Assessment of the Challenges and Prospects of Reproductive Healthcare Services for Women in Lokoja, Nigeria.

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Abstract
This study assessed the challenges and prospects of reproductive healthcare services for women in Lokoja, Nigeria. The study was hinged on three specific objectives which include ascertaining the state of women reproductive services, determining whether women have access to reproductive healthcare services, and identifying the challenges facing women access to reproductive healthcare services in Lokoja, Nigeria. This study used the Andersen Health Behavioural Model to explain the social phenomena studied; and adopted the survey research design with simple random sampling techniques as well as the stratified sampling techniques to reach and elicited responses from the 120 selected sample. Questionnaire and In-Depth Interview (IDI) were used as the primary instrument of data collection. Data were analyzed using the Statistical Package for Social Sciences (SPSS) software, while the qualitative data was content analyzed descriptively to support the quantitative aspects of the findings. The findings indicated that 57. 20 percent of women in Lokoja were aware of maternal healthcare services in their areas and 68. 20 percent equally utilized it, 64.50 percent of women in Lokoja had access to maternal healthcare services because they are cheap and affordable. The major challenges facing women access to maternal healthcare services were financial constraints, ignorance, husband's restriction, not listening to media sources and socio-cultural beliefs of the people. The study therefore recommended, among others, that women should be educated and sensitized with their husbands, on the importance of maternal care.

Key Words: Challenges, Healthcare, Prospects, Reproductive, Women.

Évaluation des défis et perspectives des services de santé en matière de reproduction pour les femmes à Lokoja, Nigéria.

Abstrait
Cette étude a évalué les défis et les perspectives des services de santé reproductive pour les femmes à Lokoja, au Nigeria. L'étude s'articulait autour de trois objectifs spécifiques, à savoir déterminer l'état des services de reproduction pour les femmes, déterminer si les femmes avaient accès aux services de santé en matière de reproduction et identifier les problèmes auxquels ces femmes sont confrontées pour accéder aux services de santé en matière de reproduction à Lokoja, au Nigéria. Cette étude a utilisé le modèle comportemental de santé d'Andersen pour expliquer les phénomènes sociaux étudiés; et a adopté le plan de recherche de l'enquête avec des techniques simples d'échantillonnage aléatoire, ainsi que les techniques d'échantillonnage stratifié permettant d'obtenir des réponses et d'obtenir des réponses de

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l’échantillon sélectionné. Le questionnaire et les entretiens approfondis (IDI) ont été utilisés comme principal instrument de collecte de données. Les données ont été analysées à l'aide du logiciel SPSS (Statistical Package for Social Sciences), tandis que les données qualitatives ont été analysées de manière descriptive afin d'analyser les aspects quantitatifs des résultats. Les résultats ont indiqué que 57,2% des femmes de Lokoja étaient au courant des services de santé maternelle dans leur région et que 68,2% les utilisaient également, 64,50% des femmes de Lokoja avaient accès aux services de santé maternelle, car ils étaient bon marché et abordables. Les principaux problèmes rencontrés par les femmes pour accéder aux services de soins de santé maternels étaient les contraintes financières, l'ignorance, les restrictions imposées par le mari, l'absence d'écoute des sources médiatiques et les croyances socioculturelles de la population. L'étude a donc recommandé, entre autres, que les femmes soient sensibilisées et sensibilisées avec leur mari à l'importance des soins maternels.

Mots-clés: Défis, Santé, Perspectives, Reproduction, Femmes.

Introduction

Health is central to community well-being, personal welfare and has strong influence on people’s earning capacity. It is fundamental to people’s ability to enjoy and appreciate all other aspects of life. The healthcare utilization of a population is related to availability, geographical access, quality, cost of services, perceived benefits, as well as social-economic and cultural structure, and personal characteristics of the users (Onah, Ikeako., & Iloabahie, 2009; Chakraborty, Islam., Chowdhury., Bari., & Ahkter, 2003). The joys of motherhood is childbearing, it is a source of sorrow to many households as many women lose their lives during child birth. Every single day, Nigeria loses about 2, 300 under five years old and 145 women of childbearing age (Federal Ministry of Health, 2005). Discussions on reproductive and sexual health rights which had hitherto been a ‘taboo’ in traditional African societies are on the increase (Aniekwu, 2006). While the right to health has been an internationally recognized human right, reproductive health rights gained formal acceptance in 1993 and the need for women to have access to quality reproductive health services such as medical care, planned family, safe pregnancy, delivery care, treatment and prevention of sexually transmitted infections, such as HIV/AIDS is increasingly gaining recognition in Africa at large and Nigeria in particular (World Health Organization, 2004). Despite this recognition, reproductive health of women is still one of the major health challenges in Nigeria. Women represent a vulnerable population group as a result of biological and gender-related differences.

Reproductive ill-health accounts for 20 percent of the global burden of ill-health of women compared to 14 percent for men (World Health Organization, 2008). According to Shiffman (2007), the health status of countries has been assessed using women reproductive health indicators such as maternal mortality rates, antenatal care coverage, and proportion of delivery supervised by skilled birth attendants, unmet need for family planning among others. This clearly underscores the fact that, all efforts must be on deck by both government and non-governmental organization to ensure that women have access to reproductive health service. The International Conference on Population and Development (ICPD) and the Millennium Development Goals (MDGs) had, set goals to reduce maternal mortality and improve access to reproductive health services. The MDG target number 5 to reduce maternal mortality by three-quarter in order to achieve universal access to reproductive health by the year 2015.(World Health Organization, 2004).

The current population of Nigeria is 197,403,529 people based on the latest United Nations estimate (United Nations, Department of Economic and Social Affairs, Population

Division, 2017). Nigeria population is equivalent to 2.57 percent of the total world population (World Population Prospects, 2017). About two-third of the population live in rural areas, and most rural dwellers are involved in the agriculture sector (Ibrahim (2005). In 2008, the adult literacy rate for both sexes was 74.8 percent. Nigeria has a high total fertility rate estimated at 5.5 births per woman (compared to a world average of 2.5). The fertility preference of Nigerian women is closely related to the number of living children. Despite the decline in childhood deaths, fertility rate has reduced partly due to the family planning prevalence rate and the high unmet need for contraception (Babalola & Fatusi, 2009). According to WHO data published in 2015; the life expectancy at birth was estimated at 54.5 years (WHO, 2015). The health system in Nigeria is largely driven by the public sector (Okpani & Abimbola, 2015). The national government's health expenditure per capita and budget allocation to reproductive health are low. The healthcare infrastructures and manpower are grossly inadequate, with most of the available healthcare resources located in urban areas. Healthcare financing is mainly through personal income or out-of -pocket payment (World Bank, 2015).

Health is inaccessible to majority of the population (UNICEF, 2012). Most people seeking healthcare services patronize traditional healers or unorthodox healthcare providers. Women in Nigeria face numerous reproductive health challenges such as an unacceptably high maternal mortality rate (MMR), high unmet need for contraception, infertility, human immunodeficiency virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) epidemic and so on. Interestingly, wide disparity in women's reproductive health exists between different geographical zones within Nigeria due to social, cultural, environmental and physical factors (Ladipo, 2008). Until quite recently, reproductive and sexual rights were considered by most Africans as issues for discussion only by 'queers' and liberal feminist groups (Aniekwu, 2006). The typical traditional African values and societal norms view reproduction and sexual practices as very private issues not meant for public discussion. Thus, it was more or less a "sacrilege" to advocate for sexual rights, safe abortion and reproductive choice. Cultural practices like female genital mutilation (FGM) are accepted by many societies and the practice is not considered harmful or illegal by many. Many aspects of reproduction such as safe motherhood and family planning services were not regarded as 'rights' per se (Aniekwu, 2006). It is against this background that this study seeks to assess the reproductive health care services for women in Lokoja, Nigeria.

Statement of the Problem

High maternal morbidity and mortality rate is a huge public problem in the developing countries of the world, including Nigeria. The maternal mortality rate in Nigeria is 630 deaths per thousand live births and Nigeria ranks 10th position in the World record of health indicators (Criminal Investigation Agency World Fact book, 2012). With an estimated 52,000 annual deaths, Nigeria accounts for about 10 percent of all maternal deaths, globally and has the second highest mortality rate in the World, after India. It is also reported that, for every woman that dies from pregnancy-related causes, 20 to 30 more will develop short- and long-term damage to their reproductive organs resulting in disabilities such as obstetric fistula, pelvic inflammatory disease, a ruptured uterus, etc. (World Health Organization (WHO), 2007; Shiffman & Okonofua, 2007). Despite the existence of national programs for improving maternal and child health in Nigeria and Kogi State, maternal mortality and morbidity continue to be high. Studies suggest that the majority of maternal deaths can be prevented or reduced if women have access to or visited maternal health services during pregnancy, childbirth and the first month after delivery (Dayaratna, Winfrey, Hardee, Smith, Mumford, McGreevey, Sine & Berg 2000; WHO, 2004; Federal Ministry of Health, 2005).

However, many women in developing countries do not have access to maternal healthcare services. The use of such services remain low in sub-Saharan Africa including

Nigeria and Lokoja in Kogi State (Babalola & Fatusi, 2009); where only 58 percent of women have attended at least one maternal clinic during pregnancy, 39 percent of births are attended to by skilled professional, 35 percent of deliveries take place in a health-facility and 43.7 percent receive postnatal care (WHO, 2012). Kogi state health system, like that of Nigeria as a whole, is failing to guarantee even the most basic health services to citizens, especially the poor and vulnerable. Maternal health indicators have remained below the country and the state targets including the Millennium Development Goals have recorded very slow progress over the years. Most women, particularly pregnant women, cannot afford health services. Many of the local health centres and the rural clinics are not functional and those that are open to the communities are poorly equipped with facilities and poorly staffed. Typical rural health centres often have not more than one nurse at any given time and there are no doctors. The nurse is forced to act as doctor. In serious cases, patients are referred to bigger hospitals in towns or cities or at time their referrals are delayed primarily because of the absence of a competent or qualified doctor to do so. Private specialist services are extremely costly and are not easily affordable by the average woman. Most Public hospitals are general hospitals. (Mukhtar, 2018).

Objectives

The aim of this study was to assess the challenges and prospects of reproductive healthcare services for women in Lokoja Metropolis, Nigeria. Specifically, the objectives of this study were to:

(i) Ascertain the state of women reproductive healthcare services in Lokoja Metropolis, Nigeria.
(ii) Determine whether women have access to reproductive healthcare services in Lokoja Metropolis, Nigeria.
(iii) Identify the challenges facing women access to reproductive healthcare services in Lokoja Metropolis, Nigeria.

Literature Review

The Concept of Reproductive Health Services

Reproductive health services embrace the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as other methods of their choice for reduction of fertility which are not against the law, the right to appropriate health services which will enable women go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. Reproductive health services are the constellation of methods, techniques and services that contribute to reproductive health and wellbeing by preventing and solving reproductive health problem (Atsenuwa & Aniekwu, 2007; Gbadamosi, 2007). The scope of reproductive health covers a wide range of services including, family planning counselling, information, education, communication and services, education and services for antenatal care, safe delivery and post–natal care, and infant and women's health care; prevention and treatment of infertility; prevention and treatment of infections, sexually transmitted diseases, including HIV/AIDS; breast cancer and cancers of the reproductive system, and other reproductive health conditions (ICPD, 2000).

According to report by International Conference on Population and Development (2000) reproductive rights embrace certain human rights that are already recognized in national laws, internal human rights document and other census document. These rights rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes

their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community (ICPD, 2000). Thus the essential elements of a comprehensive reproductive health package are: comprehensive sexuality education, access to contraception, safe abortion, maternity care, and diagnosis and treatment of sexually transmitted infections (STIs), including HIV, diagnosis and treatment of breast and cervical cancers and other cancers that affect the reproductive system. According to International Women Health Coalition (IWHC, 2008), this package of services enable girls and women to decide whether and when to get pregnant, to decide whether to carry a pregnancy to term, and to experience pregnancy and childbirth safely.

Components of Reproductive Healthcare

Maternal Health refers to the health of women during pregnancy, childbirth and the postpartum period (WHO, 2000). It implies safe motherhood and reduction of maternal mortality and morbidity through the provision of maternal health services in the context of primary health services based on the concept of informed choice, including education, information and safe abortions (Aniekwu, 2002). The management science for Health (MSH, 2006) has listed the scope of maternal health as follows: (a) prenatal care, safe delivery essential obstetric care, (b) prevention and management of infertility and sexual dysfunction in both men and women (c) prevention and management of complications of abortion and provision of safe abortion services where the law so permits (d) treatment of reproductive tract infections especially sexually transmitted infections (STIs) including HIV infections and Acquired immune deficiency syndrome (AIDs) (e) ensuring adequate family planning service delivery and post-abortion (MSH, 2006).

Andersen Behavioural Model (ABM)

This study adopted the Andersen's Health Behavioural Model to explain the challenges and prospects of the utilization of healthcare delivery services by women in Lokoja, Nigeria. The model was propounded by Ronald M. Andersen in 1968 to empirically test hypotheses about inequality of access to health services in the USA. The theory is based on the assumption that individual's use of health services is a function of their predisposition to use services (predisposing factors), as well as their need for health care (illness level). According to Andersen and Newman, (1968, cited in Ricketts & Goldsmith 2005) patient's illness level (representing the need factor) is considered the major determinant of health care utilization. The theory addresses the concern that some sectors of society- in particular people from ethnic groups. That is people who live in inner cities and people who live in rural areas-receive less health care provision than the rest of the population (Andersen, & Newman, 1973), Andersen's model views access to services as a result of decisions made by an individual, which are constrained by their position in society and the availability of health care services. The model contains three sets of predictive factors. It assumes that a sequence of factors determine the utilization of health services.

However Andersen's Health Behavioural Model analyses access to health service utilization from a socio-demographic perspective. This tallies with the objective of this study; hence the study was conducted based on Andersen's model and is explained below. Anderson' (1968) Health Behavioural Model assumes that certain characteristics contribute to, or determine an individual's access and utilization of health services. He divided these characteristics into three categories, and proposed that access and utilization of health services is dependent on**:**

- Predisposing Characteristics

- Enabling Characteristics
- Need based Characteristics

Predisposing Characteristics: It is postulated that some women are more likely to use services than others and this likelihood can be predicted by individual characteristics. Women that possess certain characteristics have been found to be more disposed towards health services use, even though these characteristics are not directly responsible for the utilization. These characteristics include demographic factors, such as sex, parity and age, social structural factors, which is a reflection of the woman's social standing or status and is measured by characteristic such as educational attainment and occupation of the head of the family; and attitudinal -belief factors, where individuals who have stronger faith in the efficacy of treatment are more inclined towards healthcare utilization (Anderson & Newman, 2005).

Enabling Characteristics: These are resources a woman need in order to actualize health services utilization even in the presence of predisposing factors. These resources are defined as enabling as they make health services available to the individual and are found at the family and community levels. Family resources include income, health insurance coverage and location of residence (Andersen, & Newman, 2005). Family income is an important enabling factor as it determines the amount of funds available to an individual to cover healthcare and related cost, e.g. physician consultation, transportation costs, resources at the community level include the number of health facilities and health personnel available for use to an individual.

A greater number of health facilities and personnel reduce the unpleasantness of queuing-up for limited services and might be used more frequently by individuals. Community level resources also include the nature of the area where an individual resides, i.e. region of the country or whether residence is in the urban/rural area. This is because local norm and values influence individual's behaviour towards the practice of medicine (Anderson &Newman, 2005).

Need-based characteristics : Measures of this characteristics include perceived needs i.e. the perception of illness and its severity or the probability of an illness occurring; and needs as evaluated by health professional (Burgard, 2004; Anderson& Newman 2005). A woman's needs for care may be influenced by past experience in pregnancy and childbirth or personal preference. Thus, perceived need serves as a stimulus for the use of health services. Perceived illness can be measured by the number of disability days, and symptoms experienced by the individual during a specified time frame (Anderson & Newman, 2005).

Methodology

This study was conducted in Lokoja Metropolis between May and July, 2018. The study used the survey research design. Lokoja population according to the 2006 National population census figure stood at 169, 829. The simple random sampling technique and stratified sampling technique were employed in the selection of sample. In the first stage, Lokoja Metropolis was divided into four (4) council wards Ganaja I and II, Lokoja I and II wards respectively. One hundred and twenty respondents (women of reproductive age) were selected randomly from selected wards. Lastly, civil society organizations involved in Reproductive Health Advocacy and Health professional workers were identified. Two (2) key informants were selected randomly from the council wards. Where there were no Civil Society Organisations (CSOs), informants comprising mainly of nurses and social workers were selected from each of the 4 council wards bringing the total number of key informants to four (4). The quantitative data generated from the field through structured questionnaire was analysed using the Statistical Package for Social Sciences (SPSS) data base programme. The results were presented in simple frequency tables and percentages, while the qualitative data

gathered via In-depth Interview (IDI) was analyzed descriptively to support the quantitative aspects of the findings.

Results:

Table 1: Distribution of the Socio-Demographic Characteristics of Respondents

Variable	Category	Frequency	Percentage (%)
Sex	Female	110	100.0
Age	15-25	34	30.90
	26-35	45	40.90
	36-45	25	22.70
	46 & above	6	5.50
Marital Status	Married	103	93.70
	Divorced	4	3.60
	Widowed	3	2.70
Educational Status	No Formal	43	39.10
	Primary	16	14.50
	Secondary	29	26.40
	Tertiary	22	20.00
Occupational Status	Unemployed	51	46.40
	Student	22	20.00
	Business	22	20.00
	Civil/Public Service	15	13.60
Religion	Islam	23	20.90
	Christianity	87	79.10
No. of Children	1	15	13.60
	2	14	12.70
	3	21	19.10
	4	14	12.70
	5	46	41.80
Total		**110**	**100**

Source: Field Survey, 2018.

Table 1 shows the socio-demographic characteristics of the respondents. Results indicated that all the respondents who participated in the study were females. Majority of them 45(40.90%) were within the age of 26-35 years, 34(30.90%) of the respondents were between 15-25 years of age; 25(22.70%) of the respondents were between 36-45 years of age, while the remaining 6(5.50%) of the respondents were aged 46 years and above. From this finding, it implies that majority of the respondents who fell within the age bracket of 15-25, 26-35 as well as 36 and slightly above were all in their active reproductive years and hence the need for the access and use of reproductive healthcare service in Lokoja. Furthermore, the table revealed that majority of the respondents representing 103(93.70%) were married, 4(3.60%) were divorced, 3(2.70%) of the respondents were widowed. Also, a few of the respondents constituting 43(39.10%) of the entire respondents had no formal education, 29(26.40%) had secondary education, while the remaining 16(14.50%) had primary education. Findings revealed that most of the

respondents may not be aware of reproductive healthcare services that are available in Lokoja given the level of illiteracy among some women in the study area.
Additionally, the table equally indicated that most of the respondents representing 51(46.40%) were unemployed, 22(20.0%) of the total respondents were students, 22(20.0%) were into various kind of businesses, while the remaining 15(13.0%) were in the civil/public service. Findings indicates that 46.40% of the women who took part in this study had no formal education which leaves them with little or no employment opportunities and thereby affected their purchasing power in relation to reproductive healthcare services in Lokoja.

Majority of the respondents constituting 87(79.10%) practiced Christianity, while the remaining 23(20.90%) were Muslims. This implies that more Christians than Muslims were involved in the study and which could be responsible for the level of reproductive healthcare utilisation in Lokoja by the respondents. On the number of children by respondents, most of them representing 46(41.80%) had five (5) children, 21(19.10%) reported having three (3) children, 15(13.60%) expressed having a child, while the remaining 14(12.70%) said they had two (2) and four (4) children respectively. This indicates that more women had five (5) children than every other respondents who participated in the study and which probably means that there is the huge need for the utilisation of reproductive healthcare services by women in Lokoja.

Table 2: The State of health and availability of Reproductive Healthcare Services for women in Lokoja Local Government Area

State of health	**Frequency**	**Percent (%)**
High	15	13.6
Moderate	78	70.9
Low	8	7.3
Not sure	9	8.2
Total	**110**	**100.0**

Source: Field Survey, 2018.

As shown on Table 2, majority of the respondents (78 or 70.90%) expressed that availability of reproductive healthcare services for women in Lokoja were moderate, 15(13.6%) reported that health services available in Lokoja were high, a few 9(8.2%) were not sure of the state of health in Lokoja among women, while a few others representing 8(7.3%) of the respondents noted that the state in Lokoja was low. Given their views on the state of availability of reproductive healthcare, some interviewees while corroborating the above findings were of the opinion that the state of reproductive healthcare services for women in Lokoja is moderate (good) while others were of the opinion that the state of maternal health services in Lokoja is poor.
A Matron in Lokoja general hospital said:

> the state of women reproductive healthcare services here in Lokoja is good because most of the women attend hospital services to access the services available except those in the interior aspect of town that may not want to access the services because of ignorance (IDl/Female/Matron/July 8/2018)

More so, another interviewee reported in simply terms:

> The state of reproductive healthcare services for women in Lokoja is moderate."(IDI/Female/Civil Service/July10/2018)

However, other interviewees lamented the state of reproductive health in Lokoja L.G.A. One of them, a medical director in one of the hospitals in Lokoja noted:

> There is still much to be expected than desired. The state has not gotten to what is called 'optimal basic working efficient care (IDI/Female/Unemployed/July 10/2018)

Table 3: Women's knowledge of the health centres in Lokoja

Knowledge of Healthcare Services	**Frequency**	**Percentage (%)**
Yes	63	57.27
No	47	42.73
Total	**110**	**100.0**

Source: Field Survey, 2018.

Table 3 showed that majority of the women in Lokoja constituting 63(57.27%) are highly knowledgeable of the existence and availability of reproductive healthcare services (centres) in Lokoja, while the remaining 47(42.73%) of the entire respondents reported not being aware of the availability of healthcare centres in Lokoja. This implies that a little less than a half of the respondents were probably not utilizing reproductive healthcare services because they were not aware of the availability of these services.

Table 4: Reproductive healthcare service available for women in Lokoja Metropolis

Health services	**Frequency**	**Percent (%)**
Antenatal, postnatal, treatment of STDs.	36	32.7
Antenatal, family planning, and use of contraceptives	16	14.5
Antenatal, delivery services and immunization	48	43.6
Antenatal	6	5.5
Postnatal and delivery services	4	3.6
Total	**110**	**100.0**

Source: Field Survey, 2018.

Table 4 indicates that many of the respondents 48(43.60%) reported the types of reproductive healthcare services that are available in Lokoja local government as antenatal, delivery and immunization services while 4(3.60%) opined postnatal and delivery services.

All the interviewees agreed to the services available to women. One of the interviewee mentioned:

> Prenatal, antenatal, postnatal, immunization, family planning, post-abortal care, treatment of sexually transmitted diseases, give advice, and use of contraceptives on the health of women within the vicinity (IDI/Female/Lokoja Resident/July 20/2018).

Table 5: The level of women's access to reproductive health care service in Lokoja Local Government Area

Respondents view	Frequency	Percent (%)
High	19	17.3
Moderate	71	64.5
Low	20	18.2
Total	**110**	**100.0**

Source: Field Survey, 2018.

Table 5 indicate that majority (71 or 64.50%) of the respondents rated access to reproductive health as being moderate, while 19(17.30%) said it was high.

All the interviewees agreed that women in Lokoja have access to reproductive health care services. One of them noted:

> Women in Lokoja have access to reproductive healthcare services because there are hospitals around such as federal university clinic, comprehensive hospital and general hospital. It is available and affordable and within the geographical location of all the women except for those that don't attend the services for reasons best known to them however more should be done on the healthcare system (IDI/Female/Lokoja Resident/ July 26/2018)

Another interviewee added:

> Yes to what is available, but there should be more available healthcare services for women(IDI/Female/Student/July 27/2018)

Table 6: How the women perceive the cost of transportation to the Reproductive Health Centers in Lokoja

Cost of transport	Frequency	Percent (%)
High	26	23.6
Moderate	57	51.8
Low	27	24.5
Total	**110**	**100.0**

Source: Field Survey, 2018.

Table 6 explains that there is moderate cost of transportation to the reproductive healthcare centers in Lokoja locality as perceived by majority of the respondents 57(51.80 percent), others 27(24.50 percent) rated it as low.

Table 7: Respondents' Views on who takes health decision in the family

Health decision	Frequency	Percent (%)
My husband	75	68.2
Wife	5	4.5
Husband and wife	27	24.5
Relatives	3	2.7
Total	**110**	**100.0**

Source: Field Survey, 2018.

The finding of this study also show that the husbands of the women in Lokoja take most health decisions in their families as expressed by over 75(68.20%) of the respondents. In some families, however, it has been found that both wives and their husbands jointly take health decisions in the families, a view expressed by over 27(24.50%), wives 5(4.50%) take health decisions and other few 3(2.70%) decisions are made by relatives of the women respondents.

Table 8: Respondents' Views on Who pays for maternal health care Services in the family in Lokoja LGA

Health payment	Frequency	Percent (%)
Wife	4	3.6
Husband	86	78.2
Wife and husband	20	18.2
Total	110	100.0

Source: Field Survey, 2018

The above table revealed that majority 86(78.20%) of the respondents reported that their husbands pay for maternal healthcare services. In few other families, however both wives and their husbands 20(18.20%) jointly pay for maternal healthcare services with a few respondents saying that it is the wife that pay (4 or 3.60%).

Table 9: factors limiting women's easier access to reproductive healthcare service in Lokoja Metropolitan

Limiting factors	Frequency	Percent (%)
Financial constraints and dependency on husbands	44	40.0
Husbands restrictions of their wives	7	6.4
Ignorance	31	28.2
Social cultural factors	13	11.8
Inadequate basic amenities	15	13.6
Total	**110**	**100.0**

Source: Field Survey, 2018

Table 9 indicates that majority of the entire respondents constituting 44(40.00 %) reported financial constraint and dependency on their husbands, others 31(28.20 %) identified ignorance,

and inadequate basic amenities 15(13.60 %) and a few (7 or 6.4 %) identified husbands restriction as a factor. A few others (13 or 11.60 %) reported social cultural factors as limiting women's easier access to reproductive healthcare services.

According to a midwife who agreed that there are factors limiting women's easier access to reproductive healthcare services:

> Some women have the knowledge and are willing to attend hospitals but their husbands wouldn't allow them. Financial constraints also prevent some women from coming to the hospital because their husbands would say they don't have the money to foot their bills justifying this on the basis that even their great grandparents give birth at home requiring only the services of traditional birth attendants. At times, some women don't come to the hospitals until there are complications blaming this on poor road networks and lack of means of transportation especially for those in the rural areas. Ignorant is also a factor that limits women's easier access to reproductive healthcare services. Again, the health care providers don't cover all areas in Lokoja (IDI/Female/Midwife/July 29/2018).

In a similar a doctor explained:

> Socio-cultural factors where most women don't come to the hospital without the permission of their husbands, most women don't have self dependency, and this is a limitation. They still depend on solidly on their husbands for money to attend hospital for delivery and other services. The belief that a woman who gives birth in the hospital is a weakling hence they prefer delivery at home especially those in the villages. There is also the issue of financial constraint. Class difference canalso constitute a limitation e.g the belief that a particular hospital is meant for the rich (IDI/Male/Medical Doctor/July 29/2018).

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Discussion of Findings

A hundred and ten (110) respondents participated in the study. The results indicated that most of the respondents were aged between 26-35 years, while about a few were in the age bracket of 15-25 years, and a few others fell within the age of 36-45 years and those aged 46 years and above represented a very little of the entire respondents. From the above findings, implies that most of the respondents were within their active reproductive years and why the need to access and utilize quality reproductive healthcare services in Lokoja. Majority of the respondents were married, and represent responsible women who were expected to have had the needed experience of access and use of reproductive healthcare services, a few of them were divorced, while other few were widowed. Most of the respondents were unemployed; a few of them were still studying as students, and were into business, while others were in the

civil/public service. The findings imply that unemployment could be part of the challenges or factors being faced by majority of the respondents constraining them from easily accessing reproductive healthcare services in Lokoja. Also, findings revealed that most of the women had no formal education, less than half had primary education, a few others had secondary education, a few had tertiary education. Findings indicate that most of the respondents had no formal education. This can account for the slightly poor level of utilisation of reproductive healthcare services in Lokoja. Majority of the respondents were Christians, while the remaining few were Muslims. This implies that drawing from the religious belief of the large chunk of the respondents, probably, reproductive healthcare services may not be adequately utilised in Lokoja. Again, most of the respondents had five (5) children, some of the respondents had four (4) children, a little less than half had three (3) children, a few others had between two (2) children, and one (1) child. From the findings, it implies that most of the respondents had one form of challenge or another over time during delivery to be able of forming opinions that could be expressed in the study.

This study set out to first, ascertaining the state of women reproductive healthcare services in Lokoja Metropolis, Nigeria. Second, determining whether women in Lokoja Metropolis have access to reproductive healthcare services, and third, identifying the challenges facing women access to reproductive healthcare services in Lokoja Metropolis, Nigeria. As regards the state of women reproductive healthcare services in Lokoja Metropolis, it was discovered that majority of the women reported that the state of reproductive healthcare services to them is slightly moderate, with a few others stating that is very low. This findings supports the ones provided by (Mukhtar, 2018; UNICEF, 2012; Babalola & Fatusi, 2009)., who observed that Kogi State health system, like that of Nigeria, is failing to guarantee even the most basic health services to citizens, especially the poor and vulnerable since health is inaccessible to majority of the population and that most women, particularly pregnant women cannot afford health services. Use of such services remain low in sub-Saharan Africa including Nigeria and Lokoja. Maternal health indicators have remained below the country, many of the local health centres and the rural clinics are not functional and those that are open to the communities are poorly equipped with facilities and poorly staffed. Typical rural health centres often have not more than one nurse at any given time and there are no doctors.

On the challenges facing women access to reproductive healthcare services in Lokoja, Metropolis, Nigeria. This study discovered that most of the respondents reported financial constraints, and dependency on their spouses, others identified ignorance and inadequate basic amenities as well as socio-cultural factors as limiting their easier access to these services in Lokoja. This findings corroborates one by the World Bank, (2015); Ladipo, (2008) who stressed that women seeking healthcare services in Nigeria face numerous challenges such as unacceptably high maternal mortality rate (MMR), high unmet need for contraception, infertility, human in the health infrastructure and manpower are grossly inadequate. Furthermore, findings shows that majority of the women in Lokoja had knowledge of the existence of and available healthcare centres in Lokoja, while the remaining few reported not having knowledge of reproductive healthcare services available in Lokoja. This probably accounts for why there is low level of utilisation of the reproductive healthcare services made available by Kogi State government in Lokoja.

Findings further indicates that majority of the women respondent listed the types of reproductive healthcare services that are available in Lokoja as antenatal, delivery and immunization services, while a few others listing antenatal ,postnatal, treatment of STDs, postnatal, and delivery services. This findings is in line with the views of the (Atsenuwa & Aniekwu, 2007; Gbadamosi, 2007; Federal ministry of health, 2001; ICPD, 2000). Observed that the scope of reproductive health covers a wide range of services, These services according

to them include; family planning counselling, information, education, communication and services, education and services for antenatal care, safe delivery and post–natal care, and infant and women's health care; prevention and treatment of infertility; prevention and treatment of infections, sexually transmitted diseases, including HIV/AIDS; breast cancer and cancers of the reproductive system, and other reproductive health conditions; and active discouragement of harmful traditional practices, such as female genital mutilation.

Finally, results showed that majority of the women in Lokoja have been using the available healthcare centres in the locality for delivery while a few others have not been using the healthcare services for delivery. This implies that the available health care centres in Lokoja, have given most women in the locality easy access to reproductive healthcare services as found in this study. Many women who have not been using the healthcare centers available in Lokoja for delivery did not because they don't believe in delivering in the hospital. A few others choose not to deliver in the hospital due to the fear of their time been wasted while delivering in the hospital. This findings agrees with one provided by (UNICEF, 2012), observed that health is inaccessible to majority of the population and hence most women seeking healthcare services patronize traditional healers or unorthodox healthcare providers.

Conclusion

This study assessed the challenges and prospects of reproductive healthcare services for women in Lokoja, Metropolis, Nigeria, Results of the study that the state of healthcare services and availability of maternal healthcare in Lokoja is moderate. The respondents in the area are aware of the maternal healthcare services at their disposal. This therefore implies that, due to the fact that the population of the study is informed, most women in the area of study were likely to access the services and this can consequently help to reduce maternal health problems within the area. The study found out that women in Lokoja have access had some access to maternal healthcare services in Lokoja Metropolis but were not adequately utilizing these services due a handful of reasons. Husband's (men) played a major role in health decision making of most healthcare services use and payment of maternal health bills for their wives. Majority of the respondents were not educated which means most of the women are illiterates and accounts for the low use of reproductive healthcare services in Lokoja Metropolis. The findings revealed that factors like., financial constraints, unemployment among women, husband's restrictions, ignorance, social cultural factors and inadequate basic amenities among others were responsible for low use of healthcare services.

Recommendations

Based on the Findings of the study, the following recommendations are suggested:

1. The level of illiteracy is very high amongst the women, health workshops and seminars should be organized by the government at the local government and state level to enlighten and sensitize the women on health care utilization. Nongovernmental organizations (NGOs) which are concerned with health related issues also have vital roles to play in organizing seminars and workshops geared towards health care utilization.
2. The professional healthcare givers like nurses, doctors and traditional birth attendants should be sent on further studies and retraining programmes to acquire the requisite knowledge of healthcare utilization practice to be better poised to provide qualitative services to health users within Lokoja Metropolis to ensure that every woman have access and utilizes maternal healthcare services.
3. The government at the local, state and federal levels, should as a matter of urgency create and improve road network within for easy access to healthcare facilities, and utilization by women.

4. The ministry of health in conjunction with other agencies should embark on the renovation of existing health care structures and also equip them with modern and state of the arts equipment for better health care delivery as well as provision of adequate and skilled manpower.
5. The study also recommends that District and Religious heads should be involved in the dissemination of information to women concerning health care utilization for health facilities located in theie community.

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