ARTICLE

PERSISTENT CHALLENGES AND BARRIERS ENCOUNTERED BY WOMEN ATTENDING FORMAL ANTENATAL CARE IN SOUTH EAST NIGERIA

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ABSTRACT

This paper presents the challenges and barriers to accessing formal maternity care in South East Nigeria from women's perspectives. It is drawn from a study that explored the concept of safe motherhood. The study used a hermeneutic phenomenological approach guided by post-structural feminism. Data were collected through individual semi-structured interviews with 17 women who were attending a formal healthcare facility for antenatal care. Four aspects of the challenges and barriers encountered by women when accessing care in a formal healthcare setting as reported by the participants of the study are as follows: financial constraints, lack of autonomy, negative attitude of the healthcare providers, and healthcare worker strikes. Some participants linked the economic status of women to the lack of education which had an impact on their ability to make an independent decision as to whether to seek formal maternity healthcare or not. Negative attitudes, and frequent strikes of healthcare workers in many cases, discourage women from using the formal maternity healthcare facilities. It is evident that Nigeria did not achieve the Millennium Development Goal (MDG) 5, which is to improve maternal health. Achieving the Sustainable Development Goal (SDG) 3.1, which is to reduce the global maternal mortality ratio, requires more than technical approaches. Genuine political will is required if the health system is to be affordable for all women. There is the need to address the gender-related issues that sustain women's low socio-economic status. The government needs to pay the workers as and when due, and a performance appraisal should be in place to ensure improvement in the quality of care offered to women.

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INTRODUCTION AND BACKGROUND INFORMATION

Antenatal care (ANC) in a formal maternity care setting is one of the recommended strategies for reducing global maternal mortality (MM). In Nigeria, as in many low-income countries, traditional and modern healthcare systems exist alongside each other. While the former is commonly known as informal or unofficial healthcare, the latter is referred to as formal or official (hospital-based) healthcare. It is the belief of south-eastern Nigerian women that none of the settings (formal and informal) are inferior to others or without risk (Izugbara and Ukwayi 2007, 150–151). However, given that emphasis is laid on screening and risk assessment, the effectiveness of hospital-based ANC has been questioned on the basis that pregnancy complications cannot always be predicted (Carroli, Rooney, and Villar 2001).

Maternal death is acknowledged as one of the major public health indicators with a huge gap existing between the less-resourced and rich countries, and between the rich and the poor within the same region. There is increased interest in the concepts of Millennium Development Goal 5 (MDG-5), dealing with safe motherhood (SM) which is now target 3.1 of Sustainable Development Goal 3 (SDG-3), the reduction of the global maternal mortality ratio (MMR) to less than 70 per 100 000 live births by 2030 (United Nations 2015). There is a decrease in global MM from 532 000 in 1990 to 303 000 in 2015. Unfortunately, with an increase in the estimated maternal deaths from 40 000 in 2010 (WHO et al. 2012, 1) to 58 000 in 2015 (WHO et al. 2015, xi), Nigeria did not only not achieve MDG-5, but has one of the highest levels of maternal deaths worldwide. Studies in Nigeria present the figure as ranging from 756 (Nwagha et al. 2010, 323) to 2 969 per 100 000 live births in different regions (Ngwan and Swende 2011, 565).

A strong correlation is found between MM in Nigeria and the lack of political will, demonstrated in weak management and implementation of health policies and services, and compounded by socio-economic factors (Harrison 2010, 459–460; Kawuwa, Mairiga, and Usman 2006). Yet the majority of the MDG-5 related studies in Nigeria follow the international trend, focusing on identifying medical problems such as haemorrhage, hypertensive disorders, obstructed or prolonged labour, ruptured uterus, sepsis, and unsafe abortion, as the leading causes of death during pregnancy and childbirth (Kawuwa et al. 2006, 544; Nwagha et al. 2010, 323).

Women utilising formal health facilities in Nigeria, as in many other countries, are confronted with a variety of challenges. Financial affordability of service was among the reasons given by urban women for seeking care from the mostly rural-based healthcare providers known as traditional birth attendants (TBAs) in Nigeria, as noted by Izugbara and Afangideh (2005, 117). The same was reported by Matsuoka et al. (2010, 255) in

Cambodia, and Choudhury and Ahmed (2011, 11) in Bangladesh, among others. The Nigerian Demographic Health Survey of 2008 showed that only one-third of births (35%) take place within a formal healthcare facility. Attending the hospital for ANC is not a guarantee that birth will happen in the hospital. In all, the situation in Nigeria is a typical example of how complex factors interconnect and constrain the progress towards MM reduction.

PROBLEM STATEMENT

Contemporary discourse around maternal health (MH) as it relates to sub-Saharan Africa has been consistently linked with death and danger. It can be argued that this has led to an intensified western medical model approach, resonant with neoliberal values such as hospital-based births, and using what Fonn and Ravindran (2011, 14) referred to as "technology-based vertical programmes" with emphasis on identifying and managing risk, which are not locally suitable in many cases. Consequently, a majority of studies have focused on clinical causes and on calculating the number of deaths. It is crucial to note that technical maternity care on its own cannot prevent maternal death. The recent work by The Elephant Collective in the Republic of Ireland provides clear evidence in this regard (The Elephant Collective, 2015). It shows that preventing MM can also be challenging even in countries with a high level of formal maternity care. The SM initiative (MDG-5) took a reductionist biomedical technical approach in which the broader determinants of MH were given little or no attention. It limits our understanding of the complexities surrounding women's lives (Ohaja 2012, 33). The question remains: will the newly launched SDG-3.1 make any difference?

PURPOSE OF THE STUDY

The overall purpose of the study was to explore the concept of SM as experienced and understood by women, midwives and TBAs in South East Nigeria. The part of the findings presented in this paper concerns the persistent challenges and barriers encountered by women attending formal maternity care facilities.

METHODOLOGY

A qualitative hermeneutic phenomenological approach according to Gadamer (2004), guided by post-structural feminism (Weedon 1997), was used in this study (Ohaja and Murphy-Lawless In Press). The focus of hermeneutic phenomenology is on lived experience and its meaning. One of the aspects that set Gadamer apart from other phenomenologists is his acknowledgement of how historical, social and cultural factors have an impact on people's lived experiences. However, he does not explicitly address gender- and power-related issues. By using post-structural feminist principles to guide

this study, gender- and power-related structures are questioned in terms of how they influence women's experiences and their decision to seek maternity care (Weedon 1997), thereby contextualising the challenges and barriers to achieving MDG-5.

STUDY SETTING

The principal study sites were two university teaching hospitals located in two of the five states of Nigeria's south-eastern region, and both serve as referral centres for other health facilities including government and privately-owned hospitals. TBAs who own private birth homes refer women to formal health facilities including private, other government and teaching hospitals. A majority of the populace in these states are small-scale traders and farmers.

DATA COLLECTION

Individual semi-structured interviews which lasted 30–60 minutes were conducted in July 2011 to August 2011 and in December 2012 to January 2013. A mixture of English and the Igbo language was used during interviews with the women. The interviews took place in one of the private rooms within the hospital environment. Each woman was interviewed on the day of her antenatal visit thereby avoiding any undue stress from making a separate journey for the purpose of the interview. All interviews were dialogical in nature and the participants' well-being was a central issue. The interviews were conducted by one of the authors who is a native Nigerian and speaks the Igbo language fluently, therefore no translator was required. Open-ended questions were used in ascertaining the participants' views, and probing questions helped to obtain deeper and meaningful answers and to clarify the issues raised by the participants (Ohaja and Murphy-Lawless In Press). Given that the Igbo people live in communities where experiences are shared, the women were also asked about the challenges encountered by other women in their community. Key issues raised by the participants were noted during each interview after which these were reiterated to ensure that all their experiences were captured correctly. Recruitment was stopped when no new information was emerging.

DATA ANALYSIS

The interviews were tape-recorded and later transcribed. Even though some women were interviewed using the local language, all interviews were directly transcribed into English (Ohaja and Murphy-Lawless In Press). The transcripts were then read several times independently by both authors to extract common trends that weave through the dialogue with the participants. The data presented here were manually coded. There was constant movement between the individual transcripts and the common phrases, the aim of which was to determine whether the participants assigned the same meaning to

the themes and the commonalities extracted from individual transcripts were clustered resulting in the final themes, four of which are presented in this paper. This is congruent with the hermeneutic circle as explained by Gadamer (2004), and is akin to reflexivity commonly used by feminist researchers. In the spirit of post-structural feminist analysis, the interview transcripts were further read. This involved paying particular attention to the subjective and unique voices as well as the language used by the participants when narrating their experiences and the influence of the existing social structures in shaping these experiential accounts thereby addressing the issue of power (Weedon 1997).

ETHICAL CONSIDERATIONS

As the study was conducted in part fulfilment of a PhD in midwifery, the Faculty of Health Science at Trinity College Dublin granted ethical permission. Ethical clearance was also obtained from two tertiary hospitals located in South East Nigeria. The midwives in charge of the antenatal clinics or classes acted as gatekeepers for approaching the women. Their role involved creating awareness of and explaining the research aim and objectives to the women in the local language during antenatal education classes. The English version of the information leaflets were made available for women should they wish to read further about the research. The women expressed interest in person to the interviewer who as a fluent Igbo speaker was able to give further clarification before the interviews. Verbal and/or written consent was obtained from the participants before the interviews, and women under the age of eighteen were excluded from participating in the study. In this paper, the quotes from the women have been anonymised thereby protecting their individual identity.

FINDINGS

Biographic information

A purposive sample of 17 women who were attending ANC in two teaching hospitals was interviewed. Taking into account that many women present later in pregnancy than is common in western countries, the women who participated in this study were recruited in the last trimester (30–32 weeks of gestation) and interviewed at 32–40 weeks of their pregnancy. Interviewing at this time ensured that women who were pregnant for the first time were able to speak of their experience of pregnancy with a reasonable sense of confidence. As noted by Nwagha et al. (2008, 67) the average gestational age at booking in South East Nigeria is 26.12 (± 7.6 weeks). Our study participants included both multiparous (n = 7) and primiparous (n = 10) women ranging in age from 20 to 42 years. All participants were married with varied education levels, tertiary (n = 12) and secondary (n = 5). Women under the age of 18 were excluded from participating in the study.

There are wide-ranging complex challenges and barriers to accessing formal ANC in Nigeria as in many other countries. This paper reports on four of the aspects revealed in this study: financial constraints, lack of autonomy, attitude of healthcare providers in the formal sector, and healthcare worker strikes.

Financial constraints

Women's attendance at a formal healthcare setting for maternity care is largely influenced by their socio-economic status. All the participants unanimously mentioned financial constraints as one of the main reasons that keep women away from formal healthcare facilities.

> "When you come for antenatal they ask you to buy drug, or to do urine test, you will pay for all those things. In the maternity home, you don't really spend much, maybe that scare women away from the hospital."

Women reported that sometimes they may not get the attention of the healthcare provider if unable to "pay before service".

> "Here sometimes you have to pay before they attend to you. Failure to do that, nobody will look at you. That is why the other hospitals attract women."

Some women explained how they remained scared that they may not be attended to by a healthcare provider because it has not been possible for them to undergo required medical tests.

> "Last month I was supposed to come I was scared because ... I had no money ... Even now that I am here I am still scared because I don't have the money…"

The participants appealed for help as the government hospitals are more expensive, which makes it even more difficult for women who are unemployed. However, they believed that with education, the financial status of women will improve as they will be in a better position of finding employment.

> "... teaching hospital is very expensive ... They just need to help us because money is somehow difficult to get ... and not everyone has a job that gives money maybe due to lack of education."

Another woman commented:

> "A lot of pregnant women keep away from government hospital because the money is too much for them and many cannot afford it. They need to reduce the cost for the women to come so they will be safe during and after giving birth."

Lack of autonomy

Many women did not seek formal healthcare or had delayed in doing so due to their feeling constrained in acting for themselves: they rely on their husband, mother and/

or mother-in-law to instruct them to act in line with traditional social mores. The lack of education was given as a reason for the inability of some women to make decisions independently. The mothers-in-law are reported to be discouraging women from attending formal healthcare facilities on the basis that pregnancy and childbirth are normal life events. Aversion to caesarean section is a prime reason. Such advice might be considered inadequate and even dangerous in the event of complications.

> "A lot of women rely on their husbands and/or mothers-in-law for decision-making ..."

Some of the participants who attended the formal healthcare centres were of the opinion that when educated, women are able to argue their points.

> "Some are advised by their mother-in-law ... when women are not educated they yield to whatever advice they are given."

Importantly, the participants acknowledged the frustration experienced by some of the women who rely on their husbands for everything they need.

> "... many women are housewives. There is one in my area ... she is pregnant ... in fact she is supposed to be here today, the man doesn't give her money for food, does not even take care of her and all that ... You know it is frustrating."

Attitude of healthcare providers in the formal sector

Another important aspect of the findings relates to the disrespectful and uncaring attitude and behaviour of the staff. The troubles with the formal healthcare system are multifaceted and range from the offhand attitude of the care providers, issues of inaccessibility due to distance, to uncertainty about the functionality of the system due to disagreement between the government and the workers in relation to pay, which often leads to general strikes. The participants in this study were bitter about the treatment of some of the healthcare providers which makes them reluctant and scared about attending the hospital for care.

> "The nurse (midwife) on duty ... was just talking to me rudely that I have not come to the clinic ... that is how we play with our lives and all that ... Honestly speaking, they scare people away ... so many medical practitioners do it, they are harsh to patients."

Clearly the women who participated in this study knew the type of care that is acceptable. For instance, they spoke about their desire to be given detailed and accurate information about their care and for the health professionals to show some concern about their feelings. Interestingly, the women discussed their experiences with one another which they found helpful and reassuring.

> "One of the women sitting beside me this morning was complaining bitterly about the doctor that is on this morning ... she wanted an explanation from the doctor … the doctor told her to walk out from the office, no explanation was given to her, she got scared instead ..."

Another woman stated:

> "I didn't like the way one of the doctors attended to me, she was rude and told me I should leave the office ... I was discussing with one other woman she encouraged me to stay, maybe she [the doctor] wasn't happy that day ..."

The negative and unacceptable behaviour of midwives and doctors was perceived as more of an issue within the state-owned hospitals. The participants reported that women get better treatment in the private hospitals.

> "They will treat you anyhow you want in fact they can be loyal in order to get money but here in government hospital, they behave anyhow at the end of the month they get paid ..."

Two of the women made positive remarks about the treatment they received:

> "Generally the doctors are good. Most of the problems are caused by the nurses. Some of them are very uncaring."

> "I don't know of others, but the way the nurses (midwives) attend to me, and the doctors, I really appreciate it. I have said it everywhere ... they are really trying."

Healthcare worker strikes

Disagreement between the government and workers over pay often leads to frequent strike disruption by health workers. As a result, women were not guaranteed that the hospital would be functioning when they needed the services most, during labour for instance.

> "I went there (a private hospital) when I was sick because this hospital and the other government hospitals were on strike … If the government hospitals are on strike at the time of delivery at least you are guaranteed of another place where you are registered."

Another woman stated:

> "You know, this place is a government hospital; they can go on strike any time, any moment so I booked in other places."

Some of the women registered in more than one health facility because they were not certain of services at the government hospitals should they be in labour.

> "I started somewhere at the general hospital … because the staff of the teaching hospital were on strike ... But I came and registered here when I was four months pregnant."

DISCUSSION

With the most recent estimate of MM by WHO et al. (2015) showing Nigeria as having the highest MM worldwide, it became obvious that MDG-5 was not an appropriate strategy for dealing with MH issues in the country. The findings of this study reflect the persistent imbalance in Nigerian society whereby women have a lower social status within the family, and in the wider socio-political context. The troubles with the formal healthcare system and ANC in particular are multifaceted and range from the offhand attitude of the care providers, to uncertainty about the functionality of the system due to disagreement between the government and the workers in relation to pay, which often leads to general strikes.

Among the challenges faced by women seeking formal maternity care is financial incapacity. A worrying finding of the present study is that women still face the risk of not receiving the required care in the formal health setting if they are unable to pay beforehand. Harrison (2010) noted that in urban areas where the hospitals are somewhat better equipped, women died in the hands of good doctors simply because they did not have the money to pay for the service. A series of studies has highlighted the impact of poverty on MH (Aftab et al. 2012, 5; Izugbara and Ngilangwa 2010, 1; Liljestrand and Sambath 2012, 62). The focus of MDG-1 is on the reduction of poverty and, as argued by Izugbara and Ngilangwa (2010, 1), the complex implications of poverty on maternal outcomes have not been given due recognition in the existing literature. Ajala (2009) investigated the socio-cultural factors influencing maternal and child healthcare in Osun state in South West Nigeria, where the poor economic status was among the barriers to seeking formal healthcare.

Interestingly, poverty reduction is among the background factors that contributed to lowering MM in Cambodia from 472 per 100 000 in 2000 to 2005 to 206 per 100 000 in 2006 to 2010 (Liljestrand and Sambath 2012, 62). It is important to highlight that even though most of the women who attended formal healthcare expressed concern about the expensive nature of such care for local women, it was difficult for some of them to meet the financial demands. For instance, some women reported that there had been times they did not attend antenatal visits or were afraid to attend because they had not paid for some of the medical tests. “They need to help us because money is difficult to get,” said one woman. On a positive note, expressing concern on behalf of other women can also be seen as a sign of collegiality and willingness to challenge the status quo as a group.

Reliance on others, primarily husbands and mothers-in-law, for decisions about care seeking was another challenge or barrier mentioned by the participants in this study. A number of the women who attended ANC at the formal healthcare facilities expressed concern over the fact that some women had to wait for others (mothers-in-law and husbands) to make decisions for them relating to their care. The socio-economic inequality that persists in Nigeria and in most low-income countries means that women have to rely on others for not only decision-making but also to provide them with money needed for formal healthcare. Iyaniwura and Yussuf (2009, 111) reported that 36.1 per

cent of respondents in their study of utilisation of ANC and delivery services in South West Nigeria, used the services of TBAs to please their husbands. Weak decision-making ability of the pregnant women was also identified in Kenya by Fosto, Ezeh, and Essendi (2009, 1). In relation to the influence of mothers-in-law, evidence from the literature revealed that the role they played in decisions about where to seek ANC is based on the notion that pregnancy is a normal life event requiring no medical intervention (Finlayson and Downe 2013, 6). There seems to be an acceptance of the dominant discourse of the man "being in charge" by some of the women who participated in this study. This raises the question of whether women are contributing to their own subordination or have simply been trapped within the dominant culture.

Another significant issue mentioned by women in this study is the behaviour of the healthcare profession which they presented as disrespectful and abusive, indicating that women appreciate good quality care. Igboanugo and Martin (2011, 69) reported that women in their study had a good understanding of the characteristics of good quality maternity services. The women were critical of the quality of care and attitudes of the service providers among other things. Similarly, 98 per cent of respondents in Okafor, Ugwu and Obi's (2015) questionnaire-based study reported that they experienced at least one episode of abusive and disrespectful care during childbirth. Disrespectful and abusive care in maternity care settings has recently gained international attention. Finlayson and Downe (2013, 8) listed Africa, Asia and South America as parts of the world where this is especially prevalent. In a more recent systematic review of 65 studies conducted in 34 countries, Bohren et al. (2015, 5) reported that the mistreatment of women during pregnancy and birthing is a worldwide issue. They identified that disrespect and abuse in health facilities occur in different forms ranging from physical, verbal and sexual abuse to stigma and discrimination, from failure to adhere to professional standards of care, to poor rapport between women and providers and health system conditions and constraints. Other forms of abuse include the lack of support, neglect, and loss of autonomy, all of which disempower women in a systematic way.

In addition to the offhand attitudes of the healthcare professionals, frequent strike disruptions by healthcare workers were mentioned by the participants in the study as an obstacle. Women had limited trust in the formal healthcare facilities and could not rely on them, particularly the state-owned hospitals. Uncertainty about the functionality of government-owned hospitals is a major problem in Nigeria. As a result, most of the participants registered for care in more than one health centre, including private hospitals and maternity homes, the latter run by TBAs, so as to avoid being stranded without a caregiver during labour. This places additional financial burdens on women who are already financially constrained. So, in order to adequately deal with the SDG-3.1, urgent attention needs to be paid to these challenges encountered by women.

CONCLUSIONS

The findings highlight that the emphasis placed on medical causes of MM hindered the achievement of MDG-5. It presents the disconnection between the local situation and the internationally devised programmes. Superiority is ascribed to the dominant obstetric care model while little attention is paid to the influence of structural factors that lead to neglecting entirely the quality of care within that model. The fact that the formal healthcare is unaffordable for many women warrants urgent attention. In this article, significant issues that support the findings of previous studies have been identified. In order for this problem of high MM to be solved successfully, it needs to be approached from a holistic perspective.

RECOMMENDATIONS

Financial constraints: A free health service needs to be introduced in all the states.

Lack of autonomy: A comprehensive approach to care that will take cognisance of the complex determinants that shape and constrain women's social status and have an impact on their health is required. Perhaps women need to unite as a group to have their voices heard by society leaders and health managers. Involving the women in MH discussion is critical if the SDG-3.1 is to be achieved.

Attitude of healthcare providers in the formal sector: There is a need for quality assurance mechanisms to appraise the performance of healthcare workers, including their treatment of pregnant women with the hope of eradicating abusive and disrespectful care to ensure good quality care for the women.

Healthcare worker strikes: The government needs to display genuine commitment to the welfare of its citizens and to the improvement of MH in particular, including paying the healthcare workers as and when due.

LIMITATIONS

It can be argued that the findings presented here are based on the perspectives of women recruited from just two of the five states of South East Nigeria which may limit their transferability even within the wider context of Nigeria. The participants could also be described as a "bias group" given that they were using the formal healthcare facilities. A point has to be made that these findings support those of previous studies in Nigeria and other regions of the developing world.

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