uterus, postpartum hemorrhage, puerperal sepsis and possibly death.

3. Community Hostility

Rivalry between local health workers and skilled birth attendants has been observed by midwives serving in the North Eastern zone of Nigeria (personal communication)**.** Several midwives in the Midwives Service Scheme have complained of uncooperative attitude of their subordinates, who complain of having to work under supervision of midwives in the scheme, often referring to the fact that these midwives are not of the same ethnic group (Personal communication). It should be realized that employees can be internal enemies of a program if they are dissatisfied (Kotler, 1999).These attendants should be educated on the need to learn from the midwives and not harass them. The attendants should see the midwives as partners in health care delivery and as fellow Nigerians working to promote health of fellow Nigerians.

Terrorism has become a major issue in the Northern zones of Nigeria where 'Boko Haram', a fascist group that is anti western education, is unleashing terrorism to Christian residents and sometimes other residents irrespective of their religious inclinations. For example, the National Primary Healthcare Development Agency (NPHCDA), reported in 2011 that its operations in North-East states were being hampered by the activities of the Boko Haram islamist sect and lamented that some of the staff posted to the zone had to return, denying children and their mothers the opportunity of immunization due to the emerging security threat posed by Boko Haram (Ojeme, 2011).

4. Educational Barriers

A major problem in the northern zones where Midwives Service Scheme is not yielding expected results is mass illiteracy perpetuated by religious leaders who believe that exposure to western education will prevent people from adhering to their religious teachings. The levels of morbidity and mortality have been associated with level of education (Harrison, 1997). The literacy level in Nigeria varies markedly between urban and rural areas, between North and South, and is known to be lowest in the Northern zones of Nigeria, which are currently resistant to the Midwives Service Scheme.

According to the 2006 Census in Nigeria, the entire population of all ages who could read and write in any language was 78.6%. This consisted of 84.35%

male and 72.65% female. The level of literacy among male and female children population in rural and urban areas varied between 40.9% and 82.6% among male while that of female ranged between 14.6% and 74.7%. With regards to adult population aged 15 years and above, the level of literacy ranged between 14.6% and 62.8% for female while that of male ranged between 40.9% and 81.3% (Yusuf et al., 2013). The regional variation in health indices are closely related to the literacy rate in the various geographical zones of Nigeria. For example Lagos State, which has the highest literacy rate (92%) in Nigeria is in the South West Zone which has the lowest maternal mortality rate while Borno State with lowest literacy rate (14.5%), (UNESCO, 2012) is in the North East, which has the highest maternal mortality rate in Nigeria as well as resistance to change. This is also the state where child marriage and deep seated cultural barriers are rife.

5. Cultural Barriers

Cultural practices harmful to health abound in Nigeria. Many cultural barriers are inextricably intertwined with illiteracy, ignorance, poverty and misconceptions. Knowledge comes through education and knowledge can prevent poverty and malnutrition. The care or lack of care of women is determined to a large extent in most developing countries, by the influence of traditional or cultural factors. Most communities in rural Nigeria tend to adhere to the old local belief of their forefathers that pregnancy and delivery is the province of Traditional Birth Attendants. In a study of health seeking behavior in Ologbo, a rural community in the South South geopolitical zone of Nigeria, it was found that, private maternity center was the most preferred place for childbirth (37.3%), followed by Traditional Birth Attendants (TBAs) (25.5%). Government facility was preferred by only 15.7%. Reasons for the low preference included irregularity of staff at work (31.4%), poor quality of services (24.3%), and high costs (19.2%).

The cultural pattern in some developing countries is such that women occupy subordinate position in the community. In Nigeria, decision making both in the family and in public sphere is still largely left to the man (Ezekwem, 2002). The acceptance or not of modern maternity practices may therefore depend on the husbands who may prefer their pregnant wives to assist in the farms or perform household duties rather than attend antenatal clinics. Although it is common knowledge that maternity services in many developing countries are poorly utilized and that some areas have very scanty or no maternity services, it is nevertheless very difficult to assess the degree of relevant data whereas in developed countries, accurate data are readily obtained from hospitals, maternity centers or national health statistics and these data are very often representative of the situation in general populations.

In most developing countries, especially in the rural areas, national health statistics are either not available or inaccurate. An important reason is that many women do not utilize hospital facilities because they are frightened, cannot afford the expenses or prefer to use traditional methods (Nylander, 1990; Osubor et al, 2006). This explains why most epidemiological investigations (using hospital data) from developing countries, cannot give a true representation of what obtains in the general population (Harrison, 1985; Ekwempu, 1988).

Vast discrepancies continue to exist in access to maternal health care between the developed and developing world, richer and poorer women, urban and rural women, and educated and uneducated women. At least, 35% of women in the developing countries still receive no antenatal care, almost 50% give birth without skilled attendant and 70% receive no postpartum care. In contrast, maternal health care is nearly universal in developed countries. A range of barriers; (delays) limit women's access to care including distance (Thaddeus and Maine, 1994), cost multiple on women's time, poverty and lack of decision making power. Ensuring that women have access to maternal health care, particularly at delivery and in case complication is essential to saving their lives (AbouZahr, 1997).

BRIDGING GAPS THROUGH PARTNERSHIPS AND MASS EDUCATION CAMPAIGNS

A comprehensive approach to successful implementation of the Midwives Service Scheme in Nigeria includes utilizing innovative health communications to the policy makers, politicians, rural and urban dwellers with special attention to the zones in which the scheme is not currently effective. There is need for partnership (Cheng et al., 2009) among the stakeholders such as the policy makers, politicians, opinion leaders, religious leaders, school teachers, traditional birth attendants, nurses, midwives, doctors, and organizations involved in print and electronic media. The aim of this is to improve the general educational level of all members of the community and create awareness among the stakeholders. The electronic and print media will help to jingle adverts on maternal health care on radio and television and also display such adverts in local

newspapers. This message will include information on the primary health centers and maternities such as location in the various communities, available facilities and affordable pricing. Sermons in churches and mosques should include health messages on maternal health. Maternal health and reproductive health should also be taught in schools. The effect of this will be to inculcate maternal and reproductive health promotion in adolescents, who will grow up to implement these teachings in their families. In addition they will also inform their parents and help to reinforce messages already received by parents in mosques, churches, markets and print and electronic media.

Home Visiting

Midwives and volunteers should endeavor to visit pregnant women at home. This tends to win the confidence of pregnant women and break social barriers between the patients and the staff in the health center. Apart from giving the patient psychological enhancement, it serves to educate the midwifery staff about the social environment of the patient (Park, 2007).

Edutainment

This is a term developed from education and entertainment. The strategy is to educate people while they are being entertained (Cheng et al., 2009). Primary health centers should be reinvented and launched with entertainment while partnerships are being developed among the stakeholders. Partnerships serve to integrate and involve the members of the community in the promotion of their own health using locally available resources in a win-win situation. Appropriate health communication through information education and communication materials or Health education directed to policy makers at all tiers of government can modify the behavior of political leaders and motivate them to act in the best interest of their followers. Such health communication can be done through print and electronic media and persuasive interpersonal communication. Since politicians often invite dance troupes while campaigning, health messages can be encoded in the songs and demonstrations by the dancers to the target audience. This will promote both the politician and the health of the community.

Social Environmental Modification

Desirable behavior of utilizing primary health care facilities can be achieved through social environmental modification, which is based on the fact that most individuals will not readily accept something new until it has been approved by the group to which they belong (Park, 2007). This implies that if antenatal services and delivery are approved by the religious group that a woman belongs, she will readily accept such services. Therefore developing partnerships with pastors, Imams, opinion leaders and other service chiefs in the community will facilitate primary health care utilization in the North-Western and North Eastern zones that are currently resistant to change.

Regulating the Environment

There is a need for the government to legislate on 'place of delivery'. Deliveries must take place in medical institutions with skilled birth attendants. It is a colossal failure on the part of the government to attempt to train illiterate Traditional Birth Attendants for child birth supervision. Traditional Birth Attendants are unable to make early diagnosis and offer appropriate treatment as they cannot measure blood pressure and other indicators necessary for monitoring progress in labor (Inegbenebor, 2007). Traditional Birth Attendants may be integrated into the services of the primary health centers for the purpose of building partnerships and public relations with the communities but should never be left alone to supervise deliveries. There should also be legislation against private practices by Traditional Birth Attendants. The men (who are usually the family bread winners and decision makers) and women in the affected zone should educated in the mosques, churches and markets by trained health educators, who should persuade and motivate women to use the facilities in the primary health centers. The dangers of not using health facilities should be demonstrated by local drama and pictorial presentation.

CONCLUSION

Breaking the barriers to the realization of the concept of midwives service scheme and applying innovative approach of social marketing principles are likely to bridge the gap between the goals expected during conceptualization of this program and the current reality being faced by the organizing agency, eliminate program stagnation and accelerate progress towards the realization of the fifth millennium development goal. Optimizing the results and improving the health indicators in all zones in Nigeria can be achieved through inter-sectoral coordination and collaboration between the Ministries of Education, Agriculture, Health,

Environment, Works, Transport and women Affairs as follows:

- The ministry of Education should improve on enrolment in the primary schools and motivate teachers
- The Ministry of Agriculture should ensure production of adequate food.
- The Ministry of Health should ensure that immunization is effective and educate the public on the combination of locally available food stuff that will form a balanced diet for the girl child so that she will be optimally developed and prepared for childbirth.
- The ministries of health and Environment should ensure that the environment is hygienic enough to avoid infections that will be conducive to stunting of the girl child.
- The Ministries of works and Transport should ensure that the roads are motorable and that waterways are devoid of danger so that transport of pregnant women to health facilities will be facilitated during labor and emergencies.
- The Ministry of Women Affairs should ensure that women's rights are protected and women are empowered through training and apprenticeship. To facilitate women empowerment, women should be educated on how to access low interest loans through non-governmental organizations such as Live above Poverty Organization (LAPO).

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Dr Ute Inegbenebor conducted the literature search and wrote all aspects of this article.