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Contents

Maternal Outcomes and Psychosocial Dilemma in sub-Saharan Africa: the case of Nigeria

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Abstract

Against the backdrop of persistent high maternal and infant morbidity and mortality, low acceptability of family planning programmes and increasing abortion rates, this paper observes that maternal outcomes in sub-Saharan Africa are events that depend on socio-cultural factors. The influence of male role, socio-economic status of women and access and use of health facilities on these outcomes are reinforced through the interplay of social - cultural beliefs and practices. A combination of these factors has led to psychosocial crises both at micro-individual and macro-society levels. To the extent that Talcott Parsons' Voluntary Social Action theory supposes that individuals are constrained, in their health seeking behaviour by culture, the present study argues strongly that re-definitions can be made in the face of obsolescence and manifest dysfunctionality of aspects of culture that are implicated in high maternal/infant morbidity and mortality and consequent psychosocial dilemma in sub-Saharan Africa. Recommendations affirm the essence of scaling up community responses and sensitization of key stakeholders to appreciate issues surrounding maternal events.

Keywords: psychosocial, morbidity, mortality, outcomes, dilemma and dysfunctionality

Background

High incidence of maternal and infant morbidity and mortality is posing a serious psychosocial dilemma in most parts of Africa. This crisis is

compounded by the African value that places a high premium on children, especially males, to the extent that women strive to give birth even when their lives are threatened (Nwokocha, 2004; Arkutu, 1995).

Maternal situation in sub-Saharan Africa is characterized by contradictions in that although maternal morbidity/mortality in the region is higher than any other part of the world, its population size is one of the largest (WHO & World Bank, 1997). High fertility in the region provides a kind of insurance and or replacement of children, for families, in the face of high infant mortality rate. This paper argues that maternal activities and subsequent outcomes are closely linked with socio-cultural variables such as male role and responsibility during maternal periods, socioeconomic status of women, access and use of health facilities and cultural beliefs and practices. Although Parsons' Voluntary Social Action theory amplifies the same assertion to the point that individuals' freedom is recognized as only expressible within existing social and cultural norms and values in a particular milieu, the present study views that limitation as unnecessary especially where beliefs and practices are taken as constant, hence unalterable.

The above position derives from the conviction that as man-made, re-definitions and re-adjustments of these norms and values can be achieved in a socio-cultural environment without injuring the collective aspirations of individuals in affected communities. For instance, the impingement of male role and responsibility during maternal periods, gender inequality, inaccessibility and non-use of maternal health facilities and other factors on maternal outcomes can be re-assessed and re-defined to reflect contemporary reality. Achieving behavioural change as proposed by this paper translates to understanding the essence of perceptual and attitudinal modifications that could lead to positive reproductive outcomes in the context they occur.

Socio-cultural Factors affecting Maternal Outcomes in sub-Saharan Africa

This paper examines the relationship between socio-cultural factors and maternal outcomes with emphasis on male role as directed by cultural beliefs and practices; socio-economic status of women; family planning; and access and use of maternal health facilities. Male role, for instance, derives from patriarchy which defines activities of individuals in the society by

influencing virtually all aspects of human endeavor in most societies. Patriarchy seen in the light of such wholesome inequity has been perceived as an over-arching category of male dominance (Barrett, 1988), a situation carefully sustained by men through ages (Sen *et al.*, 1994).

Studies have shown that socialization into sexuality and gender roles begins early in the family and community and are reinforced through the interplay of familial, social, economic and cultural forces, which are subsumed in patriarchy (Isiugo-Abanihe 2003; Moore & Helzner, 1996; Sen *et al.*, 1994; Obura, 1991). Panos Institute (2001) thus stated that though it is granted that women die or become ill during pregnancy and childbirth for many reasons, in poorer countries, multiple disadvantages combine to put them at higher risk. So, women suffer the effect of poverty than men. The conclusion of the above submission is that many reasons are responsible for why poverty has a female face, more so, in developing countries.

The feminization of poverty according to Akande (2000) is the tragic consequence of women's unequal access to economic opportunities. Individual and communal values, norms and perceptions, in addition, are noted as responsible for the persistence of some cultural and religious practices and demographic behaviour in Africa and other parts of the world (McQuillan, 2004). For instance, female circumcision, which is commonly practiced in Africa and Middle East, has been implicated in maternal deaths (Odebiyi & Aina, 1998). It has been observed that infection and obstetric complications that arise as a result of such practice place considerable strain on already inadequate health facilities (Odebiyi & Aina, 1998). Records indicate that female circumcision is widely practiced in 26 African countries, revealing the wide nature of the practice in the continent (Mbugua, 1997). Research indicates that the socioeconomic status of women in terms of education, involvement in reproductive health decisions, nutrition and work as revealed in their subordinate status contributes to poor maternal outcomes (United Nations, 2000).

It has been noted that 99 percent of the women that die each year from pregnancy-related causes come from the developing world (Bulatao & Ross 2002; Population Reference Bureau, 2000; Shiffman, 2000; Abouzahr & Royston, 1991). It is also revealed that about 52 percent of births in the developing countries are attended by trained personnel suggesting that maternal

health programmes in these areas are inadequate. Consequently, a woman's life time risk of dying from pregnancy-related complications during childbirth is 1 in 48 in the less developed world, relative to 1,800 in the developed world (Population Reference Bureau, 2000). The discrepancy between the developing and developed world for this measure (risk of dying from pregnancy) is higher than for any other major public health indicators (WHO, 1998).

Sub-Saharan Africa is characterized by low use of family planning services. Okonofua *et al* (1999) found that even where such services are substantially used, couples' control over reproduction is far from perfect, a situation that explains the substantial number of undesired reproductive events. Interestingly, (Harbison & Robinson 2002) assert that human beings are now able to control their fertility precisely as never before. They further stated that almost everywhere, the cohesiveness and strength of the extended kin group is waning to the extent that the individual or, at most, the nuclear husband-wife family is becoming the dominant decision making unit.

Studies show that the reasons why women die in pregnancy and childbirth are many layered (Orubuloye, 2000; Erinosho, 1998; Jafarey and Korejo, 1995).Behind medical reasons, there are logistic causes which include failures in the health system, lack of transport facilities, et cetera. The above factors, especially in the developing nations, make the use of effective methods of family planning not only imperative but also inevitable. It has been observed that compared to women elsewhere, those in sub-Saharan Africa bear children at younger ages, have larger families and make much less use of family planning, (Centers for Disease Control and Prevention, 2000). In Nigeria, discrepancies in utilization of family planning services have been pointed out. (Adedokun 2000) specifically reported that even though remarkable progress has been made in family planning in Nigeria, Northern Nigeria and all rural areas have lagged behind. This generalization is faulted because the adoption of family planning for fertility regulation among some individuals in rural areas exceeds by far that of some people in urban centres.

Some couples are said to oppose contraceptive methods for religious reasons. Among Nigerian women in particular, the NDHS (1999) data reveal that 59.5 percent of those in marital union were not using any form of contraception at the time of that survey. The NDHS (2003) found that

although 79 percent of Nigerian women are aware of at least one method of family planning and 77 percent know a modern method, only 29 percent had ever used any of these methods, while only 13 percent of currently married women are using any of the methods (NDHS, 1999; 2003). This confirms the position of Shittu *et al* (2002) that conventional family planning services have not gained acceptance among Nigeria's population.

According to a (United Nations' 2000) observation, access is often understood in a narrow way in terms of physical proximity to services. In a broader sense, access is multidimensional and depends on the perceived need for care; how much knowledge people have about when and where to seek care and the extent to which people are able to overcome physical, economic, social and cultural barriers.

Conceptual Framework

Conceptual framework for this study demonstrates the complexity related to maternal outcomes. It shows that these events occur as a result of interaction of several variables at both micro-individual and macro-society levels.

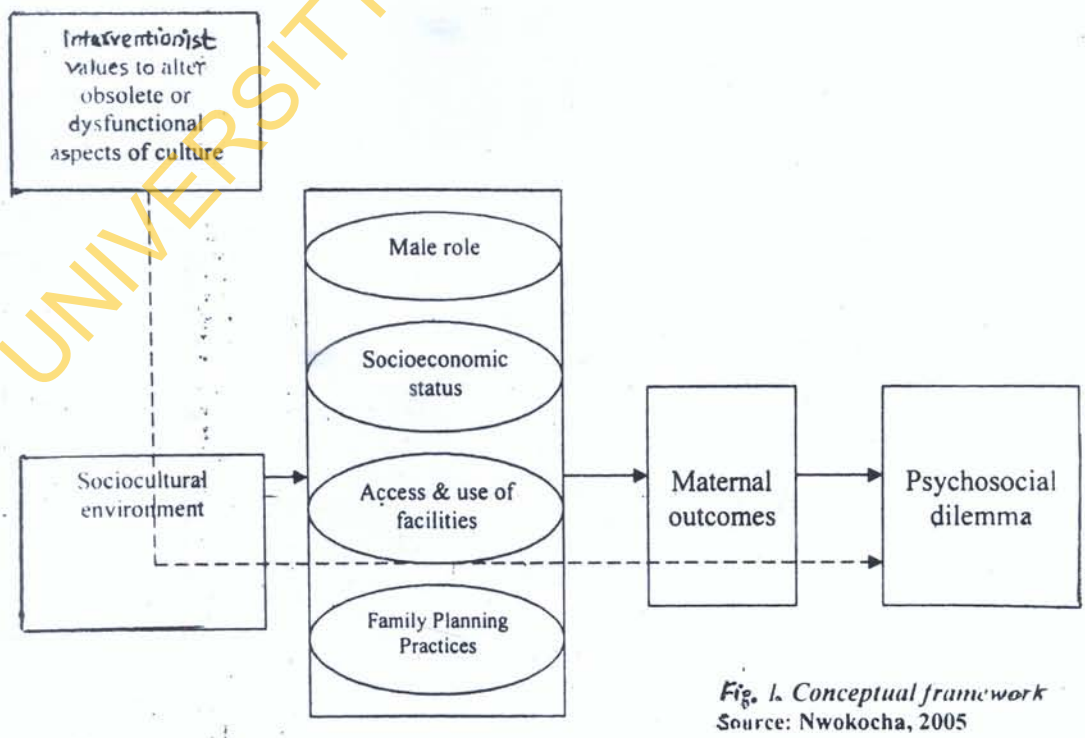

Fig. 1. Conceptual framework
Source: Nwokocha, 2005

The diagram highlights the links between sociocultural environment and perception and actions of individuals in a given milieu. This framework utilizes the voluntaristic social action theory by Talcott Parsons as the theoretical baseline from which the entire conceptual synthesis is designed. The theory supposes that individuals notwithstanding their culturally ascribed freedom to act in ways perceived as most appropriate to achieving a particular end, their activities are still guided by cultural values in relevant societies. Hence, that freedom is limited.

As shown in Fig.1. sociocultural environment influences male role towards maternal outcomes, socioeconomic status of community members, access and use of maternal facilities and family planning practices. A society that values patriarchal ethos, for instance, might limit the extent that males get involved in maternal activities on one hand and prescribe how far women are allowed involvement in socioeconomic activities on the other. Encouraging male indifference, no matter the degree, at maternal periods while limiting activities of women in society impinges negatively on maternal outcomes. Except in few cases, such situation affects access and use of maternal health facilities, including family planning programmes and practices, even where normative and religious values allow women freedom to these.

With very few exceptions, Nigerian communities are patrilineal hence males are favored by norms and values relative to females. Male-dominating ideology, in whatever context it exists, exerts strong influence on maternal records. Negative maternal outcomes in Nigeria and sub-Saharan Africa at large are linkable to disequilibrium in sociocultural environment. Among estimated 27million Nigerian women of reproductive ages, for instance, 1 in 13 dies due to causes related to pregnancy, which in the final analysis is traceable to social and cultural variables (UNICEF, 2000; NDHS,1999; WHO and The World Bank, 1997). In some areas, the result is even worse than this national average.

Consequent on these outcomes, individuals and communities experience crises that affect their psychological and social dispositions respectively. This paper proposes that sociocultural environments that contribute to negative maternal outcomes should be continuously re-adjusted to reflect the reality of times. There is need to introduce interventionist norms and

values to alter dysfunctional aspects of culture that are implicated in negative outcomes and by implication psychosocial crisis in the thematic region.

Between Family Planning and Abortion Rate: the Missing Link

This section reviews the relationship between family planning and abortion rates between developed and developing societies as a way of understanding the relationship between these variables. The analysis is undertaken to examine the assumption that family planning programmes empower individuals and groups against abortion which in most cases is procured in response to unwanted pregnancies. Studies have shown that about 133 million births occur globally yearly; of this number, one in four is estimated to be unintended, that is, either mistimed or never wanted (Bongaarts and Westoff, 2000 citing Alan Guttmacher Institute 1999; Bongaarts, 1997). These scholars further observed that an estimated 46 million induced abortions are performed annually, making the total number of unintended pregnancies 79 million every year. This means that almost as many unintended as intended pregnancies occur each year.

The implication of the situation according to Bongaarts and Westoff (2000) is that more than half of these unintended pregnancies end in induced abortion which has health implications (see also Cu Le *et al.*, 2004). This is notwithstanding that women, their partners, families and caregivers all struggle as they make and execute decisions related to abortion, (Piet-Pelon, 1999). In addition, Bongaarts and Westoff (2000) noted that more than half of all pregnancies in the developed world are unintended, higher than 42 percent in the developing world which also explains the higher rate of abortion in the developed than developing world. This is contradictory in view of overwhelming consensus in literature that acceptability, access and use of family planning programmes are far higher in the developed than developing societies.

This paper questions the reliability of family planning programmes in ensuring that only wanted pregnancies are experienced among individuals in various societies. Our contention is that the links between these variables are lost either because the theoretical and practical do not converge sufficiently to allow individuals achieve desired maternal outcomes or that data are misleading. It could

also be that some variables are intervening between family planning and unintended pregnancies to the extent that their interdependence is lost. Whatever may be the reason(s) for the manifest disjuncture, this section establishes the unusual disagreement between family planning practices and abortion rate.

Although studies have shown that less number of abortions is procured in the developing than developed societies, the former experiences more negative outcomes related to this act than the latter. In Nigeria, an estimated 610, 000 women engage in illegal induced abortion, alone, each year (Oye-Adeniran *et al.*, 2002); this is an abortion rate of 1 in 45 going by an estimated 27, 347 500 women of reproductive age for the year 2000 (NPC 1998). Attempts at examining the factors that predispose women to abortion have been made. The opinion of (Goto *et al* 2000) is that low social acceptability of child rearing outside of marriage accounts for the increasing number of abortions among young people.

According to Family Care International (2002), majority of these abortions, especially in the developing world, are unsafe arising from inadequate skills among provider, hazardous techniques and unsanitary facilities (see also Berer, 2002). While highlighting WHO's submission, (Becker *et al*. 2002), noted that complications from unsafe abortion lead to about one-fifth of all maternal deaths. The WHO (1998), in a statement noted that unsafe abortion is one of the great neglected problems of health care in Africa. Many women, who resort to abortion, do so either in the event of contraceptive failure or because of the lack of access to suiting contraception (Arends-Kuenning, 2002). Report suggests that sub-Saharan Africa is the poorest in terms of access to contraception (Setty-Venugopal *et al*., 2002).

According to WHO (1994), as cited by (Solo *et al.* 1999), unsafe abortion constitutes a major public health problem throughout the world. It noted that approximately 20 million women undergo unsafe abortion and about 70,000 women die annually from complications related to unsafe abortion. Similarly, (Ashford 2001) affirmed that going by the WHO estimates, 13 percent of maternal deaths globally, each year, results from complications of abortion (see also Ransom and Yinger, 2002). According to Bongaarts

(1997), the proportion of pregnancies ending in abortion ranged from 13 percent in Africa to 29 percent in Asia and 40 percent in Latin America.

In Nigeria, induced abortion currently accounts for 20,000 of the estimated 50,000 maternal deaths each year; it is the single largest contributor to maternal mortality (Otoide *et al.*, 2001). In addition, induced abortion has been implicated in chronic pelvic inflammatory disease, ectopic pregnancy, secondary infertility, secondary amenorrhea, spontaneous abortion and prematurity in Nigerian women, (Okonofua *et al.*, 1996). Despite these obvious consequences, Okonofua *et al.* (1999) are of the view that the extent of the problem of morbidity and mortality related to induced abortion among Nigeria women has not been appreciated. They argued that substantive data concerning the circumstances leading to unwanted pregnancy and the number and characteristics of women seeking induced abortion are lacking, largely due to the difficulty of eliciting abortion histories from respondents. Under-reporting is mostly evident where abortion is illegal. Expectedly, induced abortion is among the most difficult indicators to measure (Ahman and Shah, 2002).

Similar observation was made by the WHO (1998) when it asserted that data on safe abortion are scarce and inevitably unreliable due to legal and ethical/moral constraints that hinder data collection. It is pointed out that under-reporting and misreporting are common because women are reluctant to admit to an induced abortion especially when it is illegal. Barroso (2001) and Jewkes *et al* (1997) had equally observed that in countries with restrictive abortion legislation, the illegality of abortion drive many women to undergo the procedure outside those countries or in unsafe conditions within these countries (see also Rossier 2003).

Perceiving that abortion plays a key role in lowering the level of unwanted fertility (Bongaarts, 1997), Japan became one of the first countries to legalize induced abortion through the Eugenic protection law of 1948 (Goto *et al.*, 2000). They further pointed out that this law was revised as the maternal body protection law in 1996, which invariably made abortion widely accepted in the Japanese society. Legalizing abortion would mean both freedom and openness to abort pregnancies that are unintended through the services of competent personnel. Such approval although would lessen the

difficulty faced by researchers as reliable/quality data on abortion can then be generated with minimum stress; its implication is that a very large number of women will undergo that experience with little or no stigmatization..

The WHO (1998) had stated specifically that in the developing countries, especially in rural areas, many deaths are not registered; when a death is reported, the cause is frequently not known, not shown on the death certificate or deliberately concealed. It further observed that an abortion may not be mentioned to protect the family and all references to pregnancy may be avoided, particularly for unmarried women.

Research from Southwest Nigeria indicates an incidence ratio of 20 to 30 induced abortions per 100 live births (Henshaw *et al.*, 1998; Okonofua *et al.*, 1999). The above figures affirm the position of the Upadhyay, (2001) that many women engage in induced abortion due to their inability to make informed choices about family planning. In Ibadan particularly, typical multiple complications from illegally induced abortion were reported in a study of 840 patients. Of that number, 59 patients or 7 percent died as a result of these complications (WHO, 1998). It was also pointed out that for some survivors, permanent disability resulted from unsafe abortion. However, Otoide *et al* (2001) maintain that abortion-related deaths and other complications arise only when an abortion is performed late in the pregnancy or is done by a quack. Other consequences of poorly performed abortions are related to high incidence of ectopic pregnancy, premature delivery and increased risks of spontaneous abortion in subsequent pregnancies (WHO 1998; Solo *et al.*, 1999).

Moving beyond Maternal Crises in Africa: the way Forward

Studies have repeatedly shown that maternal and infant morbidity and mortality in developing societies particularly sub-Saharan Africa are very high (Population Reference Bureau, 2002; WHO, 2000). The value for children, frequent pregnancies characterized by poor maternal care and some cultural beliefs and practices are implicated in African maternal crises. The consistency of this finding confirms its validity as well. Scientific activities have, however, gone beyond identification of causes and effects of phenomena to suggesting interventions aimed at alleviation through a holistic approach.

Towards the end of the 20th century, intellectual activities that thrived in disciplinary seclusion and peripheral and inconclusive analysis of major events such as maternal outcomes became obsolete with contemporary reality. With the evolution and or methodological transition from disciplinary (also monolithic) to transdisciplinary and multidisciplinary analysis, maternal morbidity and mortality characterized by complexity are comprehensively understood. The present study adopts this methodological shift to recommend context specific remedies towards reducing, appreciably, maternal mishaps and psychosocial dilemma in relevant societies.

In Africa where a large majority of the population, including women, reside in rural communities, traditional medicine is still conceived in most parts as efficacious. Although a number of reasons are responsible for why most women in villages depend on the services of Traditional Birth Attendants (TBAs) for prenatal activities, delivery and postpartum care, this paper suggests that this category of health care providers should be trained to recognize pregnancy related complications early. This will enable them treat or refer such cases to facilities that have relevant competence before they become life threatening. Importantly, TBAs need to be properly sensitized to regard orthodox medicine and practitioners as partners rather than opponents, and vice versa. Integrating both systems is the surest approach to achieving medical breakthrough in Africa.

Also, allocating a large proportion of budgetary funds to the health sector will not only lead to improvement in health facilities and encouragement of medical practitioners but will also contribute to making treatment fees affordable. Literature shows clearly that high medical fees are linked to low and non-use of health facilities in sub-Saharan Africa. Moreover, research activities will improve with funding. The MacArthur Foundation Research Support has, for instance, led to the discovery of the "anti-shock garment" by researcher at the University College Hospital (UCH) Ibadan, Nigeria. The garment sustains women experiencing hemorrhage related to pregnancy by reducing and or stopping bleeding before treatment is administered. This is necessary considering the inadequate blood banking system in the country worsened by HIV/AIDS threat. The necessity of this discovery cannot be overstated given that hemorrhage is the most common medical cause of maternal deaths (Ransom and Yinger, 2002).

People in sub-Saharan Africa are challenged to design a structure that will ensure that women that experience psychosocial dilemma as a result of negative maternal outcomes are adequately supported by significant others – husbands, children, cousins and in-laws. On the other hand, beyond the woman in question, other family members who are indirectly affected by some maternal outcomes – here referred to as people affected by maternal outcomes (PABMO) need to be supported socially, financially and emotionally by their communities.

Scaling up society responses by sensitizing community members, opinion and religious leaders on the need to abandon beliefs and practices that impinge negatively on maternal outcomes has become inevitable considering the persistence of high maternal and infant morbidity and mortality in the region. The *Ewu-ukwu* ceremony among the Mbaise-Igbo, for instance, which is exclusively for women that have had at least ten pregnancies exposes women in the area to life of repeated child bearing. Although the quest to belong to the *Ewu-ukwu* group is usually burning, this paper argues that achieving such status through a life threatening custom such as *Ewu-ukwu* is dangerous and unnecessary. Consequently, it is suggested that the same status should rather be conferred on deserving women through an assessment of their contributions in sustaining marital relationships with their spouses over, at least, twenty-five years. Ascription to high status, it is recommended should be tied to sustainability of nuptiality by women for at least the suggested period.

Conclusion

This study confirms the impingement of sociocultural factors on maternal outcomes in whatever context they occur. Findings, however, indicate a need for theoretical shift from Parsons' voluntary social action theory with a view to emphasizing the essence of adjusting cultural values that negatively affect maternal results. Maternal outcomes in Nigeria and sub-Saharan Africa generally, question the sacrosanctity of cultural norms and values where these negativities are traceable to dysfunctional aspects of culture. In the developed world, reproductive outcomes particularly the rate of mistimed/unwanted pregnancy and consequent abortion validate the universality of this same question about culture inviolability.

The discrepancy between family planning programmes and abortion rates in our review of developed and developing countries calls for deeper analysis of the science and reality of the *missing link*. This investigation is timely in view of criticisms against fertility reduction as a realistic check against population growth and underdevelopment, rekindling centuries-old debate between the Malthusians and Marxists scholars. Our focus, in the present paper, is neither to reactivate these polarized views nor analyze the epistemological contributions or relevance of each of these schools in understanding the social system. To demonstrate the inconsistency of family planning practices or the lack of such in ameliorating the rate of unwanted pregnancy and abortion, in practical terms, is even more challenging.

Although this analysis focused largely on sub-Saharan Africa given its consistent maternal outcomes crises, data however show that reproductive mishap is global. The task before researchers and decision makers is to contextualize effective interventions that will alter obsolete or dysfunctional aspects of culture that undermine desired maternal outcomes and in this way contribute to turning inherent psychosocial dilemma into maternal triumph. The present study, following currents in the scientific community requiring that research activities go beyond identifying causes and effects of phenomena to suggesting context specific interventions, thus generates solutions to sub-Saharan African maternal dilemma through a multidisciplinary and holistic approach

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