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Reproductive Health Care and Its Challenges: A Study of Olorunda Local Government Area, Osun State, Nigeria

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Abstract Every two minutes, a woman dies during pregnancy or childbirth. Trends in maternal mortality, reveals alarming setbacks for women's health over recent years, as maternal deaths either increased or stagnated in nearly all regions of the world. While pregnancy should be a time of immense hope and a positive experience for all women, it is tragically still a shockingly dangerous experience for millions around the world who lack access to high quality, respectful health care. The high mortality rate of women is directly linked with the state of reproductive health care services available and accessible and vice versa. The study investigated the challenges confronting reproductive health care services in Olorunda local government area of Osun State, Nigeria. The Health Belief Model and Reference Group theories were used as the theoretical orientations for the study. The study is an exploratory qualitative study of Olorunda Local government area of Osun State, Nigeria. A multi-staged sampling technique was adopted. 24 IDIs, 8 KIIs and 4 FGDs were elicit data for the study. Qualitative data obtained was content analyzed. The study revealed that shortage of medical personnel, cultural and religious beliefs, inadequate health care equipment, bad road network, inadequate sensitization programmes, are the common challenges confronting reproductive health care services in the study area. The study recommended that there is need to intensify awareness and enlightenment programmes focusing on he importance of reproductive health care, provision of adequate medical facilities and staff, provision of motorable access rural roads and the engagement of community and religious leaders as relevant stakeholders in the eradication of faulty stereotypes against healthcare programmes.

Keywords Reproductive health care, Religion, Culture, Challenges, Maternal mortality, Nigeria

1. Introduction

According to Section 17(3) (c) of the Nigerian constitution (1999), the right to health is acknowledged as a basic human right in Nigeria. It further declares that the state "is obligated to set up its decisions to guarantee sufficient medical and health services for all individuals, and to guarantee the welfare, security, and health of everyone are not put at risk or mistreated." The continuity of any society is attached to the state of their reproductive health. However, due to legal, cultural, and faith-based obstacles around women's reproductive rights 800 women die from pregnancy- or childbirth-related complications around the world every day [1], and 99% of these maternal deaths occur in developing countries, mostly Africa. In sub-Saharan Africa, Maternal Mortality Rate (MMR) is 546, having 10000 maternal deaths and a life-time risk of maternal death of 1 in 36, which is very high [2]. The mortality rate from delivery in Nigeria is 1 in 13; this is because of the inadequate availability of modern healthcare services [3]. Most deaths are preventable if they have gone through the antenatal programme, undergone necessary blood tests, scans, etc. in modern health care centres [4]; [5].

Nigeria is still grappling with a challenged reproductive health rights [6]. Factors that hinder the enjoyment of these rights include inadequate or nonexistent laws and policies, systematic corruption, poor infrastructure, inadequate health services, and difficulty accessing licenced healthcare providers, which is made worse by the division of duties for medical provision among the state's three levels of government [7]. Because of this, Osun State's reproductive health care system still functions similarly to that of the majority of Nigerian states. Research reveals that in Osun State's rural regions, almost 70% of women lack proper access to contemporary reproductive health treatments. Women in Rural areas are more at the less privileged side because of factors such as widespread poverty, illiteracy, ignorance, disease, low women's status, unrestricted sexual behaviour that contributes to a high rate of increase in population, detrimental cultural practices, and inadequate social services all work together to promote reproductive ill health [8]. It is subsequently

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unsurprising that these weak developmental indications are having an adverse effect on the sexual and reproductive health of women in Osun State, Nigeria.

Furthermore, women's lives continue to differ greatly based on factors such as age, class, geography, and cultural background. In a similar vein, their sexual requirements and lifestyles may range greatly throughout the state [9]. In addition, Osun State faces the challenges of a patriarchal society in which women face discrimination in many areas of life, including the lack of proper access to services related to reproductive health [10]. Over time, economic development and expansion have been linked to inaccessibility and the unfavourable health outcomes experienced by women in the area. Traditional methods of healthcare delivery are frequently used in rural areas. Because mainstream media outlets like the internet, radio, and television are inaccessible to most residents, they lack education and orientation. Despite the WHO's regulations, how many rural women have access to this knowledge? Will these women trust contemporary methods that include a great deal of bureaucracy? Do these women even live in communities with modern facilities? Are contemporary medical professionals willing to remain and work in these remote places, treating patients and provide all necessary services?

This clarifies the preference of certain women for orthodox, conventional and religious clinics. However, the majority of women who seek medical attention frequently work with both conventional and modern healthcare practitioners in the region. In spite of this, women's reproductive health in rural regions is rapidly declining. Accordingly, the use of contemporary reproductive health treatments in this setting is occasionally decided by the men and impacted by their own religious convictions and opinion of the effectiveness of the services [11]. Why will women in rural areas prefer traditional healthcare services to modern healthcare services? What are the possible barriers to not accepting and utilising modern health care? Or could it be that these rural women face some challenges in their attempt to utilise modern facilities? What can the government and other stakeholders do to eradicate the unhealthy belief system that prevents the utilisation of modern health care in rural areas? How can we make modern health care more available or accessible to all? As a result, this study will assess the challenges of reproductive health interventions in the rural areas of Osun State, Nigeria.

2. Brief Literature Review

Conceptual concerns about reproductive health remained at the forefront of the development discourse on women for many years. Scholars have attempted severally to reinterpret the notion of reproductive health, with the ability to reproduce, the right to safe sex, and the freedom to sexual activity continuing to be key tenets [12]. The World Health Organisation defines reproductive health as a condition of total physical, mental, and social well-being in all aspects pertaining to the reproductive system and its activities and processes, not only the absence of sickness or infirmity [13]. Therefore, having reproductive health means that an individual may have a meaningful and safe sexual life, reproduce, and have the freedom to choose if, when, and how frequently to do so [14]. Nevertheless, the free-to-use prediction is limited in its scope and depends too heavily on the current healthcare system. A second issue is that the resources that are offered tend to be concentrated geographically in big cities, do not reach the poor, and are not distributed equally among the most successful treatments [15].

In Nigeria, the medical community faces significant obstacles in addressing various health-related issues. The first priority is to reverse the brain drain problem, which is now having a negative impact on Nigeria's national life in key sectors other than the health sector. It is paradoxical that these developing nations, who ought to be receiving labour, are instead providing labour. As a result, there are now fewer human resources available, particularly among highly qualified medical professionals. To make matters worse, several of the medical experts on hand would prefer to operate private medical practices than work in public health institutions. These private hospitals are typically extremely costly, making them unaffordable for the common individual. There are situations when the system makes it challenging and irritating for medical practitioners to practise successfully [16].

Also, social standards have a significant influence in shaping health care behaviours at the individual and group levels, and cultural differences can impact how responsive the healthcare system is to the needs of a varied community. Cultural practices may influence the development of health policies and initiatives at the national level [17]. The issue regarding accessibility, price, supply, and long-term viability also affects end users. The distribution of health services is severely lacking, making the presence of medical facilities a serious issue. In a typical situation, a primary health facility need to be located not more than five km away. Just 13.9% of expected yearly births in Nigeria occur in health facilities, according to a nationwide survey on critical obstetric care facilities conducted by the Federal Ministry of Health [18].

Nonetheless, a few state governments' policy measures have lately started to show some encouraging effects. These efforts have the support of the state commissioner for health, a former executive secretary for primary health care. Even with all of this, the problems still exist, thus many academics have developed what they see as solutions to lessen the difficulties that women have while accessing reproductive health care. Some believe that a preventative strategy is necessary to address the issues surrounding reproductive health, while others advocate for a long-term solution. For example, Amoah recommends that preventative measures be used as doing so will require developing methods to address the primary causes of women's reproductive difficulties. In a similar vein, it is believed that women's reproductive health issues will be resolved by preventative measures. According to his opinion, policy makers and other stakeholders ought to be involved in providing women with information and

services related to reproductive health as well as developing successful communication plans that will influence behaviour [19].

This approach was previously used by the Lagos State Government, which established five maternal and child care centres (MCCS) with adequate staffing and equipment to offer a range of services, such as family planning and antenatal and postnatal care to ensure women's safety during childbirth. The goal of the initiative was to stop the rising number of maternal and child deaths. Surulere, Ikorodu, Isolo, Ifako-Ijaye, and Ajeromi are the locations of the MCCs, with Alimosho, Ibeju-Lekki, Epe, and Badagry as additional locations [20]. The Ondo state government's Abiye programme is one recent project that appears to be effective. This programme in Ondo State's remote areas uses cell phones to save the lives of indigenous pregnant women. As per the World Bank report of 2008, 51.6% of Nigerians reside in rural areas, and the majority of them are isolated from contemporary medical services, leaving expectant mothers susceptible to avoidable negative consequences. The majority of these unfavourable results are caused by people delaying seeking care, arriving at health centres when needed, receiving care there, and, when appropriate, being sent to more sophisticated facilities. Pregnant women who participate in the Ondo state project get prenatal treatment in primary health care facilities, where they are also provided with a cell phone. To ensure that the pregnancy is tracked, the expectant mothers are placed in government-paid caller-user groups and are followed by qualified staff. The medical staff's number can be reached at no cost. The Ifedore Local Government Area in the state of Ondo is home to the pilot programme [21]. The toll-free lines are the main reason that the wait time for medical attention is nearly nonexistent. The programmes also address the issue of pregnant women's delays in arriving at health facilities, since ambulances are available to transport them there upon request. The medical staff ride about on motorcycles with a First Aid package during crises.

In Sub-Saharan Africa, disparities in access to reproductive health treatments are significantly predicted by factors like as occupation, wealth, insurance, and education [22]. However, the majority of earlier research has concentrated on the factors that influence service utilisation within a nation or area [23].

3. Theoretical Framework

3.1. Health Belief Model (HBM)

Social psychologists Godfrey Hochbaum, Stephen Kegels, Howard Leventhal, and Irwin Rosenstock proposed and developed the health belief model in the 1950s in reaction to the varying frequency and prevalence of tuberculosis (TB) infections that were becoming more prevalent in society. Health belief model was developed for the following reasons; to ascertain a person's propensity to engage in or refrain from programmes aimed at preventing disease and promoting initiatives to improve the general public's health, assist individuals in adopting a healthier lifestyle and cultivating a more optimistic outlook towards preventative healthcare measures, use the desire to avoid unhealthy activities to help individuals choose and take healthy decisions and ascertain which person would or would not take any illness prevention measures that support leading a healthy lifestyle. The modifying factors include social, psychosocial, structural variables and cues to actions. The HBM has provided explanations on why people should develop preventive health behavior. It highlights the reasons a rural woman might undergo genetic testing, health screenings, vaccinations, self-examination of her breasts, and usage of contraceptives, despite the fact that she has not been privileged of seeing this been done before either on the social media or in the city. The theory has been used to investigate adherence to a variety of illness regimens, including those related to hypertension, diabetes, and renal disease. Health Belief Model is therefore seen as a theory that explains what really motivates people to take positive health actions and preventive health behaviors [24].

3.2. Reference Group Theory

According to the notion, each person's gains from belonging to a group may be used to measure the effect a group has on its members. It could be a social or religious group in which a person is a member. A group's influence grows with the advantages it provides to its members. According to Siegel and Siegel (1968) as quoted in [25], a group's members each have different roles that it plays. Members can gather and evaluate information about their environment through the group's agency. In addition, the group has the power to shape some parts of reality that are personal to each member and to exert influence over elements of the social and physical environment that affect them individually. A craving for affection and attachment may be induced by the group. A person's beliefs and attitudes are significantly influenced by the group to which they belong. Having said that, the theory can help us comprehend the mechanisms influencing the development of attitudes and the acceptance or rejection of ideals or concepts that originate from outside the group. Put differently, people generally follow the standards set by their organisation. Human behaviour is, therefore, a process of actualization. The social environment—that is, the neighbourhood or society one lives in or values highly—influences behaviour. In accordance with the principles of the group reference theory, it follows that knowledge of the sociocultural and religious groups to which the individuals belong is crucial to understanding how and why people do not use modern healthcare services and family planning, or why some people do adopt them, as these groups will heavily influence their decisions. Understanding their socialization, how their views have developed and become ingrained, and their group dynamics are crucial to the behaviour modification process. The idea views the person as well as his or her social-cultural

surroundings as two important aspects that influence the use of family planning and contemporary medical services. For example, if a society's culture opposes family planning, then its citizens will also oppose family planning in accordance with their culture. According to the same logic, adherents of a religion that forbids family planning will likewise do so. Regardless of the benefits of family planning and contemporary healthcare, it will be challenging for members of the community to embrace these practices if they are contrary to tradition or religion as the case may be. Therefore, the Group Reference theory identifies the characteristics that may be converted into practical efforts that offer acceptable tactics for intervention by focusing on the social, cultural, and religious context of family planning. These factors, which include things like social networks and culture, are primarily what help people establish attitudes and accept change. Given this context, the Reference Group theory would be a useful point of reference for analysing how contemporary healthcare is used in Osun State's rural areas.

4. Methodology

This study adopted the exploratory research design. It is a purely qualitative study. Multi staged sampling technique was used to select 60 rural women from the study area. All the respondents were personally interviewed by the researcher, using the prepared interview schedule guide. Direct observation of reproductive health facilities were also carried out and documented. The study population for this study comprises women, health workers, staff of the Ministry of Health in the study area. and all women of reproductive age in the study area. The participants were purposively selected and interviewed. In-depth interviews (IDI), key informant interviews (KII), and focus group discussions (FGD) were used to collect data.

5. Findings and Discussion

Reproductive health challenges among women in rural communities

The objective of the study is to investigate the challenges of reproductive health care services among women in Olorunda local government area of Osun State. To achieve this aim, participants were asked questions relating to reproductive health. This was in acknowledgment of the WHO definition. The World Health Organisation defines reproductive health as a condition of full mental, social, and physical health rather than simply the nonexistence of illness or disability in every aspect related to the reproductive system and to its operations and activities [26]. In this study, participants were asked about the challenges of reproductive health among women in rural communities. The patterns of responses are shown below:

This question generated a lot of responses. One participant expressed that:

> *"We have a lot of reproductive health challenges among us here. I had complications of frequent bleeding during the pregnancy, and I still had to give birth at home because the nearest medical center is far away. I delivered the child with the assistance of a traditional birth attendant. Unfortunately the child died shortly after the delivery because of the stress.* (24 years old/Female).

> *When I was about to give birth to my first baby, I was told the cervix was tight, so the baby was stressed due to long hours of labour. I laoured had to give birth. Unfortunately, the baby died before the naming ceremony. Because of the inavailability of medical personnel in our area, I used traditional health services available during pregnancy.* (32 years old/Female).

> *I delivered my second child at the government primary health care centre in the local government. Because of my unpleasant experience during the birth of my first child, since the health center was far away, I decide to move in with my sister who lives close to the health when my due date was getting nearer. Though they did not have enough staff there, but it was still far better than my first experience.* (28 years old/Female).

This above shows that the challenges confronting pregnant women in the rural areas in the study are enormous. Another participant also added follows;

> *I live far away from the only existing government health care facility in our area. My husband is a poor farmer and we are just managing. But because of the unpleasant childbirth experience of some people around us using traditional birth attendants, my husband insisted that I must use the government health facility though far away. They asked me to come several times, not minding the economic hardship, and gave me a long list of things to bring to the hospital when I want to deliver, e.g., bleach, dettol, etc.* (23 years old/Female /Nursing mother).

> *When I became pregnant, I registered for antenatal at the nearby government clinic. My experience was pleasant because I was well attended to.* (23 years old/ Female/Nursing mother).

> *"I have three children, but one of them died before we could get the hospital due to bad road and distance. I gave birth to all my children through home delivery with the aid of a traditional birth attendant because we do not have any doctors or hospitals in this community.* (31 years old/Female).

These responses show that the absence and distance of healthcare facilities created a recourse to traditional reproductive health care services as a result of the challenges of accessibility of modern health care.

Another participant, who is a trader, further buttressed this fact when she said:

"I prefer modern healthcare but I have no choice than to opt for traditional reproductive healthcare. When I had my baby, I was taken to the home of traditional birth attendants because it was midnight when I started labouring and we don't have any doctors or hospitals here in Abudu village. So it has always been difficult to access modern health care. In fact, I had some miscarriages as a result of the unavailability of modern health services in this community.
(29 year/female)

The challenges were further buttressed in (KII) key informant interview by a nurse at the health center. Only one nurse was met in an apartment with little or no equipment. She responded as follows:

"Most women who come to the clinic are educated on their reproductive health. They are taught things like family planning, neonate care and immunization. However we don't have machines to scan through to know some things about the fetus. Where there is no capacity to handle the difficult cases, we refer to them to Osun State University Teaching Hospital. This village clinic is not well equipped with modern facilities for most of the cases. So we always encourage the women to go to the nearest urban area".
(46 years/old/Nurse).

This was corroborated by a respondent when the researcher asked another participant about the facilities at the clinic in their area, she expressed that:

"No facilities are here. There is no facility for urine, blood, and other tests. It only has pregnancy testing facilities. Also, there is no facility for Ceasarian sections. If CS is required to save both the mother and the baby, there is no functional operating theatre. If there is a complication, she normally refers them to government hospitals that are very very far from here. Many women who had complications during childbirth lost both their babies and their lives. If your husband has a car or motorcycle, it could be better; but even at that, they are not always successful because the road leading to the main road is not tarred. Taking pregnant women who are already stressed on that gully road is too stressful for their conditions. (34 years old/female).

In an FGD with the participants, it was generally agreed that government has to come to the aid of the residents in the study area when they expressed as follows;

"We do not have adequate medical facilities and equipment here. Our women are suffering especially when they want to give birth. Some have to travel long distances at high cost in pain and on bad road even as they are pregnant. Apart from that, the existing clinic does not have adequate personnel. It is not easy for us at all. That is why many people resort to traditional birth attendants which is very risky because they lack the equipment for scan and lack the training. In most cases, when things boomerang for the traditional birth attendants during child delivery, the hurriedly discharge the woman and tell the family to rush her to government clinic which is sometimes late. We have lost many of our women to death due to such scenarios (29 years old/female resident).

6. Discussion of Major Findings

From the above, the research shows that there are indeed reproductive challenges among women in the study area. The study identified lack of adequate health infrastructure, facilities and personnel, lack of drugs especially those that were essential for pregnant women, no ultrasound services, and no place for Ceasarian sections as some of the challenges confronting reproductive health care in the rural areas. Pregnant women are mostly referred to hospitals in town which is sometimes late for good healthcare services. Also, the deplorable condition of roads linking the rural communities to the towns was identified as a major challenge because it made it difficult for pregnant women to get to hospitals in town with records of some losing their lives on the way especially in cases of emergency. This supports the findings of [27]; [28[; [29], that lack of personnel and basic supplies, including medications, low-skilled labour, and other necessities, is a deterrent and may result in unfavourable pregnancy outcomes for women. Also according to findings by [30]; [31], the clinics were likely to record higher rates of maternal and infant mortality because they lacked an effective and functional operating theatre, particularly when a C-section was necessary.

It was also revealed that since there is little or no modern medical equipment in most of the parts of the study area, most women have resorted to patronizing traditional healthcare services more than modern healthcare services. This is because apart from the bad road network to hospitals in town, lack of adequate staff, facilities and drugs in the village clinics, another major problem is finance. It was revealed that access to modern healthcare is too expensive for the women considering their income levels, and this has resulted into their patronage of traditional healthcare birth attendants. Based on these findings, the study recommends as below.

7. Recommendations

Government should provide standard modern healthcare services in rural communities so as to help rural women overcome reproductive challenges. Every facility established should be well equipped with the necessary equipment, and competent and qualified personnel i.e. health workers should be employed in order to ensure the proper and incessant functioning of quality healthcare service delivery.

Government should make provision for the availability of obstetric ultrasound machines nearer to rural women and

there should be regular maintenance for effective functioning so that pregnant women will be able to take scans when they are due. Importantly, the equipment should be properly maintained.

Modern healthcare services provided by the government should be less expensive and more affordable so that they can be accessible to rural dwellers, especially low-income earners. The government should also make antenatal care free or subsidized to the extent that it will be affordable for low-income households as an encouragement to have a high rate of utilization of antenatal care among rural women.

There should also be an orientation programme to sensitize pregnant women to the importance of not only antenatal care during pregnancy but also postnatal care after child delivery.

There should be adequately equipped operation theatres that could conveniently carry out C-sections in strategic areas like districts or centres not far from the villages, areas, or centres that join them together for easy access. This will reduce the high rate of death of pregnant women and child mortality, and it will also give the rural inhabitants confidence in going through surgery when the need arises without any fear.

The challenges facing the health system can be minimized if there is equitable distribution of health care workers, especially in rural areas. Health workers in the rural areas should be given special incentives to encourage them and there should be a systematic and routine supervision sytem to ensure that they are at their duty posts.

Government should also make access roads to the rural areas motorable so that village women that want to come to hospitals in town especially during emergencies can easily be transported so as to curb untimely deaths.

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