Access to Maternal Healthcare in an Urban Slum: The Case of Makoko Community in Lagos Metropolis, Nigeria

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Extended Abstract

1.0 Introduction

Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. It encompasses the health care dimensions of family planning, preconception, prenatal and postnatal care in order to reduce maternal morbidity and mortality (WHO, 2012). Maternal morbidity and mortality have remained an endemic health issue for women over the years. To stem the tide of maternal health issues, the United Nations had as its fifth Millennium Development Goal a commitment to reducing maternal mortality by three quarters between 1990 and 2015 (UN, 2005). Subsequently, commitments by countries as a result of this goal have resulted in the reduction of maternal deaths. For instance, in 2013, an estimated 289,000 maternal deaths occurred globally, indicating a decline of 45% from 1990. Similarly, the global maternal mortality ratio stood at 210 maternal deaths per 100,000 live births in 2013, showing a reduction from the 380 maternal deaths per 100,000 live births witnessed in 1990 (WHO, 2014).

Despite this progress, maternal mortality still remains an endemic problem in the developing world, where about 99% (286,000) of these deaths occurred in 2013. Maternal mortality ratio stood at 230 deaths per 100,000 live births in the developing countries, being fourteen times higher than the 16 deaths per 100,000 live births in the developed world. sub-Saharan Africa however, remains the region with the highest ratio of maternal mortality (followed by southern Asia at 24% (69,000)). It accounted for 62% (179, 000) of the global deaths in 2013. Thus, in sub-Saharan Africa, a woman's life time risk of dying during or following a pregnancy is 1 in 52 as compared to 1 in 3400 for the developed world. However, within the developing countries, there are still variations, with some countries such as Sierra Leone, having as high as 1000 or more deaths per 100,000 live births (WHO, 2014).

Most of these deaths are however, avoidable as observed by the World Health Organization. This is because the health-care solutions to prevent or manage maternal health issues are well known. Nevertheless, the lack of access to family planning; antenatal care in pregnancy; skilled care during childbirth; and care and support in the weeks after childbirth are the factors that lead to these deaths (WHO, 2012). And poor women in the rural areas and urban slums are particularly vulnerable as they are least likely to have access to adequate health care. Factors such as poverty; ignorance; distance; lack of information and inadequate services do prevent these women from receiving or seeking care during pregnancy and childbirth.

The target year 2015 for the achievement of the Fifth Millennium Development Goal of improving maternal health is here. The questions arise – has the goal been realized or met in Nigeria? Has its targets of reducing maternal mortality ratio by three-quarters and the achievement of universal access to reproductive health been achieved in Nigeria? These are some of the contending issues that this study aims to unravel with a survey of the access of child bearing women in Makoko community, an urban slum within the Lagos metropolis of Nigeria, to maternal healthcare.

1.1 Statement of Problem

Nigeria presently ranks as one of the two countries that accounted for one third of all global maternal deaths in 2013 - accounting for 14% (40,000) of the overall deaths (WHO, 2014). This fact though alarming is however, not surprising due to the revelations of the national demographic survey. The National Demographic and Health Survey (NDHS) 2013, findings reveal a gloomy picture about maternal health in Nigeria. The survey reveals that contraceptive usage by married women still stood at 15% in 2013. The aftermath of this is the high fertility rate that stood at 5.5 children per woman in the same year. However, despite this high fertility rate, access to maternal healthcare is limited. For example, the survey reveals that only 38% of the births were delivered by a skilled health provider (midwife, doctor or nurse), while only 36% of them were delivered in a health facility. On the other hand, only 51% of the mothers received at least four antenatal care visits during the pregnancy, while equally, only 40% of them received a postnatal check-up within the first two days of giving birth (National Population Commission & ICF International, 2014).

These statistics show that efforts by Nigeria to reduce maternal deaths based on the fifth millennium development goal's aspiration has not yielded the desired result. The scenario reveals that access to maternal health care still remains a mirage. Reducing maternal deaths in Nigeria can only be achieved if all child bearing women have unhindered access to maternal health care. However, access to maternal healthcare is mediated by other socioeconomic variables such as the place of residence. For example, people living in the rural areas and in the urban fringes do not have the same access to healthcare as those living in the urban centers. This calls for differential policy interventions by the government in order to allow equity of access. This study is therefore designed to investigate the access of women of child bearing age living in urban slums in Nigeria to maternal healthcare with a focus on the Makoko community, a slum area within the fringes of the Lagos metropolis. The study specifically will investigate access to maternal healthcare from the view points of knowledge and affordability of family planning; affordability and distance to healthcare provider and facility for antenatal care; delivery by skilled health provider (midwife, doctor, nurse) and in a health facility and postnatal care within the first two days of giving birth.

1.2 Theoretical Frameworks

The study adopts an eclectic theoretical approach. The structural functionalist, conflict and symbolic interactionism perspectives will serve as the theoretical underpinnings of the study. Structural functionalists argue that society could be viewed as a unified system that is made of differentiated but interrelated parts that work together for the effective functioning of the whole society. Therefore, a dysfunction in any of the parts affects the effective functioning of the society. From this vein, the family institution is one of the component parts of the society that

ensures societal continuity by reproducing its members, while the health institution ensures system maintenance by taking care of the sick and health needs of societal members. The family adequately reproduces her members through a functional healthcare system. Therefore, a dysfunctional health institution affects the family's reproductive role and this in turn disrupts the societal functioning. Maternal mortality therefore, goes beyond being an individual problem to a societal problem. High mortality rate impedes human and societal development. The conflict theory on the other hand focuses on explaining the structuring of society from the perspective of historical materialism. It argues that at all times, human society is structured into two classes – the dominant and the dominated. The dominant class comprises the ruling class (government) and therefore, makes policies to protect its class interest. Urban slums are manifestations of the lopsided policies, of the ruling class. Slums become haven to the less privileged who have no access to adequate housing, hence slums are lacking in basic amenities including healthcare facilities. For symbolic interactionism theorists, the social world could be explained from the basis of the social interactions that occur between individuals and the meanings derived from such interactions by the individuals. Thus, the meanings that individuals give to their interactions with one another and to the symbols within their socio-cultural environment, affect their response to such symbols. For example, the meanings that people give to orthodox healthcare vis-à-vis unorthodox care affects their response to either healthcare system. Where the meaning given to orthodox healthcare is positive, people will make use of the facilities but if it is negative, they will not make use of it. In urban slums, where the level of awareness of the importance of modern maternal healthcare is low, child bearing women may not subscribe to modern maternal healthcare even where such facilities are available within their community. They may still prefer the unorthodox maternal healthcare due to the positive meaning they attach to it.

1.3 Methods

- **Research Design –** The study utilizes the non-experimental design. A combination of methods will be used to gather both quantitative and qualitative data. The cross sectional survey method will be used to gather the quantitative data, while focus group discussion will be used to gather the qualitative data.
- **Research Setting** – Makoko community, an urban slum in the Lagos metropolis of Nigeria is the location of study. Makoko is a multi-ethnic fishing community with a population size of 85,840 comprising of 43,280 males and 41,540 females. Some of the residents live on water due to inadequate landmass. The dominant occupation of residents is fishing and trading.
- **Study population –** This will comprise of child bearing women, ages 15-49 years, both married and single.
- **Sample Size and Technique –** A sample size of 230 women will be drawn for the study using the multi-stage simple random sampling technique.
- **Data Collection-** Quantitative data will be gathered using the questionnaire. Questions will be asked on access to family planning; antenatal care; safe delivery and postnatal care. Similarly, focus group discussion will be used to gather the qualitative data on the same issues. Two groups of women – young (ages 15-25) and old (ages25 and above), comprising of 6 discussants each, will be used for the focus group discussion.

1.4 Expected Findings – It is expected that the study will unravel the following –

- Access of child bearing women of Makoko community to modern family planning, in terms of knowledge, affordability and distance to healthcare provider and facility.
- Access of child bearing women of Makoko community to antenatal care, in terms of affordability and distance to healthcare provider and facility.
- Access of child bearing women of Makoko community to safe delivery, in terms of delivery by skilled health provider (midwife, doctor or nurse) and delivery in a health facility.
- Access of child bearing women of Makoko community to postnatal check-up within the first two days of giving birth.

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