

THE IMPACT OF POVERTY ON MATERNAL MORBIDITY IN SHANGA LOCAL GOVERNMENT AREA OF KEBBI STATE

¹Muhammad Garba Yauri
&

Auwalu Sale Yakasai Ph.D²

Department of Sociology
Al-Qalam University, Katsina

Corresponding Author: muhammadgarbayauri@auk.edu.ng

Abstract

This paper explored the impact of poverty on maternal morbidity, characterized by limited access to essential resources such as healthcare; sustained nutrition and education, which significantly exacerbate maternal morbidity in Shanga Local Government Area of Kebbi State. In most of the lower income communities in developing countries, women often face barriers to accessing quality prenatal care, leading to delayed or inadequate medical attention during pregnancy. It is against this background that the paper examined the incidence of maternal morbidity in Shanga LGA. The Relative deprivation theory was adopted as the paper's theoretical framework. Questionnaire and key informant interview were utilized as the primary instruments of data collection. Purposive sampling technique was used to select only women aged between 15 and 59 years who were included in the study. Data collected from the questionnaire were analysed descriptively using tables and percentages while data from KII were analysed descriptively. Findings from the study indicated that the prevalence of maternal morbidity was high in Shanga Local Government Area of Kebbi State. The study also discovered that due to poverty, most women do not have transport to go to the hospital for antenatal care as well as lack money to buy nutritious food and drugs in Shanga Local Government. The study recommends that Government should bring antenatal clinics closer to the communities and also empower women with loans and skill acquisition programmes to enable them cater for their needs, especially during pregnancy.

Keywords: Empowerment, Maternal Morbidity, Maternal Health, Pregnancy,

Introduction

The problem of high rates of maternal morbidity has proved difficult to tackle in many developing countries. Maternal mortality refers to deaths due to complications from pregnancy or childbirth (United Nations Children Fund [UNICEF], 2023). According to the World Health Organization (2023), maternal mortality is unacceptable. In 2020, over 287 000 women died while pregnant or after giving delivery. In 2020, low and lower middle-income countries accounted for about 95% of all maternal fatalities, with the majority of them preventable (WHO, 2023). Maternal mortality is disproportionately concentrated in the world's poorest regions and conflict-affected countries. In 2020, Sub-Saharan Africa accounted for almost 70% of all maternal fatalities (WHO, 2023). According to Galal (2024), the maternal death rate in South Sudan, Chad, and Nigeria exceeded 1,000 in 2020. South Sudan had the greatest rate of maternal fatalities per 100,000 live births. That year, for every 100,000 children, 1,223 mothers died from any cause connected to or aggravated by pregnancy or its management. The maternal death rate in Chad was 1,063. Nigeria had 1,047 fatalities per 100,000 live births.

In Nigeria, the northern areas (North West, north east and to some extent, north central) have the highest maternal death rates in several states (Gulumbe *et al.*, 2018). For example, Kebbi State in Nigeria's northwestern region has one of the lowest reproductive health indices (Gulumbe *et al.*, 2018). More than two-thirds (71%) of pregnant women in the state received no antenatal care, 91% gave birth at home, and less than 10% had competent delivery attendance during their most recent birth, among other factors (National Population Commission, cited by Gulumbe *et al.*, 2018).

According to the World Health Organization (2023), the major complications that cause nearly 75% of all maternal deaths are severe bleeding (mostly bleeding after childbirth), infections (usually after childbirth), high blood pressure during pregnancy (pre-eclampsia and eclampsia), delivery complications, and unsafe abortion. However, beyond these medical causes, poverty remains the key driver of maternal morbidity in low income countries such as Nigeria. According to the World Poverty Clock (2023), 71 million Nigerians are extremely poor. Within Nigeria, data showed further that 65% of the poor (86 million people) live in the North, while 35% (nearly 47 million) live in the South. Kebbi State is the 7th poorest state in Nigeria with 82.2 % (NBS, 2022). Women constitute over 60% of the poorest people in Nigeria and going by the IMF statistics that Nigeria has over 87 million people in extreme poverty that translates to approximately 52 million women on the clutches of extreme poverty (Ifeanyi *et al.*, 2019).

Several studies have shown that there is a correlation between poverty and maternal mortality. For example Esperat *et al* (2007) asserted that one frequently stated explanation for the rich-poor difference in pregnancy outcomes is that poorer women receive less prenatal care. Nagahawatte and Goldenberg (2011) also stated that poor women have fewer connections to the obstetric care system than wealthy women, and access to a health care practitioner in the event of an obstetric emergency can be critical. Poor women may face barriers to receiving prenatal care, including inability to pay for otherwise available services, failure to seek services due to prior negative experiences (receiving culturally inappropriate and unsatisfying services, reproach and sanctions for poor health habits), lack of transportation, and depression (Milligan *et al.*, 2002).

It is obvious from the above discourse that there is a correlation between poverty and maternal morbidity. It is therefore worrisome looking at the fact that Kebbi State is the 7th poorest state in Nigeria (National Bureau of Statistics, 2022). It is against this background that this study examines the effect of poverty on maternal morbidity in Shanga Local Government Area of Kebbi State.

Aim and Objectives of the Study

The research examined the impact of poverty on maternal morbidity with regards to sociocultural practices on maternal morbidity in Shanga Local Government Area of Kebbi State. The specific objectives were to:

- (a) Examine the prevalence of maternal morbidity in Shanga Local Government Area of Kebbi State.
- (b) Assess the effect of poverty on maternal morbidity in Shanga Local Government Area of Kebbi State.
- (c) Suggest possible solutions to the problem of maternal morbidity in Shanga Local Government Area of Kebbi State.

Conceptual Clarification

Maternal Death

A maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy... from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. The major complications that account for 75% of maternal deaths are severe bleeding, infection, unsafe abortion, high blood pressure, and prolonged or obstructed labour. Most maternal deaths can be prevented through effective interventions and care during pregnancy and delivery. Often seen as a public health concern, the issue of maternal mortality and morbidity must also be understood as a matter of human rights. International human rights treaty bodies have clarified States' obligations concerning maternal mortality and morbidity and recognized that maternal deaths can amount to violations of women's rights to life, to the highest attainable standard of health, and to equality and non-discrimination (World Health Organization 2018). Maternal death as used in this study refers to the death of a woman while pregnant or within 42 days of the termination of pregnancy, irrespective of the duration and site of the pregnancy, from the cause related to or aggravated by the pregnancy or its management.

Maternal Morbidity

Chakhtoura (2019), conceptualized maternal morbidity as an unexpected short-or long-term health problem that results from being pregnant or giving birth. Some common conditions that predispose women to maternal morbidity are cardiovascular disease, infection, bleeding, high blood pressure, blood clots. These problems require additional medical care, such as hospitalization and long-term rehabilitation, and can affect a woman's quality of life. For Vema (2013), maternal morbidity includes near-miss case, meaning women almost die from pregnancy or giving birth but survive. Some women who have near-misses are left with serious lifelong health problems and disabilities. Near-miss cases are sometimes counted separately from general maternal morbidity.

Poverty

The definition of poverty varies depending on the social, cultural and political systems in a particular region (Narayan, *et al*, 2000). Poverty is a multidimensional social phenomenon. In its 2000/2001 World Development Report, World Bank (2001) established that poverty is multidimensional and has important noneconomic dimensions; second, that poverty is always specific to a location and a social group, and awareness of these specifics is essential to the design of policies and programs intended to attack poverty; and third, that despite differences in the way poverty is experienced by different groups and in different places, there are striking similarities in the experience of poverty in very different countries, from Russia to Brazil, Nigeria to Indonesia.

Poor people's lives are marked by powerlessness and voicelessness, which limit their options and shape the quality of their relationships with employers, markets, the government, and even nongovernmental organizations (NGOs). Institutions, both formal and informal, mediate and restrict impoverished people's access to opportunities.

The World Bank/CBN (1996) described poverty in Nigeria as “wide spread and severe” despite numerous attempts to tackle the problem. The National Bureau of Statistics (2022) Multidimensional Poverty Index survey revealed that 63% of persons living within Nigeria (133 million people) are multidimensionally poor. The data showed further that 65% of the poor (86 million people) live in the North, while 35% (nearly 47 million) live in the South. Kebbi State is the 7th poorest state in Nigeria with 82.2 % (NBS, 2022). Women constitute over 60% of the poorest people in Nigeria and going by the IMF statistics that Nigeria has over 87 million people in extreme poverty translates to approximately 52 million women on the clutches of extreme poverty (Ifeanyi *et al*, 2019). Poverty is a major cause of maternal death, as it hinders many women from receiving proper and enough medical attention because they cannot afford good antenatal care (Lanre-Abba, 2008). Therefore, Poverty as seen from the lenses of this study refers to the inability of women to access maternal health services.

Antenatal care: This is a basic component of maternal care on which the life of mothers and babies depend however, poverty negatively affects the utilization of health services. According to the Nigeria Demographic and Health Survey ([NDHS]2003), 30% of Nigerian women cited the problem of getting money for treatment, while 24% cited the problems of accessibility to health facilities and transportation. Due to poverty, more than seven in ten women who delivered outside a health facility received no postnatal care at all (NDHS, 2003).

Literature Review

This section of the paper examines relevant literature regarding the effect of poverty on maternal morbidity.

The State of Maternal Morbidity in Nigeria

Maternal mortality refers to deaths caused by problems during pregnancy or childbirth. In 2020, about 800 women died per day from preventable pregnancy and delivery complications. In 2020, a maternal fatality occurred nearly every two minutes (WHO, 2023). Between 2000 and 2020, the maternal mortality ratio (MMR, number of maternal deaths per 100,000 live births) declined by roughly 34% globally (WHO, 2023) in 2020, low and lower middle-income countries accounted for about 95% of all maternal fatalities (WHO, 2023). According to the UN interagency estimates, the worldwide maternal mortality ratio (MMR) fell by 34% between 2000 and 2020, from 339 to 223 deaths per 100,000 live births (World Health Organization, UNICEF, United Nations Population Fund and The World Bank, 2023). This amounts to an average annual rate of decline of 2.1%. Though there was tremendous progress in reducing worldwide MMR between 2000 and 2015, the numbers have remained stable when average reduction rates between 2016 and 2022 (UNICEF, 2023). The rate of decline in most regions halted, but MMR grew in Western Europe and North America, as well as Latin America and the Caribbean, between 2016 and 2022.

The MMR in low-income countries in 2020 was 430 per 100,000 live births, compared to 12 per 100,000 in high-income countries (WHO, 2023). Sub-Saharan Africa and Southern Asia were responsible for approximately 87% (253 000) of the predicted global maternal fatalities in 2020 (WHO, 2023). In nine countries experiencing severe humanitarian crises, maternal mortality

rates were more than double the worldwide norm (551 maternal deaths per 100,000 live births versus 223 overall) (World Health Organization, 2023)

According to the WHO (2023), the maternal mortality rate in the African Region in 2020 was predicted to be 531 deaths per 100,000 live births. South Sudan has the highest maternal mortality rate, with 1223 fatalities, followed by Chad with 1063 deaths and Nigeria with 1047 deaths per 100,000 live births. Sub-Saharan Africa alone accounted for around 70% of maternal mortality (202 000), with Southern Asia accounting for approximately 16% (47 000) (WHO, 2023). The World Bank (2020), noted that Nigeria's maternal mortality ratio has improved from 1,148 in 2000 to 1,047 in 2020. Maternal mortality in Nigeria is greater than the regional norm. The maternal mortality ratio is the number of women who die from pregnancy-related causes while pregnant or within 42 days after pregnancy termination per 100,000 live births.

In Nigeria, the northern regions (north east and north west) have the highest MMR, with estimated maternal mortality of more than 1000/100,000 live births in various states (Gulumbe, *et al*, 2018). For example, Kebbi State, in Nigeria's northwestern region, has one of the poorest reproductive health indices (Gulumbe *et al.*, 2018). More than two-thirds (71%) of pregnant women in the state never had antenatal care; 91% of women gave birth at home; and less than 10% had competent birth attendance during their most recent birth, among other things (National Population Commission quoted by Gulumbe *et al.*, 2018). In recognition of these appalling statistics, the Nigeria Minister of Health recently established the "Task Force on Accelerated Reduction of Maternal Mortality in Nigeria" and stated that six northern states, including Kebbi, had the highest burden in Nigeria (Adewole cited in Gulumbe *et al.*, 2018). Prior to this, the State Government of Kebbi and Adamawa in 2013 acquired a grant of 30 million Euros (six billion naira) from the European Union Commission to help lower MMR in the two states (Abdul' Aziz referenced in Gulumbe *et al.*, 2018). Despite these efforts, attaining a significant drop in MMR in Kebbi State remains challenging.

Effects of Poverty on Maternal Morbidity

Graham, Fitzmaurice, Bell, and Cairns (2004) investigated the relationship between poverty and maternal mortality. According to them, there is evidence of significant differences in access to and adoption of maternity services across a wide range of poor nations, and a tool has recently been devised to reveal similar disparities in the risk of maternal mortality. These risks, they explain, are the result of disparities in underlying health status, different lifetime exposure to pregnancy, unequal physical, economic, and social access to preventive services for normal pregnancy and delivery, and significant disparities in the use of quality emergency obstetric care (Graham *et al.*, 2004). Poverty exacerbates every other risk factor for maternal death and morbidity, from hideous female subjugation to maternal malnutrition and poor medical and physical infrastructure (Harrison, 1998). The link between poverty and maternal mortality highlights the need to address this reproductive health issue (Lanre-Abba, 2008).

Socioeconomic status is a risk factor for maternal mortality (Jeong *et al.* 2020). Some low-income countries (LICs) have more than 100 times the maternal mortality rate of high-income countries (HICs) due to pre-eclampsia/eclampsia (Goldenberg *et al.*, 2011), anesthesia-related problems, obstetric complications, or difficulties with caesarean sections (C-sections) (Sobhy *et al.*, 2016). Furthermore, residential regions, such as rural areas, affect bad maternal health outcomes because of disparities in maternal health care utilization, such as prenatal care at a health facility or facility-based delivery (Long, 2010). Maternal mortality in HICs has been significantly reduced in recent decades, but it remains at approximately 10 per 100,000 newborns (Goldenberg, 2011). Numerous research such as Goldenberg (2011) have investigated the risk factors for

maternal mortality in LICs, but few have looked at the relationship between socioeconomic position and maternal mortality in HICs.

Financial obstacles have had a negative impact on health-care delivery, including limiting access for vulnerable groups such as poor women (Orude, 2021). User fees were implemented in Nigeria's health-care system in the 1980s, during the country's Structural Adjustment Programme (Orude, 2021). However, the harmful impact of user fees on access to healthcare services in underdeveloped countries is widely known (Reproductive Rights and Women Advocates Research and Documentation Centre, 2008: 130). User fees pose health concerns and cause many fatalities in poor populations, because they limit people's financial ability to obtain health-care services, as the majority of the world's 1.5 billion poor are women (Reproductive Rights and Women Advocates Research and Documentation Centre, 2008).

In underdeveloped nations like Nigeria, women face limited access to quality health care, which has worsened with the implementation of user fees (Cohen, 1994; Alubo, 1999). In Nigeria, status, power, and privilege influence the quality of medical care (Alubo, 1999). Poverty hinders women's access to quality antenatal care, leading to higher maternal death rates (Lanre-Abass, 2008). In rural Africa, women have a one-in-eight risk of dying during childbirth due to high fecundity, complex pregnancies, and limited healthcare access. (Alubo 1999; Mathews 2002). In Nigeria, many women are born into a cycle of deprivation, including lack of education and limited access to medical care (Harrison, 1985). Sub-Saharan Africa has one of the highest maternal mortality rates globally due to inadequate health infrastructure (Giddens, 2006). The high frequency of maternal mortality in various parts of the world indicates disparities in access to excellent health care and emphasizes the wealth disparity (WHO, 2023).

Theoretical framework

This paper adopted the Relative Deprivation theory. The Relative Deprivation theory is associated with Samuel Stouffer (1966). The theory is defined as the lack of resources to sustain the diet, lifestyle, activities and amenities that an individual or group are accustomed to or that are widely encouraged or approved in the society to which they belong. Measuring relative deprivation allows for an objective comparison between the situation of the individual or group compared to the rest of society. Deprivation may also emphasise the individual experience of discontent when being deprived of something to which one believes oneself to be entitled, however emphasizing the prospective of the individual makes objective measurement problematic, (Iain Walker, 2001). It is a term used in the social sciences to describe feelings or measures of economic, political, or social deprivation that are relative rather than absolute. The term is inextricably linked to similar terms like poverty and social exclusion.

The concept of deprivation theory of poverty has important consequences for both behaviour and attitudes, including feelings of stress, political attitudes, and participation in collective action. The deprivation theory of poverty posits that individuals and families in poverty experience a lack of essential resources, leading to adverse consequences. In the context of maternal morbidity, poverty can exacerbate health disparities and contribute to heightened risks during pregnancy and childbirth. Limited access to quality healthcare, inadequate nutrition, and stressful living conditions can amplify the impact of poverty on maternal well-being. Insufficient financial resources may deter pregnant individuals from seeking a timely prenatal care which may lead to die during the delivery. Nevertheless, increase the likelihood of complications.

In impoverished settings, the absence of proper nutrition and healthcare infrastructure can contribute to higher rates of maternal morbidity, including complications such as anaemia, hypertension, and infections. The stress associated with economic hardship may also negatively affect maternal health. Chronic stress can contribute to adverse outcomes during pregnancy and hinder overall maternal well-being. Moreover, the lack of access to education and information in impoverished communities may result in a lack of awareness about proper maternal care practices. In summary, the deprivation theory of poverty underscores how the scarcity of resources in impoverished conditions can significantly impact maternal morbidity. Addressing poverty through comprehensive strategies, including improved healthcare access, education, and economic support is crucial to mitigating the adverse effects on maternal health.

Methodology

Shanga Local Government area was created from the present of Yauri Local Government Area of Kebbi State on 20th of December 1996, with its headquarters situated at Shanga by military administration during regime of President Sani Abacha, commander in-chief of the Armed Forces of the Federal Republic of Nigeria. The Local Government consists of four (4) Districts i.e. Shanga, Kwanji, Sawashi and Rafin Kirya districts being administered by an appointed district head of 39 village units. The population of the area is characterized by peasant farmers and petty traders.

Survey research design was used to collect the opinion of women on the relationship between poverty and maternal morbidity. Questionnaire and key informant interview were used as the primary instrument of data collection. The population of study consisted of only women attending antenatal care at the General Hospital Shanga located opposite Shanga local government secretariat in Kebbi State. The sample size of study consisted of 40 women who were selected through purposive and accidental sampling techniques. The use of purposive sampling was because only women were the target population while accidental sampling was utilized to pick only women who came to the clinic for antenatal care. Also, key informant interview was conducted with 4 health officials at Shanga Hospital. The respondents were selected using purposive sampling technique. Data collected through the questionnaire were analysed quantitatively using frequency tables and percentages while data collected through key informant interview were analysed descriptively to complement the quantitative data.

Data Presentation and Analysis

This section presents and analyses the data collected from the field. Forty Questionnaire copies were administered to respondents in health centres of Shanga local government. A total 32 questionnaire copies representing 84 percentage were completed and returned. Eight (8) representing 16 percent were not returned. The analysis of data is divided into two sections: socio-demographic characteristics of the respondents and the substantive issues of the research.

Section A: Bio-data of the respondents

Table 1: Distribution of Respondents based on age

Age	Frequency	Percentage (%)
15-30	18	56.25
31-60	10	31.25
61 & above	4	12.5
Total	32	100

Sources: Field Survey (2023)

The result in table 1 indicates that eighteen respondents were aged between 15 and 30, ten between 31 and 60 and five respondents aged 61 and above. This represents 56.25%, 31.25% and 12% respectively.

Table 2: Distribution of Respondents based on level of Education

High qualification	Frequency	Percentage
Primary	19	59.75
SSCE/OND	10	31.25
MBBS/BSC/HND	3	9.75
Total	32	100

Source: Field Survey (2023)

Based on the results in table 2, 59.75% of the respondents have primary certificate as the highest qualification, 31.25% have SSCE/OND, and 9.75% have MBBS/BSC/HND. This shows that majority of the respondents have enough educational certification to respond to the questionnaire items.

Table 3: Distribution of Respondents based on occupation

Job Description	Frequency	Percentage
Farming	14	43.75
Business	13	40.25
Civil Servant	3	9.75
Others	2	6.25
Total	32	100

Source: Field Survey (2023)

The results in table 3 showed that 14 respondents representing 43.75% were farmers, 13 respondents representing 40.25%, 3 representing 9.75% of the respondents were civil servants while 2(6.25%) had other occupations. This indicates that the respondents are well informed about the issue of maternal morbidity in the community

Table 4: Distribution of Respondents based on working experience

Working experience	Frequency	Percentage
1-10	13	40.25
11-20	12	37.5
21-30	3	9.75
31 & above	4	12.5
Total	32	100

Source: Field Survey (2023)

From table 4, 40.25% of the respondents have working experience of 1-10 years, 37.5% have working experience of 11-20, while 9.75% respondents have working experience of 21-30 years and 31 above, each. This shows that the respondents are familiar with subject of the research.

Table 5: Prevalence of Maternal Morbidity

Prevalence	Frequency	Percentage
Low	9	28.13
Moderate	5	15.62
High	18	56.25
Total	32	100

Source: Field Survey, 2023

Data in table 5 indicated that majority of the respondents represented by 18 (56.62%) agreed that maternal mortality was high in the study area. Also, 28.13% (9) were of the view that maternal mortality was low while 15.62% (5) said low. In-depth interview conducted with one of the staff in Shanga hospital on the 21st of June, 2023 showed that maternal deaths were a common occurrence in the hospital. He stated that most often, pregnant women do not come for antenatal until when their condition becomes precarious and are often rushed by family and relations to the hospital for intervention. In some cases, the patients are lucky to survive, while in other circumstances; there is little the medical personnel could do to salvage the situation.

Table 6: Does Poverty Affect Maternal Morbidity?

Response	Frequency	Percentage (f)
Yes	20	62.5
No	12	37.5
Total	32	100

Source: Field of Survey (2023)

The result above showed that majority of the respondents represented by 20 (62.5%) agreed that poverty affects maternal mortality in the study area while 12 (37.5%) of the respondents said no. This means that majority of the pregnant women in the study area are economically poor and this can have a negative effect on access to maternal health services. In an interview with one of the health personnel on the 7th of June, 2023 regarding the relationship between poverty and maternal mortality, he not thus:

It is clear that economy has been crippled in almost every community in this area. This is because of the problem of banditry that affects many markets around us, we cannot sell our farm produce as usual, and many people remain in poverty. As such, it affects all aspects of life including health and pregnant issues, (KII, ward head).

It could be seen that a synthesis of the views of respondents with those of the key informants clearly shows that poverty contributes in maternal deaths in the study area.

Table 7: Consequences of Maternal Morbidity

Consequences	Frequency	Percentage
Eclampsia	12	37.5
Stunted infants	12	37.5
Depression	8	25
Total	32	100

Source: Field Survey (2023)

Table 7 showed that 37.5% have eclampsia while 37.5% have postnatal complication and 25% depression. This means that pregnant women in Shanga local government areas suffer from malnourishment, postnatal complications and depression. A participant during an interview revealed that: "A lot of women during their pregnancy are facing so many challenges which may lead to them suffering from vesico vaginal fistula (VVF), depression, eclampsia and chronic injuries," (Women leader).

Table 8: Impact of Poverty on Maternal Morbidity

Response	Frequency	Percentage
Lack of transportation fare to visit antenatal clinics due to distance	15	46.88
No money to buy drugs	6	18.75
Poor feeding due to financial difficulty	9	28.13
Others	2	
Total	32	100

Source: Field Survey (2023)

In table 8, majority of the respondents representing 15 (46.88%) stated that they were not able to access maternal clinics due to lack of transportation fare. The study also noted that majority of the respondents represented by 9 (28.13%) were not able to eat balanced diet required of pregnant women due to financial difficulty. It was also discovered that 6 (18.75%) of the respondents had no money to buy drugs whenever the need arises while 2(6.25%) gave other reasons. This means that poverty in Shanga local government area directly hinders pregnant women from access to basic needs during pregnancy periods due to insufficiency of money.

A religious cleric who was interviewed on the 18th of August, 2023 posited that:

Poverty can cause any kind of suffering for any person, so long as one remain in poverty, he may never live a good and conducive life. In addition, health issue in this country has become marketized, if one is rich one can have the best healthcare services with all his household members, those that remain in poverty will receive the poorest kind of health treatments (KII, religious cleric).

From the above expressions, it is obvious that poverty is major obstacle to accessing maternal health services in Shanga Local Government Area.

Table 9: Possible remedies for Maternal Morbidity

Remedies	Frequency	Percentage (%)
Job opportunities for women	8	25
Provision of healthcare closer to communities	11	34
Women Empowerment Programmes	9	28
Sensitization/Education	4	13
Total	32	100

Source: Field Survey (2023)

The results in table 9 indicated that 34% (9) of the respondents suggested that government should make efforts to bring maternal healthcare facilities closer to the door steps of the people, 28% (9) suggested that women should be empowered through skill acquisition programmes to enable them earn income, 25% (8) made a case for the creation of formal job opportunities for women while 13% (4) asked government and NGOs to scale up sensitization on the dangers of maternal morbidity in the study area.

Discussion

The findings of this study reveal that poverty significantly impacts maternal morbidity in Shanga Local Government, creating a complex web of challenges. Limited access to healthcare services, inadequate nutrition, and lack of transportation fare to access medical health care due to distance are some of those challenges. The findings of this study agreed with those of Orude (2021) that financial obstacles have had a negative impact on health-care delivery, including limiting access for vulnerable groups such as poor women. Additionally, the study found that lack of education and awareness lead to delay or inadequate prenatal care, increasing the risk of complications during childbirth. Addressing poverty through improved socioeconomic conditions and healthcare infrastructure is crucial for mitigating these effects on maternal health in the study area.

Conclusion

Based on the findings of this study, can be concluded that majority of pregnant women in the study area are economically poor and are not be able to take the required protein which help in reducing maternal morbidity. Poverty hinders the pregnant women's right to have access to basic needs during pregnancy due to insufficient money either in their hands or their husbands'. These problems compound the challenges faced by pregnant women which may lead to their suffering from vesico vaginal fistula (VVF), depression, eclampsia and other avoidable chronic injuries.

Recommendations

- (a) The Kebbi Sate government, in conjunction with NGOs should make it a matter of public policy to ensure that maternal clinics are built within 5km radius to enhance quick access to medical care.
- (b) It should also partner with NGOs to provide different forms of empowerment programmes such skill acquisition to enable women earn income to take care of their health
- (c) The Kebbi State government and NGOs should scale up their sensitization/education programmes to educate the people on maternal mortality issues in their communities.
- (d) It is imperative for the Kebbi Sate government to abolish all user fee charges that discourage people from seeking medical care in hospitals especially in rural communities.

References

- AL Ifeanyi, (2019). Government commitment to capacity building: a Sine Qua non for improved economic performance of Nigeria. *Journal of Emerging Trends in Economics and Management Sciences* 10 (4), 182-194, 2019.
- Chakhtoura, N., Chinn, (2019), importance of research in reducing maternal morbidity and mortality rates. *American Journal Obstetrics and Gynecology*, 221(3), 179-182.
- Cohen, M. (1994). Impact of poverty on women's health, *Can Fame Physician.*; 40: 949–958.<http://www.ncbi.nlm.nih.gov/pmc>

- Esperat, C., F. Du, Z. Yan & D. Owen. 2007. Health behaviors of low-income pregnant minority women. *West. J. Nurs. Res.* **29**: 284–300. [PubMedWeb_of Science](#) [@Google Scholar](#)
- Galal, S (2024) maternal mortality rate in Africa 2020, by country. <https://www.statista.com/statistics/1122869/maternal-mortality-rate-in-africa-by-country/>
- Giddens, A. (2006). *Sociology* 5th Edition. Cambridge: Polity Press
- Goldenberg R.L., McClure E.M., MacGuire E.R., Kamath B.D., Jobe A.H. Lessons for low-income regions following the reduction in hypertension-related maternal mortality in high-income countries. *Int. J. Obstet. Gynaecol.* 2011; **113**:91–95. Doi: 10.1016/j.ijgo.2011.01.002. [\[PubMed\]](#) [\[CrossRef\]](#) [\[Google Scholar\]](#)
- Graham W, Fitzmaurice AE, Bell JS, Cairns JA. The Familial technique for Linking maternal death and Poverty. *Lancet.* 2004; **363**:23–7. doi: 10.1016/S0140-6736(03)15165-3. [\[PubMed\]](#) [\[CrossRef\]](#) [\[Google Scholar\]](#)
- Graham, W. (2001) Can skilled attendance at delivery reduce maternal mortality in developing countries? In (Van Lerberghe, W. and De Brouwere, V. eds) *Safe Motherhood Strategies: A Review of the Evidence*, Studies in Health Services Organisation and Policy, 17, pp 97-130.
- Gulumbe, U., Alabi, O., Omisakin, O.A. *et al.* Maternal mortality ratio in selected rural communities in Kebbi State, Northwest Nigeria. *BMC Pregnancy Childbirth* **18**, 503 (2018). <https://doi.org/10.1186/s12884-018-2125-2>
- Harrison, A. (1985). Maternal mortality in Nigeria: the real issues. *African Journal of Reproductive Health*; pg 1(1):7–13
- Jong W, Jang SI, Park EC, Nam JY. The Effect of Socioeconomic Status on All-Cause Maternal Mortality: A Nationwide Population-Based Cohort Study. *Int. J Environ Res Public Health.* 2020 Jun 26; **17**(12):4606. Doi: 10.3390/ijerph17124606. PMID: 32604879; PMCID: PMC7345089.
- Lain Walker, (2001), *Relative Deprivation: Specification, Development, and Integration*, Cambridge University Press, 2001.
- Lanre-Abass B, (2008). Poverty and maternal mortality in Nigeria: towards more viable ethics of modern medical practice. *International Journal for Equity in Health* **7**, 1-9, 2008
- Long Q., Zhang T., Xu L., and Tang S., Hemminki E. Utilisation of maternal health care in western rural China under a new rural health insurance system (New Co-operative Medical System) *Trop. Med. Int. Health.* 2010; **15**:1210–1217. Doi: 10.1111/j.1365-3156.2010.02602.x. [\[PubMed\]](#) [\[CrossRef\]](#) [\[Google Scholar\]](#)
- Matthew O. (2002). Gender inequality, maternal mortality and inclusive growth in Nigeria. *Social indicators Research* **147**, 763,780, 2002
- Milligan, R. *et al* . 2002. Perceptions about prenatal care: views of urban vulnerable groups. *BMC Public Health* **2**: 25.
- Narayan D, Patel R, Schafft K, Rademacher A, KochSchulte S. Voices of the poor: can anyone hear us? New York: Oxford University Press for the World Bank; 2000. p.26-60
- National Bureau of Statistics, (2022). Maternal Mortality measurement: guidance to improve national reporting. *KUI Journal of Social Sciences* **8** (3), 155-165, 2022
- NPC [Nigeria] and ICF International. Nigeria Demographic and Health Survey 2003. In: National Population Commission. Rockville, MD: Abuja and ICF International. p. 2003.
- Ogoh, A. (1999). The promise and limits of private medicine: health policy dilemmas in Nigeria. *Health Policy and Planning* **16** (3), 313-321, 1999

- Orude, A (2021).The Influence of Poverty on Maternal Deaths in Bauchi Local Government Area, Bauchi State, North East Nigeria. *International Journal of Research and Innovation in Social Science (IJRISS)* |Volume V, Issue IV, April 2021|ISSN 2454-6186
- Reproductive Rights and Women Advocates Research and Documentation Centre, 2008
- Sobhy S., Zamora J., Dharmarajah K., Arroyo-Manzano D., Wilson M., Navaratnarajah R., Coomarasamy A., Khan K.S., Thangaratinam S. Anaesthesia-related maternal mortality in low-income and middle-income countries: A systematic review and meta-analysis. *Lancet Global Health*. 2016; 4: e320–e327. doi: 10.1016/S2214-109X (16)30003-1. [PubMed] [CrossRef] [Google Scholar]
- World Bank, (2001). Maternal Mortality. *Disease and Mortality in Sub-Saharan Africa*. 2nd edition 2001
- World Bank, (2020). Trends in maternal mortality 2000 to 2020: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division: executive summary. *World Health Organization*, 2020
- World Bank/CBN, (1996). Social Infrastructure, Maternal Mortality and Economic Growth in Nigeria. *International Journal of Anthropology and Ethnology Research Development*, 1996
- World Development Report, World Bank, (2001). Maternal Mortality: who, when, where, and why. DOI: [https://doi.org/10.1016/S0140-6736\(06\)69380-X](https://doi.org/10.1016/S0140-6736(06)69380-X)
- World Health Organization, Maternal Mortality, Key Facts (2018).
- World Health Organization, UNICEF, United Nations Population Fund and the World Bank, *Trends in Maternal Mortality: 2000 to 2020* WHO, Geneva, 2023.
- World Poverty Clock, Maternal Mortality or women’s health: time for action (2023).