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ORIGINAL ARTICLE

AN ASSESSMENT OF THE BARRIERS TO WOMEN ACCESS TO HEALTH FACILITIES IN *ISI* COMMUNITIES OF EDO STATE, SOUTH-SOUTH NIGERIA. IMPLICATION FOR POLICY DEVELOPMENT AND SOCIAL WORK

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Abstract
The focus of the paper was the assessment of barriers to women access to health facilities in *Isi* communities of Edo State, South-South Nigeria. The survey research design was adopted for this study. The purposive sampling method was used to select the research participants. This is because of the characteristics the participants must have to qualify for participation in the research. The instruments of data collection were the Focus Group Discussion (FGD) and the in-depth interview. The data collected were analysed into frequency distribution, simple percentage and cross tabulated with the variables. The results of the data analysis reveal that the women in the study area are being deprived of basic rights to health facilities by the government and where the health facilities are available the socio-cultural factors like belief systems, peer influence, logistics and poverty prevent the women from accessing the facilities. The implication of the policy development and social work practice in Nigeria were discussed. Recommendations for remedying the situation were made.

Key words: *health; women; communities; culture; facilities*

INTRODUCTION

Good health represents an ideal state towards which all human societies strive to achieve for their members. This is borne out of the ancient realization that only healthy people can fulfil their various obligations to the society and in the process ensure survival and development (Isamah 1996). Thus remaining healthy is not only regarded as desirable and a form of wealth but is vital to all people in all societies but the ways of evaluating and treating the problems of ill health varies from one group to another (Owumi 1996). As a result, each society or more comprehensively, each culture no matter its level of development evolves a health care system best suited to its own peculiar socio-political circumstances and environmental milieu (Owumi and Jerome 2008).

It is in this context that the National Health Policy recently launched by the Federal Government of Nigeria stimulates the desire and expresses the collective will of the government and the people of the country to provide a comprehensive health care for the citizenry. The policies describe the goals, structure, and strategy and policy direction of the health care delivery system envisaged. It defines the roles and responsibilities of the three tiers of government as well as those of non-governmental actors (Owumi et al. 1998). The long term goal of the health policy is

to provide the entire population with adequate access not only to primary health care but also to secondary and tertiary services through a well-functioning referral system. Sound as this may appear, the National Health Policy is only rhetoric about the health of the teeming population in the rural areas and the interest of the "underserved population" that abound in the rural areas because the health care delivery system invariably has no concrete provisions for the teeming population in the rural areas.

The paper focuses on the analysis of the factors that hinder women access to health facilities in Nigerian rural areas with special reference to *Isi* communities in Edo State Nigeria. The paper evaluates the nature or extent of health facilities available in *Isi* communities; the reason(s) why health facilities available in the area are not fully utilized by the women in *Isi* communities; the constraints to women access to the health facilities in *Isi* communities; the health facilities, programmes and policies adequate for the population of *Isi* communities especially as they relate to women health desires and requirements and the feasible panaceas to these health problems as they affect the women of *Isi* communities.

The concept of health

Azuh (1994, p. 126) notes that health is no longer an end in itself; it is a means for attaining optimal social wellbeing within the constraints of the physical, social, economic, and biological environment. As such it can no longer be viewed out of context of social and economic aspects of living. According to the World Health Organization (WHO), health can be defined as a state of complete physical, mental and social wellbeing and not merely an absence of disease and infirmity. Azuh (2012, p. 129) posited that health cannot be discussed in isolation of other dimensions such as better environment, good institutions, finance, cosmology, and so on. According to him if one is poor, the person can never be in good state of physical, mental or social wellbeing. Similarly, nutritional status will be poor if one has no money. It is indisputable that the prevalence and distribution of disease is strongly influenced by socio-economic factors like education, and gender equity and even tradition. WHO (2005) stated that health status is determined by many factors and will not be improved by a single sector/factor/approach nor through economic growth alone.

Nigeria is Africa's most populous nation with a population of over 140 million according to the 2006 census (NPC 2006). But the latest population figures of Nigeria according to the World Population Review (2014) is 173,611,131. It is paradoxical that Nigeria which is the 7th highest oil producer of the world with enormous human and natural resources is considered as a pariah nation and ranked 187th nation with poor health rating among its 191 member nations (WHO 1999). Okafor (2005) states that Nigeria suffers from extreme poverty; over 70 million people live on less than $1 per day. Nigeria has some of the worst social, economic and demographic indicators in the world. One in five children dies before the age of five, around 7 million children are not in school and around 2.6 million people are living with HIV/AIDS.

Most adversely affected by extreme poverty and socio-economic woes are women who not only suffer socio-cultural subjugation and exploitation, they are found mainly in low income and unskilled professions. Literacy rate among Nigerian women currently stands at 50% with only 28% and 30% of all current primary and secondary school enrolments being women (Izugbara et al. 2005).

Izugbara et al. (2005, p. 2) indicates that women's access to formal and quality healthcare services in Nigeria is quite low. The two main providers of western biomedicine in Nigeria are the state and private medical entrepreneurs. He posited that the efforts of these providers are however concentrated in the urban areas where only about 30% of Nigerian women live. Most Nigerian women live in remote rural communities and geographical mobility is also difficult owing to intractable transportation problems.

Alubo (1995) contends that most private medical establishments in Nigeria are poorly equipped. They often lack basic health equipment from sterilizing units to incubators. Private medical services in Nigeria are also quite expensive. Recent studies currently put the service charges of private medical establishments in Nigeria at 800–1500% higher than the rates in the public health sector (Alubo 1990, 1995). Harrison (2001) reports that research

conducted in the 1990s shows that only about 4% of Nigerian women have any steady access to private medical care. The services of private medical enterprises are often on a pay-before-service or cash-and-carry basis. That is before treatment commences, care seekers are often required to make cash deposit. Reports abound where women died at the door steps of private hospitals and clinics for not being able to meet the initial deposit requirements or while their companions are still haggling over initial deposit. When such initial deposits are exhausted, treatment is frequently withheld and or patient held hostage until payments are made (Alubo 1995).

Health services as earlier mentioned are provided by the Federal Government i.e. Federal Ministry of Health and affiliate agencies, the State and local government health sector/boards. These health institutions providers are bedevilled by a lot of anomalies, maladministration, ineptitude, under-funding, inefficiency amongst others. This has had the effect of further constraining women's access to public health services. Shortages of basic essentials, the rise in the incidence of fake drugs, and the flight of formal service providers from government health establishments have further worsened matters in the sector, leading to loss of faith in public health facilities among Nigerians (Alubo 1990, 1995, Imogie 2001, Izugbara, and Ukwayi 2003).

Izugbara et al. (2005) reported that only about 25% of Nigerian women go to public hospitals to deliver children or for other obstetric conditions. Asuquo et al. (2000) found the harsh attitudes of health staff in public hospitals to be the major reason for women not patronizing government hospitals for obstetrics care. Ekwenpu (1990), and Alubo (1985) note that Nigerian women go to informal health providers because of ignorance, illiteracy, and poverty hence poor women are their major users. Ukpong (2011) noted that owing largely to discrimination in public healthcare services, high cost of formal services and lack of geographical access to modern health services, many women in Nigeria go to chemist shops to give birth and this has resulted in morbidity in mother and infants. Currently, quacks, injectionists, medicine hawkers and patent medicine stores are estimated to be the major source of health care for about several million of women in Nigeria (Ityayar 1984, Ibanga 1992, Harrison 2001).

Isi communities, South-South Nigeria in perspective

Nigeria is Africa's demographic giant. The country has a landmass of 923,770 km2 and lies in the west coast of the continent. *Isi* communities are in the southern part of Edo State in South-South Nigeria. The members of *Isi* communities are predominantly Benins and their major occupation is farming and other agro related entrepreneurship. *Isi* communities are made up of 29 villages and several camps. Each village population is over 1,000 people while the big villages' population are over 2,500 (NPC 2006).

Politically, each village is headed by an *Odionwere* (who is the oldest indigenous male) assisted by the *Edion* Council of Elders. The *Ighiles* and *Ikpolughes* are the middle age and youths respectively and who carry out the directives and decisions of the *Edion* Councils.

There are also chiefdoms in *Isi* communities created long ago by the Oba of Benin dynasty. The *Enigie* are heads of the dukedoms and are politically superior to the *Odionweres* by virtue of being representatives of the Oba of Benin who they report to directly in the hierarchies of the administration of Benin kingdom. The *Eholor* of *Isi* is the most senior of the *Enigie* and succession to these thrones are by principle of primogeniture (Ugiagbe et al. 2007). The position of women is clear and subservient to the men because the Benin society is patriarchal in all ramifications hence ownership of property, statuses, succession, wealth etc. are exclusively issues for men.

Despite its large landmass, population and natural resources, *Isi* communities are the least developed in Edo State, South-South of Nigeria in the aspect of infrastructures and human resources development. Presently in the 21st century, *Isi* communities lack electricity, pipe borne water, motor able roads, government hospital/clinics and even good schools. There is no single industry, no fuel station, no tertiary institution and no communication gadget(s). The mask of one of the wireless telecom providers is at Ehor which is about 60 kilometres away and to receive signals, people with handsets have to climb some specific higher grounds/hills at

a specific time of the day before calls can be made.

MATERIAL AND METHODS

The study was carried out in *Isi* community, Edo State, South-South, Nigeria. A qualitative approach was adopted in this study. The target population were all adult males and females *de jure* in *Isi* communities in a relatively non transient nature and have been resident or based in *Isi* for a period of at least 10 years. Out of the 29 villages making up *Isi* communities, 10 villages were randomly selected for the research.

Sampling techniques

Sampling method was the purposive sampling method whereby the target respondents were selected priori because of certain factors: These factors include (a) respondent must be adult female, aged above 20 and permanently resident in the village, (b) be knowledgeable in Benin customs and tradition and (c) must be an indigene of the community.

The researchers therefore purposefully chose the 30 female members in each of the 10 villages which totalled 300 respondents. The researchers also purposively selected 3 men each from the 10 villages which totalled 30 men. The rationale to include men in the study is informed by the position men occupy in a typical patriarchal Benin family. Major decisions made in the family are greatly influenced by men either directly or indirectly. It was therefore necessary/ expedient to seek or sample their opinion on the issue being investigated in order to get a balanced information. The two oldest males who are indigenes were selected for the study. Purposive sampling method was used to select the respondent such that more women than men participated in the study. Thus the sample size/frame of the participating groups of four is as presented below:

Research instrument

The research instrument used for the study was the Focus Group Discussion. The respondents were sub-divided into three FGD groups and the meetings were held in Eguaeholor, Iguezomo and Ohe villages. The men were interviewed orally to get their views on the states of women's health in their community.

RESULTS

Focus Group Discussion (FGD) was used to gather information and data for this study. The FGD was used to gather information from the women while the in-depth interview was used to elicit information from the thirty men purposively selected from the 10 villages used for the study. At the conclusion of the field work, data collected through the focus group discussion and other informal means were transcribed and screened. The aim was to ensure that errors that were contained in them were revisited for correctness and processing. Data collected in this study were resolved into constituent components so that major characteristics, themes and patterns of responses can be handled effectively. In addition to the above, raw data were coded to make electronic analysis with SPSS easy. Frequency distribution, simple percentages and tabulations were some of the statistical techniques adopted in analysing data for this study. The Table 1 below shows the different barriers to women's access to health facilities in *Isi* communities. The different identified obstacles/barriers are cultural belief system, the socio-economic statuses of the women participants, and the non-availability/ inadequacy of the health facilities in the study area.

Age			*Sample size*
(i)	20–50 – Women of child-bearing age (W of CA)	–	140
(ii)	50–70 – Women above child bearing age (WACA)	–	90
(iii)	70 and above – Elderly women leaders (EWL)	–	70
(iv)	70 and above – Elderly men (*Edion* council) (EM)	–	30
	Total sample size	–	330

Barriers to women access to health

Table 1. Socio-economic characteristics of participants and Table 2 showing the barriers to women access to health facilities

Characteristics	Frequency (x)	Percentage %
Sex		
Males	30	9.09
Females	300	90.91
Total	330	100.00
Age		
(20–70)	270	81.82
(70 and above)	60	18.18
Total	330	100.00
Marital status		
Single	12	3.64
Married	288	87.27
Divorced	6	1.82
Widowed	24	7.27
Total	330	100.00
Religious affiliation		
Christianity	264	80
African religion	66	20
Total	330	100.00

While the younger women i.e. below 70 years of age expressed desires to utilize the modern health facilities and hence bemoan the absence of such health facilities, the women participants above the age of 70 felt they were satisfied with doing without modern health facilities. According to some of the members of this group, throughout their child-bearing period, they never patronised and were indeed not aided one way or the other by modern orthodox medical science. Some nostalgically relished the efficacies of herbs and other cultural practices which ensure healthy mother and child during their time. Discussant Madam E emphatically declared:

> 'I never used or took any drug from the health centres. I have 8 healthy children. I gave birth to them at home not hospital. There is too much noise about maternity centre these days, yet children still die there despite the praise and noise about your doctors, nurses and drugs. I will continue to do my best for my children and others who come to me for herbs or advice.'

On the issue of cultural constraints and health status the discussants were divided on the impact (positive/negative) on health. While the non-Christian participants strongly supported cultural belief systems as paramount to health status, the Christian participants denounced some of the cultural beliefs and constraints as fetish, barbaric and harmful. Mrs. O. (a female research discussant) declared:

> 'Some of our cultural practices are evil and bad and I avoid them as much as I can when I am pregnant. Imagine going to a herbalist to make incision on my stomach or drink some concussion all for the sake of the unborn child to be healthy or cry at birth is wrong. The modern facilities are better, open and healthier than herbalist prescription.'

All the men interviewed were of the opinion that though the traditional health system is good for women of child bearing age but agreed that the modern health facilities are still very necessary for a healthy society. They bemoan the inadequate health facilities

in the community and attribute the mortality rate to the failure of government to build and equip a modern hospital in the community. According to a male participant Pa O (Pa: a local title for elderly men in *Isi* communities):

> 'I would have long been dead but for the love and care of my children who always take me to Benin City for medical attention and always supply me with drugs. The closest health centre from here is at Eguaeholor village which is very far from my village. I was told that the type of drugs there cannot help old men like me hence I always go to Benin City.'

In similar vein, Pa E stated:

> 'We are very unlucky in this community. The government long abandoned us. The politicians only remember us during elections when they share bags of salt and miserable sums of money. We have nothing to sustain us health-wise here. The health centre is just there for nothing. You can hardly see a nurse not to talk of a doctor. It is shame and God will reward those behind this backwardness of our community in everything.'

Table 2. Causes/barriers to women access to health facilities of study area according to women participants in FGD sessions and interview of men

Responses	W of CA	WACA	EWL	EM
Lack of information/awareness on the health facilities	++	+	+	+
Usefulness of modern health facilities	+++	++	+++	+
Non-availability of health facilities	++	++	++	++
Cultural constraint	+	++	+++	++
Religion	++	+	+	++
Education	++	+++	+++	+++
Neglect of the health centre	+++	+++	+	++
Distance/logistics problem	++	++	+	++
Poverty	+++	+++	+++	+++
Peer influence	+	++	++	+

Legend: +++ where opinion was expressed by all respondents; ++ where opinion was expressed by most respondents; + where opinion was expressed by some respondents; – where opinion was not expressed at all. W of CA, women of child bearing age; WACA, women above child bearing age; EWL, elderly women leaders; EM, elderly men in *Isi* communities.

The above responses also indicate that age, religious and cultural practices influenced the responses of the women discussants. For example the women participants who are above the age of 70 felt that modern health facilities are not useful to their health and few of them bother about its proximity to their abode or village whereas all women participants of child-bearing age agreed that modern health facilities are very useful and important to their health. Also all the discussants agreed that the health centre in the community is not only inadequate but regrettable because of the neglect by the government. Poverty, logistics and non-availability of basic amenities and infrastructures unarguably are major factors affecting access to health facilities by women of *Isi* community.

DISCUSSION

Interactions and discussions at the FGD meetings and in-depth interview of the elderly men indicated that all the respondents have been resident in *Isi* community for over 10 years and all but one is illiterates. The only literate woman among them is a holder of secondary level education and a retired primary school teacher. The reason for the

above could be attributed to the deplorable state of infrastructure and lack of schools in the community.

The three FGDs revealed myriads of obstacles/barriers to women access to health facilities in *Isi* communities. These barriers according to the participants/discussants are (Table 2):

- *Lack of information/awareness* on the usefulness and availability of health facilities in *Isi* communities.
- *Financial constraints:* Most women are poor, deprived and subjugated to male domination in a typical patriarchal Benin family set up.
- *Non-availability of health facilities:* This is because there is only one maternity centre at Eguaeholor that serves the 29 villages in more than 60 kilometres square areas.
- *Cultural constraints:* Traditions and culture of the community seem to frown at modern orthodox medicine as too sophisticated, expensive and unaffordable to the local people hence women need the approval of their husbands or relations before they can visit the maternity centre. The notion of the community is that the maternity is a death trap and no go area. One of the women reacted:

  'I go to the maternity at Eguaeholor? Never. I won't go because it is a waste of time and most people who patronise it either died or have to be carried to Benin (about 72 kilometres away) for proper treatment. The nurse will only shout on you without curing the ailments.'
- *Inadequate staff:* The maternity centre is inadequately staffed with a nurse or midwife in charge assisted by an orderly.
- *Religion:* Many of the women are still idol worshipers who would rather visit a native doctor/herbalist or a soothsayer for divination than go to the maternity centre.
- *Education:* Most of the women are illiterates.
- *Neglect of the maternity by the governments:* The discussants bemoaned the total neglect of the maternity and failure to upgrade it to a clinic or hospital to serve the entire communities.
- *Distance and logistics problem:* The only available maternity for the entire community is located at Eguaeholor, the traditional headquarters of *Isi* communities and it is about 60 kilometres to some villages like Ekosi, Ekae and Iguiyase, hence the people normally look for alternatives because the roads are not motor able. One discussant rightly put it: "It is better to go to Ehor or Benin City than to go to Eguaeholor from my village. It will take almost half a day to trek to Eguaeholor, instead, we always charter motor bike to take us to Ugoneki where we get transport to Benin instead of going to Eguaeholor from Igue Oloi Nebue."
- Deplorable services at the maternity. A discussant lamented: "It is always panadol (analgesic drug) and purgative, nothing else! The only available nurse is always arrogant, saucy and abusive." The attitude of the health workers is terrible and always discourages people from patronizing them.
- Lastly the women agreed collectively that peer influence is also a barrier because their mates always discouraged them from accessing the health facilities and see it as waste of fund and time.

Most of the discussants posited that it is better to deliver their babies at home by a traditional midwife than to go to the maternity centre.

Implication for social work practice in Nigeria

This study is a pointer to the fact that Nigerian social workers have a lot to do in terms of advocacy, facilitating, initiating, enabling, empowering, enlightening, and collaboration to help enhance the quality of lives of the rural dwellers in Nigeria. The level of awareness of rural women on health related issues is generally very low. The rural women also experience high level of neglect by government in policy formulation and being targeted in programs aimed at enhancing quality of life especially heath, sexuality and basic rights to the good things of life. Social Workers in Nigeria should map out feasible strategies to bring about positive changes in the lives of rural women. This is a sure way to ensure social justice, equity and fairness on issues involving women empowerment and emancipation. The rural women deserve the good things of life and social workers should be the forerunners of the fight and struggle to better the life of women especially those in rural areas of Nigeria.

The health services providers should as a matter of urgency re-strategize how the rural women can be reached so that the women will not only have access to health services, they should get the services at subsidised rates and if possible at no cost at all. Nigeria is rich enough to provide free health services to poor rural dwellers that are actually living at the fringe and periphery of the main stream Nigerian society.

CONCLUSION

Access to and assessing health facilities in rural areas of Nigeria are topical issues that need to be looked into by all stake holders especially those saddled with the responsibility of providing health services for the people and the supervisory ministry. Maternal and infant mortality is very high in rural areas of Nigeria because of the factors earlier discussed in this paper. The sure way to stem and reverse this ugly trend is to genuinely approach and reduce the unnecessary deaths of Nigerians as a result of the inefficiency of government systems. Social workers should wake up to the responsibility of being the mouth piece of the voiceless and the advocates of the less privileged and disadvantaged members of the human society.

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