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Maternal Death in Northern Nigeria: What the Community Knows and is Saying

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Abstract:

Women's death from childbirth is common place in the developing world. WHO, 2017, estimated 67000 maternal deaths for Nigeria. Principal among the contributing factors to this tragedy is poverty. The growing poverty, especially among women greatly limits women's access to highly needed maternity care. The aim of the study is to identify the views of community of the commonness and causes of maternal death and ways to ameliorate the carnage in Northern Nigeria.

This was a community-based qualitative study undertaken in four states in northern Nigeria: Benue and Plateau states, north central Nigeria; Gombe and Taraba states, north eastern Nigeria. The instruments of the study were: (i) Focus group discussion (FGD) and (ii) Semi-structured interviews (SSI). Jos University Teaching Hospital (JUTH) ethics committee approved the study.

It was found across the states that maternal deaths were common occurrences. The deaths were on the increase and often attributed to poverty, ignorance and poor infrastructure. The majority of the population in the states under study was peasants that generate no surplus. Subsequently, little or nothing is left to pregnant women to access maternity services when needed. There were few sparsely spread functional health care facilities across the states. Furthermore, the health facilities lacked trained staff, were poorly equipped and needed basic infrastructure such as water, electricity and referral systems. Community engagement is advocated on safe motherhood issues.

The communities know that maternal death is common and are frequently related to poverty, ignorance and poor infrastructure. The community said they need fertilizer to tackle poverty and maternal deaths among them will drastically reduce.

Keywords: Poverty, maternal death, community engagement, fertilizer, northern Nigeria

1. Introduction to the Problem

World Health Organization (WHO), 2019 estimates that nearly 810 women died daily from pregnancy-related causes in 2017 globally (that is about 295000 deaths in the year). Fourteen years earlier, in 2003, Nigeria's Federal Ministry of Health (FMOH, 2003) reported that, over 54,000 women died tragically as a result of pregnancy and childbirth in Nigeria. Several institutional studies reported high maternal death in Nigeria (Melah, 2006; Hembra-Hilekaan, 2019, Samuels, 2020). Nothing has significantly changed as regard to maternal mortality since 2003 in Nigeria. Notwithstanding the efforts to reduce maternal deaths, maternal mortality continues to be a serious problem in Nigeria (NPC, 2019). While some countries working globally in tandem with the Millennium Development Goal (MDG) 5 (to reduce the global burden of maternal death by 75% by 2015), and the recent Sustainable Development Goal (SDG) 3, which seeks to significantly cut the number of deaths to 70 per 100,000 livebirths by 2030, reduced their maternal mortality levels, the Nigeria case has increased despite strategies like the campaign for institutional deliveries, training and deploying trained midwives to maternity centres. The 2017 WHO estimate reported 67000 maternal deaths for Nigeria (WHO, 2019). The FMOH 2003 report stated that adolescents and young women constituted about 84% of these deaths. Only one out of three women (34%) who delivered a year earlier got help from a skilled attendant and the most disadvantaged were again the young women of ages 14 – 19 (FMOH, 2003). The stagnated or rising maternal mortality ratio made WHO and African Union in

2004 to describe maternal and new-born deaths as silent emergency in Africa and has remained so with insignificant change for several decades (WHO, 2004). Whereas Nigeria constitutes about 2.6% of the world's population (Worldometre, 2020), it accounted for about 23% of world-wide maternal deaths in 2017 (WHO, 2019)]. Moreover, for each of these deaths, about 25 other women suffer long-term debilitating illness, the most humiliating being obstetric fistula (FMOH, 2019).

Foremost among the contributing factors to this tragedy is poverty, corruption and high level of indebtedness by all the three tiers of government in Nigeria (FMOH, 2003) making Nigeria to continue to rank very low globally in the human development index (UNDP, 2019). Nigeria's current total public debt stock of 27.4 trillion Naira (the states studied contributing 40.32 billion Naira to these debts) as at end of 2019 (DMO, 2020) limits the allocation of resources to health (Lawanson, 2013), (year 2016 estimate put national health expenditure at measly 3.6% (CIA, 2020)) creates a very weak health system that is unable to respond to the health needs of mothers and their new born babies. This frequently leads to very low access to effective obstetric care and other health services since many women and their families are not capable of coping with the cost of services provided by private commercial providers (Lawanson, 2013).

The link between poverty and maternal health has long been established and documented in several works including studies by Karshima, 2001 and Walls, 2004. These researchers have associated maternal mortality and vesico-vaginal fistula with poverty. What remains unclear is the community perception of the commonness of maternal deaths and factors associated with it.

The aim of this study therefore was to identify the knowledge and views of the community of the commonness of maternal deaths, the factors responsible for its occurrence and ways of ameliorating the problem in Northern Nigeria. There are no clear data to show the level of this knowledge and the voices of the community on maternal mortality in the study states.

2. Research Methodology

This study covered four states in northern Nigeria: Benue and Plateau states in the north central and Gombe and Taraba states in the north east. The instruments of the study were: (i) Focus group discussion and (ii) Semi-structured interviews. JUTH ethics committee approved the study.

2.1. The Focus Group Discussion (FGD)

Focus group discussions were held with eight groups, see Table 1. The items for discussion were open-ended questions that elicited discussion and not a 'yes' or 'no' type of response. The responses are as presented below.

S/No	Name of State	Urban/Number of Discussants	Rural/Number of Discussants	Total
1	Benue	Women group- 9 Discussants	Men group - 10 Discussants	19
2	Gombe	Women group-10 Discussants	Men group - 10 Discussants	20
3	Plateau	Men group - 8 Discussants	Women group- 9 Discussants	17
4	Taraba	Men group - 10 Discussants	Women group-10 Discussants	20
	Total	37 Discussants	39 Discussants	76

Table 1: Distribution of Focus Group Discussants from the Study States
Total = 38 Men Discussants and 38 Women Discussants = 76 Discussants

2.2. The Semi-Structured Interviews (SSI)

The semi-structured interviews were held with 50 respondents comprising 14 from Benue state, 11 from Plateau state, 11 from Taraba state and 14 from Gombe on the same topics discussed at the focus groups. An interview guide was developed containing same issues as raised in the FGD guide for Policy makers, Parliamentarians and Healthcare providers. The interview lasted about 45 minutes with each participant. The data from the SSI are presented alongside that of the FGD.

2.3. Method of Data Analysis

The data collected from the FGD and the SSI were translated and transcribed. Content analysis was made of the transcripts by sorting, classifying, and categorizing the data and presenting it in a narrative form and the report presented in analytical and descriptive form.

3. Challenges and Limitation of the Study

Generally, there is the problem of obtaining data from field work in Nigeria, particularly when it involves interviewing government officials. The officers are often hardly available for any interview and even when they are met and asked to participate in the interview, they make effort to elude it.

Some of the respondents in the SSI demanded for the set of questions ahead of the scheduled time for interview to enable them prepare the responses; when it was declined, they became undisposed. Given the high status and schedule of the respondents (with high official engagements) one understood the difficulty of getting appointment with researchers.

In one state government officials responded to the interview as if they were making a press statement despite assurance of confidentiality of their responses. All the same, their responses were recorded and analysed.

In another state under study, the officials of Economic and Financial Crimes Commission (EFCC) were visiting government officials or had just visited them as such they were avoiding visitors and interview with anybody. Yet, many appointments were secured, data collected and analysed and report here presented.

4. Findings from the Study

4.1. The Level of Maternal Deaths in the Study Area

The men and women FGDs reported cases of maternal deaths in their areas in the last six months. One discussant stated: *"One case of a mother in labour who needed blood and her husband went to look for blood donors and before he could come back the woman had died."* (FGD, Benue state).

The majority of the Semi-Structured Interview Respondents (SSIR) stated that they have heard of maternal deaths and two of them had lost their wives through child birth. Some few said they have not heard of such cases and some even said that such cases were on the decline. After a probing question, one of the uninformed respondents said it could occur due to poverty while another one said he was not a health worker as such he wasn't in a position to know and the other said he has heard of such cases only in workshops. For example, a respondent confessed thus: *"I have not heard of anyone who has died of either pregnancy or during child birth. But I believe that there is high mortality rate during childbirth gathering from views expressed during workshops and not that I have heard such cases personally."* (SSIR, Plateaus state). The respondent who said they have heard of a mother who died of pregnancy attributed such death to poverty, culture, and lack of access to health facilities, malnutrition, and ignorance: *"At times, it is because of some cultural beliefs they tend to wait for their husbands even when the husband had travelled and they die in the process."* (SSIR, Plateau state). While a Health Service Providers (HSPs) pointed out that, such deaths were usually attributed to witchcraft by the families as against their own findings.

The HSPs also reported that they have heard of and had women died during labour in their communities and their health facilities. One HSP reported that the incidence of maternal death was a weekly occurrence in the health facilities of the state. But one HSP from a faith-based health centre said that they do not have such cases because they do refer difficult cases to the Federal Medical Centre (FMC) without hesitation.

4.2. Factors Responsible for the Deaths of Women in Pregnancy and Childbirth

The HSPs were of the view that poverty was responsible for most of the maternal deaths. The poverty limits their ability to access maternal health services. According to them some women assumed that they can deliver on their own and therefore do not go to a health facility when in labour until when there are problems with the labour they then go to the clinic as un-booked emergencies. Because such cases are brought in late, they resulted into death.

The men and women discussants from Gombe identified cases of death amongst pregnant women and attributed it to the factors listed in the box below:

Box 1: Factors Responsible for Maternal Mortality in Gombe State as identified by FGD discussants.

- Poverty
- Ignorance
- Traditional taboo
- Malnutrition
- Lack of access roads
- Lukewarm attitude of health personnel
- None-utilization of ante-natal services

They attributed this lack of access to maternity care due to poverty or long distance from the nearest clinic. The HSPs however attributed this to early marriage, illiteracy/ignorance and poverty in the state. They also stated that there were cases of infant mortality caused by poverty, poor nutrition, illiteracy and ignorance.

While the women discussants from Taraba state attributed maternal deaths to:

Box 2. Causes of Maternal Mortality from Women FGD, Taraba State

- Poverty
- Poor transport facility in the community and the state as a whole
- Ignorance on what should be done during pregnancy
- Poor state of medical facilities

But the SSIRs attributed the frequent maternal deaths to inadequate health facilities in the rural areas, inadequate health personnel, and belief in supernatural practices, corruption, poverty and ignorance. HSPs stated that maternal deaths were usually caused by pregnancy induced hypertension, poverty and ignorance. They further alleged that utilization of modern health services depends entirely on the level of education of expectant mothers. Those that attended tertiary education often seek tertiary health service while the non-literate goes to traditional birth attendants or deliver at home and are only referred to tertiary health institution when in difficult labour.

4.3. Poverty and Maternal Mortality

Only very few of the SSIRs attributed the deaths of women during childbirth to poverty status of the victims, while the majority did. SSIRs from Benue State were of the view that the state is basically an agrarian society and women depend on their husbands for financial support. One of them emphasized: *"...And even where you find women who are able to engage in one thing or the other for profit making, the men will always claim such gains and even try to control whatever the women make."* (SSIRs, Benue state)

The respondents further stated that over 75% of the people in the state are poor. Women who are from poor families therefore find it difficult to take care of their pregnancies and attend ante-natal care services. SSIR from Gombe state also stated that there is poverty in the state and one respondent explained that in many families, a man is married to four wives and has 15 to 20 or even 30 children. One lamented thus, *"Some do take pap in the morning, danwake (bean cake) in the afternoon and cook food in the evening with local soup."* (SSIR, Gombe state) Another was of the view that poverty in the state has created street boys and girls called 'kalkare'. The SSIR said another challenge facing pregnant women is the long distance away from the FMC. According to them, Government provides for free maternal services but poverty and long distance make it difficult for pregnant women to access the free service available at the FMC. The SSIR also pointed out early marriage, illiteracy and ignorance as additional problems confronting women in their communities. Poverty causes some people to negate their responsibilities and emphasized thus, *"Culturally, a woman is not supposed to pay for her maternity care. Even if she has the money to pay, it is the responsibility of her husband to do that and that is the main point."* (SSIR, Gombe state)

The FGD said that subsistent farming is the common trade among most of the women in the state besides being full time housewives since there were no industries that could employ women. Lamenting on the state of poverty and limited opportunities for employment from private companies, a discussant said: *"Those working in the formal wage sector are all government employees and until government pays them salaries nothing goes. And many pregnant women are caught in this suffering because their husbands have not been paid or they themselves are workers but their salaries are not coming on time. This usually makes it difficult for them to take proper care of their pregnancy and other needs."* (FGD, Benue state) The FGD from Benue state were of the view that a poor person could be identified by his/her appearance and how his/her children looked. On women economic leverage, FGD from Gombe state explained that women depend on their husbands especially those who live in the purdah. Deprivation sometimes cause them to sell their bride gifts in order to cope with life. In contrast to the married and secluded they said that the working-class women and those unmarried are able to engage in economic activities of their choice and with more financial independence. According to the discussants it is the removal of subsidy on fertilizer, diversion of public funds by key government officials, laziness, and poor policy on loan scheme, poor implementation of poverty reduction schemes and high cost of social services (i.e. education and health) that are responsible for poverty.

4.4. Challenges Pregnant Women Face in the Study Area

In response to challenges faced by pregnant women in Plateau State, the men discussants were of the view that those women who are working under government establishments are not given enough maternity leave. They also lamented that there are some poor women that are subjected to hard conditions in order to survive. The women discussants also lamented the suffering of pregnant women who are poor. However, whereas the urban men discussants saw hard labour as creating more problems for such poor pregnant women; the women discussants saw it as the way out and blamed the poor pregnant women for not taking that option. A rural woman discussant ranted: *"Sometimes women become too lazy. This is very risky for any woman who is pregnant to remain without doing anything! In cases where the husband works and government did not pay salaries, the wife suffers the consequences."* (FGD, Rural Plateau state)

Talking about women owning their money, discussants concurred the idea that some women if they have their own money could pay for their treatment. However, a man discussant retorted thus, *"There was a woman who died of pregnancy and it was discovered that she had enough money round her waist that could have covered the maternity care. However, women who trust their husbands could pay for their hospital bills without waiting for their husbands; but those whom their husbands are irresponsible prefer to die with their money."* (FGD, men, Plateau state). HSPs also mentioned that the pregnant women in the state are challenged by poverty and ignorance that prevents them from accessing maternal health care services. On how to identify poor person they said that sometime a person may dress well when out of home but it is when visited at the house would one be able to know whether he/she is poor or not. One discussant said *"When you walk around this community, you will know whether there is poverty or not based on the environment, buildings, etc."* (FGD, men, Plateau state).

Box 3. Plateau Men FGD Discussants on Causes of Poverty attributed poverty to

- Laziness
- Drinking habits
- Large family size/Over population
- Lack of enterprise
- Rural-urban migration by youths
- Corruption by our leaders
- Lack of fertilizer/Lack of money to buy fertilizer

Box 4. Plateau SSI Respondents on Causes of Poverty. They attributed poverty to

- Corruption as the main problem
- Poor management of resources
- Lack of capital to start business
- Illiteracy and ignorance

Referring to fertilizer, some women discussants lamented that even where there is fertilizer, poverty won't allow someone to buy it as such they remain poor.

The women group discussants stated another effect of poverty on pregnant women. That the pregnant women are often confronted with the problem of balanced diet, anaemia, pregnancy complications, poverty, and hard labour. They emphasized that due to poverty some women find it difficult to pay for their ante-natal and delivery services. SSIR opined that poverty poses a serious challenge to pregnant women and they are not able to pay for ante-natal services. In very exceptional cases, particularly in urban areas women who work are able to earn their incomes and may not depend on their husbands for financial support. Due to financial dependence on men, women are not able to pay for their ante-natal services without being provided for by their husbands. Respondents were of the view that poverty is a very serious matter in the state such that many women are compelled to deliver at home or seek services of unqualified persons. However, a government HSP in response to the question on affordability of ante-natal services stated, *"The charges are usually affordable especially in this hospital where delivery is only one thousand Naira (N1, 000=) unlike elsewhere in this town where normal delivery is about four thousand Naira (N4, 000=)." But another HSP was of the view that 60% of pregnant women do not access ante-natal services and that they deliver at home due to poverty and lack of money to access health services.*

Generally, women depend on their husbands for financial support to do everything including accessing ante-natal services and one lamented thus, *"People are very poor; to be frank, majority of the people are too poor to look after their wives during pregnancy and delivery."* (HSP, Benue state) HSPs were of the view that the situation with poverty in the state is of great concern since the number of beggars are increasing and that beggars do occasionally besiege government offices begging for alms. They further said that poverty affects pregnant women in several ways. One provider stated, *"Poverty affects pregnant women in terms of nutrition, poor diet which also affects their health. Also because of poverty, most women cannot access medical care."* Another lamented, *"It complicates their situation, it affects them, it affects their feeding, their health, they have anaemia, the complications that will come later and the child may not even grow well."* (HSP, Plateau state). It was mentioned that wearing torn clothes, slippers, lack of quality food and inability to access health care services are common features of those who are poor. They cannot take proper care of themselves and cannot afford to pay hospital bills. They also stated that the challenges usually faced by pregnant women are: Inability to access maternal health care services due to poverty, lack of proximity to the health facilities, poor nutrition, and early marriage. One of them stated: *"As you know poverty is very excruciating in this state."* (HSP, Taraba state) HSPs too revealed that it is the poverty state of pregnant women that makes it difficult for them to access antenatal health services to the extent that when their deliveries become difficult, they are rushed to hospital as un-booked emergency. Responding to matters of women who can pay hospital bill on their own, one of them said: *"They (those who can afford to pay) are actually few. One can find few women who are civil servants, they come around to see doctor and they can afford to pay for everything, but before one can see any woman like that, one might have seen 20 women who were not able to afford to pay their hospital bills."* (HSP, Taraba state) This implies that only 5% of women in the state could afford to pay hospital bills on their own; the whooping 95% cannot afford to do so.

4.5. Perception of the State of Health Facilities and Safe Motherhood in Study Area

FGD participants decried the paucity of primary health clinics in the state. They said that sometimes one could travel up to twelve kilometres without finding a primary health clinic run by the government. Consequently, people travel long distances to have access to health facilities to treat themselves or their children. One lamented thus: *"There was a time when three children died on the same day at a hospital in Makurdi of diarrhoea. Their case could have been different if they were brought in on time."* (FGD, Benue state)

Despite the deplorable state of primary health care system in the state, women discussants agreed that they have found the health talks provided by these centres very useful. One of them said: *"Once you are pregnant and start going for ante-natal care, they teach you about personal hygiene, how to take care of yourself and pregnancy, the types of food to eat and many other things, and they do it very well. The only problem is that most of the things they teach us to do can only be achieved with money that I do not have"* (FGD, woman, Benue state)

The discussants also stated that women generally prefer to go to hospitals or clinic for their deliveries but money is the problem. They lamented the state of the health facilities in their localities and complained about lack of drugs and ambulance to convey patients to referral centres.

In the urban as well as in the rural areas, discussants complained about the nonchalant attitude of the health care staff. A man discussant decried thus: *"At times they even bring students from school of health who are on practical to take care of pregnant women; this is wrong."* (FGD, man, Plateau state)

Another group stated that primary health care services have improved greatly in the state but pointed out that the staffs of these institutions need to change their attitude to work. They revealed that private health institutions are better

equipped but their charges are higher and hardly afforded by the majority. Discussant further disclosed that in the rural areas many women still utilized the services of traditional birth attendants due to poverty and ignorance. One other men and women groups pointed out that there are no primary health care centres in their communities and even where clinics exist; there are no qualified personnel and drugs. Many of the SSIR respondents did not comment on the state of the primary health care services. Some that commented said that they existed only in terms of physical structures but poorly equipped and stocked with drugs.

But other respondent said that PHC services in Gombe state had improved and people are benefiting from it. However, another respondent disparaged the system where emphasis is being placed more on tertiary and secondary health care system against negligence of the PHC resulting in collapse of the PHC system in the state. Furthermore, one respondent retorted that the poor state of PHC services in the state has made women to prefer home delivery since they cannot reach the hospital easily. Many of the SSIRs were of the view that PHC had been helpful particularly to pregnant women and that drugs, equipment and staffing situation in government health institutions were satisfactory.

One HSP from Gombe state emphasized: *"...less than forty per cent of our pregnant women deliver in the hospitals. Reason is the health facilities in most of our rural areas are long distance away from the pregnant women. There is also the quality of health personnel who may not be qualified to attend to them. Most of these people are poor and find it difficult to pay for the good health services."*

HSPs from Gombe state also pointed out that the primary health care system is in a poor shape in the state because the local government councils have not been funding the health facilities. They also decried the poor status of infrastructure such as water and electricity and said they are factors affecting the provision of health services in the state. Additionally, primary health care centres lacked adequate funding, qualified personnel and functional equipment, consequently, the services are completely under-utilized thereby putting pressure on secondary and tertiary health care services. Subsequently, primary health care clinics are not able to fulfil their objectives. HSPs pointed out that the problem with health services is funding, lack of drug supply and utilities (water and electricity). One service provider cried out, *"Last year, we spent close to N3.5million on diesel which we would have used to improve the salaries of staff or ploughed back to raise fund or to buy equipment. For staff, there are qualified staffs, but the number can be increased for more efficiency."* (Faith-based HSP, Plateau state) Another issue raised by the respondents was the absence of subvention from government to faith-based and private sector health services so as to reduce cost of services. One faith-based health facility cited example of equipment and other assistance received from another faith-based hospital and other NGOs. On the other hand, HSPs in government facilities complained that running cost is hardly available or inadequately provided.

5. Suggestions from the Communities

Discussants suggested that since most of the women in their communities were farmers, they could be assisted with fertilizers to facilitate their farm work. They also suggested that soft loans can be given to women to farm or get involved in trading. A discussant explained that she was aware of a community where women were being taught how to make soap and body lotions for sale. She was of the view that such activity would help women to earn some money. SSIRs suggested that more women should be given access to formal education and employment, soft loans to women for farming or petty-trading and also supporting women into leadership positions as councilors in every local government councils. As regard infrastructure one (HSP, Benue state) bemoaned thus: *"Currently we have no light, there is no electricity in this hospital so the nurses and doctors work in darkness at night; we use lanterns at night and this is one of the reasons why majority of the pregnant women are reluctant to come and deliver here. So, if someone would help us with electricity, we shall be very grateful. The cables for electricity supply have already been laid."*

Another service provider also stressed that government should provide the infrastructure so that men and women can benefit from. He mentioned roads and markets to facilitate trading, fertilizer to facilitate farming, health facilities in the rural areas to bring services nearer to the people and encourage health service providers to work in the rural areas. They also suggested that there should be free medical services for pregnant women and children. The men and women discussion groups presented common suggestions as shown in the box below:

Box 5. Suggestions by Men and Women FGD Discussants from Gombe State

- Remove all discriminatory policies against women especially in relation to loan schemes
- Free interest loan to women
- Establishment of girl-child education centres in all the local government areas
- Free medical care for women and children in all government health institutions
- Free education for all children from primary to secondary schools
- Empowering women economically through skill acquisition centres

The discussants identified economic and educational empowerment as primary to accessing health services. SSIRs suggested that government should provide for educational and economic empowerment of women and also offer them employment in government service.

Service providers made the suggestions as shown in the box below:

Box 6. Suggestions by Health Service Providers from Gombe State

- Government should provide free education at all levels
- Women should be trained in various trades
- Women should be granted soft loans to engage in businesses
- Government should provide free ANC services with free drugs
- There should be a percentage allocation of jobs to women
- Female farmers should be assisted with fertilizer
- Early marriages should be discouraged

HSPs emphasized the role government needs to play in ensuring that the economic and educational positions of women are improved. The suggestions included the provision of fertilizers at affordable prices to farmers, payment of salaries to workers as and when due, the existing health facilities should be provided with functional equipment, drugs and trained staff. HSPs made the following suggestions: Fertilizers should be provided to farmers at affordable prices, there should be free medical services for all pregnant women and children, there should be credit facilities for the people to set up medium and small-scale industries, and demand creation public health enlightenment.

The SSI Respondents from Plateau state presented the following suggestions:

Box 7. Suggestions from SSI Respondents from Plateau State

- Micro credit schemes for women should be improved
- Government should stabilize the economy by minimizing inflation
- More PHC should be built in the rural areas
- Special allowances should be paid to rural health workers
- There should be sensitization workshops to educate the public
- Our public officers should stop corrupt practices

The SSI Respondents from Taraba state presented the following suggestions:

Box 8. Suggestions from Taraba State

- Make fertilizer readily available
- Women should be empowered through loans
- Girl-child education should be given attention
- Provide well equipped clinics
- Free medical care for pregnant women and children
- Free education for all children.

SSIR respondents from Taraba state also suggested that agriculture should be given priority attention; hospitals should be properly equipped.

Service providers were of the view that more health facilities should be established in the states so as to reduce the distance travelled by women to and from health facilities. One HSP from Taraba state suggested: *"It is not just the income of women that should be improved but the income of all the people in this state. The more economically empowered people we have, the better the health status of this state."*

HSPs were of the view that government has a larger responsibility in reducing poverty and ignorance in the state. They therefore opined that formal education is fundamental and it should be provided to men and women. They also suggested that cottage industries should be established in the state to help people with employment.

6. Discussion of the Findings

Maternal deaths are common and highly associated with poverty. The community said making fertilizer and other farm inputs readily available and empowering women will reduce poverty and improve safe motherhood.

The information obtained from the community was very revealing. The men and women reported that maternal deaths were common occurrences in their areas. The majority of the SSIRs stated that they have heard of maternal death and two of them had lost their wives through child birth. One HSP reported that the incidence of maternal death was a weekly occurrence in the health facilities of the state.

WHO asserts their experiences and stated that maternal mortality is unacceptably high (WHO, 2019). WHO estimates that nearly 810 women died daily from preventable pregnancy-related causes in 2017 globally (that is about 295000 deaths in the year) and Nigeria contributed 67000 maternal deaths of the global estimate in the same year (WHO, 2019). Several institutional studies have also reported high maternal mortality from the states studied (Melah, 2006; Hemba-Hilekaan, 2019, Samuels, 2020).

Fourteen years earlier, in 2003, Nigeria FMOH reported that, over 54,000 women died tragically as a result of pregnancy and childbirth in Nigeria (FMOH, 2003). This means that the maternal death burden in Nigeria over the seventeen years was on the increase. If in 2003, the figure was 54,000 and in 2017, it increased to 67,000, it should be

worrisome to the government, service providers and the general public. This made the NDHS to state that maternal mortality continues to be a serious problem in Nigeria (NPC, 2019).

Nigeria with estimated population of about 190 million in the year 2017 (UNDP, 2019) (about 2.5% of the world population), but contributed 23% of global maternal deaths burden, far ahead of India that made the second highest global contributor of maternal deaths (WHO, 2019). The high maternal deaths in Nigeria notwithstanding, the deaths are skewed against the northern zones of the country where this study was conducted (NPC, 2019, Meh, 2019). NPC, 2019 and Meh 2019 (analysed 2008 & 2013 NDHS) reported a wide disparity in MMR of 709/105 and 365/105 between Northern and Southern Nigeria. These agree with Kaka 2013, who said that pregnancy poses a serious challenge to a woman residing in Northern Nigeria.

This study also showed that the community is aware of why the pregnant women die and why they do not get the desired care in pregnancy when needed. They know that the pregnant women die from haemorrhage during labour (FGD, Benue state), from frequent delivery because of poor child survival of the children born (Saifuddin, 2012 and NBS, 2018) and hard access to health facilities because of many indirect obstacles to maternal health care (WHO, 2019 and Kaka, 2013). The major complications that account for nearly 75% of all maternal deaths globally are well known and include: haemorrhage (mostly bleeding after childbirth), infections (usually after childbirth), high blood pressure during pregnancy (pre-eclampsia and eclampsia), and difficult labour and unsafe abortion (WHO, 2019).

The direct causes of maternal death in the communities studied are not different. However the communities also identified other factors responsible for the deaths of women in pregnancy and childbirth among them and include Poverty, ignorance on what should be done during pregnancy/None-utilization of ante-natal services, traditional taboo, malnutrition, lack of access roads /poor transport facility in the community and the state as a whole and lukewarm attitude of health personnel and poor state of medical facilities. Very true to their avowal, these elements are also well-known determinants of maternal mortality (WHO, 2019, NPC, 2019 and Meh, 2019) among many other studies.

Poverty, ignorance and spousal dependence were mentioned severally by respondents as issues that dare pregnant women towards safe motherhood. Discussants were of the view that poverty was a very serious matter in the state such that many women were compelled to deliver at home or seek services of unqualified persons like traditional birth attendants or quacks. Poverty also affects the pregnant women's nutrition, poor diet which also affects their health, affects their feeding, they have anaemia, and the complications that will come later and the child may not even grow well (HSP, Plateau state).

A discussant lamented that sometimes the poverty is so daunting that delivery bill of as low as N1000.00 (\$3.00) in public health facilities was not affordable (FGD, Taraba state). Subsistent farming is the common trade among most of the women in the state. The farm produce is sold soon after harvest to meet immediate needs and nothing reserved for emergencies.

The people lamented that because of poverty, some women are subjected to hard conditions in order to survive. Whereas the urban men discussants saw hard labour as creating more problems for such poor pregnant women; the women discussants saw it as the way out and blamed the poor pregnant women for not taking that option (FGD, Plateau state).

The growing poverty, especially among women (Ebeniro, 2012) greatly adds to the obstacles limiting women's access to highly needed reproductive health services with resultant delay (Thaddeus and Maine, 1994). This often leads to very low access to effective obstetric care and other health services since many women and their families are not capable of coping with the cost of services provided by private commercial providers. The link between poverty and maternal health has long been established and documented in several works (Karshima, 2001, Wall, 2006 and Meh, 2019). These researchers have associated maternal mortality and vesico-vaginal fistula with both individual and community poverty. The community poverty index in the north is appalling. All the 19 states in Northern Nigeria except 3 (Benue, Kogi and Kwara states) are below the national poverty line (NBS, 2020) with some states like Taraba state with poverty gap index (PGI) of 42.38% (the national PGI is 12.0% while that of Lagos state is 0.7%) (NBS, 2020). This clearly explains WHO declaration of maternal mortality as a silent emergency in Nigeria (WHO, 2004), especially in the Northern States of the country. A study on health care financing at Ibadan (Lawanson, 2013) found that health care financing in the north is relatively lower and accompanied by significant poor health indices, with heavy dependence on the households in the regions. The Ibadan report clearly raises equity concerns that has been severally neglected where those least able to pay were made to bear more burden of accessing health care.

According to the community, Government provides for free maternal services but often at cost and suboptimal levels. Still, poverty and long distance make it difficult for pregnant women to access the free services available at public health facilities. Assenting the community's view, researchers reporting on the findings of a nationwide study of near misses in 42 tertiary health institution captured the challenge of distance, delay and suboptimal health system thus: *"Lack of antenatal care and place of residence further than 5 km from the hospital were associated with maternal death. Severe maternal outcomes from hypertensive disorders of pregnancy (HDP) were due to late presentations and health system challenges. To reduce maternal deaths from HDP, health system strengthening that would engender early hospital presentation and prompt treatment is recommended."* (Adamu et al 2018, pp 12). The community is also made to pay disproportionately higher than their meagre earnings to access health (Lawanson, 2013) further impoverishing them with grave consequences.

Poverty, ignorance, hard to access a suboptimal health system compounded by the subjugated women status especially in northern zones of the country precipitates the three delay concept of maternal mortality (Thaddeus and Maine, 1994) in "Too Far to Walk" contextual framework of maternal death in West Africa. This study also showed that

formal education especially among women increases utilization of modern health services. That utilization of health services among women depended also on the level of education of the mothers. The educated women would often seek for tertiary health care while the non-literate go to traditional birth attendants or deliver at home and are only referred to health institution when in difficult labour. Since 1985 Harrison KA working in Zaria, north western Nigeria, found that formal education of at least twelve years salvages the woman from the vulnerability of maternal death (Harrison, 1985). NDHS 2018 and Mey et al 2019 had the same finding about maternal mortality and health services utilization especially in the northern part of Nigeria.

Another social determinant of adverse pregnancy outcome in northern Nigeria is spousal dependence. Poverty and spousal dependence are mutually reinforcing. Poverty drives spousal dependency such that women depend on their husbands for financial sustenance to do everything including accessing maternal health services (UNDP, 2019, Lawanson, 2013, Kaka, 2013 and Ebinero 2012). The dependency is such that when the husband does not have, the woman is totally incapacitated including accessing maternity care. Sometime poverty is made to look like cultural practice or fatalistic view (Wall, 2004) as stated by a discussant (FGD, Plateau state) as against the findings of service providers.

But the study also found that not all women cherish dependency as shown by some authors (NPC, 2019, Harrison, 1985). However, these are few exceptions found most of the times in urban areas where working class women who work are able to earn their incomes and may not depend on their husbands for financial support giving support to the many-fold gain of girl child education. A service provider in response to women who can pay hospital bill on their own bemoaned that they are few. The whopping majority of the women cannot afford to do so.

The study also showed that the community is aware of the things that caused them to be poor and identified causes of poverty among them to include illiteracy, ignorance, laziness, drinking habits, early marriage, large family size, and lack of enterprises, lack of fertilizer/lack of money to buy fertilizer and lack of capital to start business, illiteracy and ignorance. Some women discussants lamented that even where there is fertilizer, poverty won't allow someone to buy it as such they remain poor.

Other issues mentioned that attribute to frequent maternal deaths include inadequate health facilities in the rural areas, inadequate health personnel. Some of the women face the challenge of long distance from the nearest clinic as alluded earlier. They said that sometimes one could travel up to twelve kilometres without finding a primary health clinic run by the government. The health services are suboptimal. Some others said sometimes the health centres existed only in terms of physical structures but poorly equipped and stocked with drugs. Consequently, people travel long distances to have access to functional health facilities to treat themselves or their children. They revealed that the private health facilities in the localities were better equipped but their charges were higher and hardly affordable by the majority and so many women resort to the services of traditional birth attendants and quacks at the expense of their health and lives. The harsh effect of long distance and suboptimal health care system in Northern Nigeria was alluded earlier in the work of Adamu et al, 2018.

HSPs pointed out that the primary health care system was in a poor shape because the Local Government Councils have not been funding it. They pointed out that the problem with health services was funding, lack of drug supply and utilities (water and electricity). One faith-based HSP cried out for subvention from government to reduce cost of services (SSI Respondent, Plateau state). They decried the situation where pregnant women that do not have money to pay are not attended to until the payment is affected. They also stated that there were cases of infant mortality caused by poverty, poor nutrition, illiteracy and ignorance (NPC, 2019, Harrison 1985). Prof Ali Mazrui, 1980 agreed with them not less in a television documentary Triple Heritage: *"Only when the African parents begin to bury fewer children will they learn to bear fewer babies"* This explains the high fertility rate and low contraceptive prevalence in the North (Saifuddin, 2012, NPC, 2019 and Meh, 2019). If the children born do not survive from malnutrition, diarrhoea and other common diseases, the push for high fertility becomes severe with the attendant risk. All the service providers complained about water and electricity supply; they said that the situation was poor and needs attention.

7. Conclusion and Policy recommendations

Based on findings from this study whereby the community said poverty is the foremost determinant of reproductive jeopardy among them and their request that making farm input readily available and empowering women will help reduce poverty and improve safe motherhood: we make the following recommendations: We advocate the social security/protection approach to safe motherhood as an additional approach in line with the women's request.

Government should purposefully strengthen and strategize the on-going Anchor Borrowers Programme to reach more farmers, especially women who are most hit by the social deprivation. Government needs to operationalize the universal health coverage so that all pregnant women and children will have free access to health care services. A system that can reduce cost or take away out of pocket expenses on the family/individuals especially when accessing maternal health care should be put in place in Nigeria, particularly the northern part of the country. This approach can expand the scope of maternal health services through effective public-private partnership and also reduce the distance pregnant women make to health facilities in their communities. In addition to the above, rural health jobs should be made more attractive to health workers so as to attract and retain qualified health staff in the communities where the impoverished women and their families live.

Government needs to address the problem of infrastructure particularly water and electricity. Because the poor state or absence of infrastructure means alternatives would have to be provided at extra cost to health service beneficiaries particularly pregnant women and this makes it unaffordable and inaccessible to them.

Girl-child education and functional adult education of women can increase their employment opportunities and reduce spousal reliance. Education will also help the women comprehend the public and clinic health education messages to the advantage of safe motherhood (Meh, 2019).

The Child's Rights Act should be domesticated and implemented in these states to resolve the problem of early marriage, lack of access to education and health care services to children. Gender sensitization programmes and demand creation media campaign should be mounted in all the local government areas of northern Nigeria so as to reduce gender inequality and empower more women.

The current survey and reporting on national definition of the Poor person or family to be sustained in order to tract trends in the achievement of the poverty reduction and social security and protection effort. Governments and non-governmental organizations need to work hard collaboratively to reduce maternal death by improving incomes of the people, particularly that of women through subsidy to agricultural inputs.

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