SOCIAL FACTORS AFFECTING MATERNAL AND CHILD HEALTH CARE SERVICES IN ENUGU EAST LOCAL GOVERNMENT AREA, ENUGU STATE, NIGERIA

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Abstract

Maternal and child health care services involve the care given to a woman during pregnancy and after birth as well as her child. This study scrutinized social factors affecting maternal and child health care services in Enugu East Local Government Area, Enugu State, Nigeria. The theoretical framework for the study is symbolic interactionist theory. Cross sectional survey design was adopted. The study participants were mothers of child bearing age (15-49) residents of Enugu East Local Government Area. The sample size was 400 respondents. Multi-stage sampling procedure was used in the study. The major instruments of data collection used were questionnaire and In Depth Interviews (IDI) guide. Quantitative data were processed using Statistical Package for Social Sciences (SPSS) and analyzed using percentages and frequency distribution tables. Qualitative data were provided from the transcription of the electronic recorded interview and field notes and analyzed using manual thematic content analysis technique. Findings of the study indicate that there is adequate provision and underutilization of maternal and child health care services in Enugu East Local Government Area. It also found some social factors affecting maternal and child health care services such as: income, accessibility/availability, education, place of· residence, employment and gender inequality. The study recommends that accessibility/availability of health care services should be ensured by the government and nongovernmental organizations. The free maternal and child health care policy established by government should be properly implemented to be effective in all the communities (both urban and rural). .

*"**Key Words:** Social factors, maternal health, maternal/child health care services, utilization of health care, provision of health care*

Introduction

Pregnancy is one of the most important events that constitute a powerful experience in the lives of women and their families (Asrat, Ayal & Demiss, 2020). In Nigeria, pregnant women and their children face unique barriers in obtaining adequate health care. Such barriers prevent access to care and create health disparities leading to poor health and maternal and child mortality. The centre point of health care services in Nigeria is Primary Health Care (PHC). It addresses the most common problems in the community by providing preventive, curative and rehabilitative services to maximize health and wellbeing (World Bank, 2011). In primary health care provision, the essential maternal" health care services during pregnancy include Antenatal Care (ANC), skilled attendant at

delivery and postpartum care and these are necessary to promote good health. To prevent unwanted outcome of pregnancy, ANC is the most important method for detecting pregnancy problems in the early period. Unfortunately, this care is not utilized in developing countries including Nigeria (WHO, 2007, Agu s& Houriuchi, 2012).

Maternal health care is discussed in conjunction with child health care because neonatal outcomes are inextricably linked to maternal health and therefore, the quality of care a mother receives during labour, delivery and in the immediate postpartum period, determines the health of her baby (Austin, Langer, Salam, Lassi, Das & Bhutta, 2014). Health status of children in a nation is a highly reliable index of the populations' health. What is done for children today, especially at their younger age will in large part determine the course of the future of the country and its future citizens. In developing and developed countries, children should therefore be placed at the centre stage in all developmental thinking and implementation (Mesfin, 2003).

Throughout the world, especially in developing countries, there is an increasing concern and interest on maternal and child health care. The International Conference on Primary Health Care, held in Alma Ata, Kazakhstan in 1978 came up with "Alma Atta Declaration" provided the platform for the mobilization of primary care movement of professionals and institutions, government, civil society groups etc that took it upon themselves to tackle the politically, socially and economically unacceptable health inequalities (Federal Ministry of Information, 2014). Also, the commitment towards maternal and child health care gained further strength after the World Summit for Children in 1991 which gave serious consideration and outlined major areas to be addressed in the provision of maternal and child health care services (Mesfin, 2003). Furthermore, the International Conference on Population and Development (ICPD) held at Cairo in 1994 gave a new impetus to reducing maternal mortality by bringing the issue of reproductive health to fore. The ICPD Programme of Action called for the provision of information on reproductive health service to promote the increased use of health services for antenatal and delivery care (United Nations 1995). Again, since the 1995 conference on women development in Beijing, the 1995 social summit in Copenhagen which dealt on the need for better health for women has been recognized and a number of efforts have been made towards that. For instance, the theme of the World Health Day 2005 was "healthy mother and children" (WHO 2005, Arlette, Merrick &Yazbeck, 2006).

In Sub Saharan Africa, more than 7 million newborn deaths are believed to result from maternal health problems and their mismanagement (Mesfin, 2003, Cockburn &Mariara, 2010). An estimated three quarter of all health care in Africa takes place at home where women particularly in their roles as mothers, generally have responsibility for promoting their family's health and nutrition source. In Nigeria, the mother's health seeking

behaviour plays a pivotal role in the timely seeking of health care for their children as they are prime care givers (Ghosh, Chakrabarti, Chakraborty & Biswas, 2013).

Over 585,000 women worldwide needlessly die yearly at childbirth. The situation is especially severe in sub-Saharan Africa (WHO, UNICEF, UNFPA, World Bank & United Nations Population Division, 2014). Unfortunately, Nigeria has one of the highest maternal mortality rates in the world. According to WHO Report, on trend in maternal mortality. rate:' '1990-2013', Nigeria is classified as one of the ten countries of the world that contribute about 60% of the world's maternal mortality burden. Though Nigeria currently has a maternal mortality ratio of 560 per 100.000 live births the ratio improved slightly, moving from 630 per 100.000 recorded in 2010. Cumulatively, on every 1000 children born with success, 194 of them might be committed to mother earth within three to five years of their births (WHO et al, 2013).

Some social factors affecting maternal and child health care services include: education, income (poverty) employment, accessibility, availability and affordability of health care services etc. According to Asrat (2020), educated women were 2.9 times more likely to get good quality prenatal care services than women with no formal education. The possible justification might be that education enables women to easily understand the importance of prenatal care services and empowers them to decide their health care service utilization. Similarly, educated women are better able to fully take all prenatal care services since they have good knowledge and favorable attitude towards prenatal care.

Some studies have shown that utilization rate increases substantially with increasing income. Low income reduces women's use-of maternal health care services and keeps millions of women from seeking care even when complications arise. Even when formal fees are low or non-existent in health facilities, there may be informal fees or other costs that pose significant barriers to women's use of services (Fenta, 2005). The costs of seeking healthcare may include costs for transportation, user fees (official and/or unofficial), medications and other supplies. Women from poor families or those with limited financial resources may have difficulty paying for such costs and are likely to be deterred from using maternal health care services (Gabrysch& Campbell, 2009). The context within which women are employed influences their access to maternal health care services. It is generally assumed that women who are working and earning money will have better autonomy and the financial ability to pay for services (Adamu, 2011).

In Enugu state (Enugu East Local Government area inclusive), the state government has established Free Maternal and Child Health Care (FMCHC) initiative to deliver free medical care to pregnant women and children. This provision is available in the primary health facilities in Enugu. However, despite the determined efforts towards improving

maternal and child health care, especially in rural areas, much still remain to be done with regards to maternal and child health care particularly in Enugu East Local Government Area. It can be observed in this area that maternal and child health care services are influenced by socioeconomic factors which is the basis for this study. The study, therefore, focuses on social factors affecting maternal and child health care services in Enugu East Local Government area of Enugu State.

Objectives of the Study
Objectives of this study include

1. To examine the extent to which maternal and child health care services are provided in Enugu East Local Government Area.
2. To investigate the extent to which maternal and child health care services are utilized in Enugu East Local Government Area
3. To identify the social factors affecting maternal and child health care services in Enugu East Local Government Area.

Brief Review of Relevant Literature
Maternal Health
In the Western world, health is often spoken of in the sense of ill health, i.e. as a pathological condition that can be verified by clinical examination. However, health is actually a multidimensional state and the conceptualizations of health vary from country to country and even from person to person. Recognizing these multiple dimensions, WHO defines health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease and infirmity".(Winkvist, 1995).

In medical terminology, the term maternal health is simply understood as pregnancy related health. The health of the mother has profound effects on the health of her children. The effects are most noticeable during pregnancy but persist throughout the child's life. Three different types of indicators have mostly been used to describe maternal health. These include; maternal mortality, morbidity for selected illnesses and nutrition related problems during pregnancy (Bergstrom & Goodburn, 2001).

Maternal mortality still remains a burden to health care system especially in the developing world. Maternal Mortality Rate (MMR) is expressed as the number of maternal deaths per 100,000 live births whereas maternal death is defined as the death of a woman while pregnant or within forty-two days of termination of pregnancy, irrespective 'of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental causes (WHO, 2005). WHO has been advocating for improvements of maternal health through safe motherhood initiative. Safe motherhood initiative was developed in 1987 in Nairobi, Kenya at an international consortium of

United Nation 'agencies, governments, non-governmental organizations as well as donors in response to the escalating levels of maternal and infant morbidity and mortality in most developing countries. Its main aim was to ensure that most pregnancies and deliveries are handled safely both at the community and' health facility level in an act to reduce maternal deaths by 70% from 1990 to 2015 (WHO, 2012). Although, most maternal and infant deaths can be prevented through safe motherhood practices, millions of women worldwide are still being affected by maternal mortality and morbidity from preventable causes (Banda, 2013).

Maternal/Child Health Care Services

Maternal/child health care seeks to address the high risk that women in many contexts face in relation to child bearing. It emphasizes the need for pregnant women to receive adequate prenatal care that protects them against avoidable complication of pregnancy and allows them to undergo a safe delivery and to receive adequate post natal care (Mesfin, 2003). Family Planning (FP), Antenatal Care (ANC), use of skilled delivery attendants and Postnatal Care (PNC) services are key maternal health services that can significantly· reduce maternal mortality. Evidence shows that high maternal, neonatal and child mortality rates are associated with inadequate provision and poor quality maternal health care. Moreover, evidences also show that skilled care before, during and after childbirth saves the lives of women and newborn babies. An estimated 74% of maternal deaths could be averted if all women had access to the interventions for preventing or treating pregnancy and birth complications in particular emergency obstetric care (Tarekegn, Lieberman and Giedraitis, 2014). The major purposes of provision of maternal health services are: prevention of maternal morbidity and mortality recognition and treatment of complications as they arise and the promotion of the health of the mother and the newborn (Mesfm, 2003). As a result, family planning, the use of ANC, skilled delivery attendants and PNC are recognized as key maternal health care services to improve health outcomes for women and children (Tarekegn et al, 2014).

Nwala, Ebunoha and Ugwu (2013) in their study revealed that majority of maternal health services available are mainly antenatal [57%] and delivery services [54.3%]. In the same vein, immunization [63.8%] was the most available child health service in the area. Both maternal and child health services were available mainly at public and private hospitals [53.6% and 52.3%] respectively. About 43.3% indicated Primary Health Centers [PHC], 38.8% reported patent medicine shop, 28.0% of the women said it was available at the TBAs while 25.5% indicated that child health services were available at the pharmacy. Available maternal and child health services known to mothers in the study area were not encouraging. ANC and delivery services for mothers and immunization for children were found to be available as indicated by at least more than half of the respondents (50%).

Social Factors Affecting Maternal and Child Health Care Services (MCHS)

Family income is an important factor that affects maternal and child health care. Individuals who are employed and are therefore earning some income are in a better position to afford transport to the health unit thus decreasing maternal mortality and morbidity (Adong, 2011). Despite their earnest intentions, many a time, mothers living in the below poverty line families and in a joint family structure have to overcome various constraints before seeking preventive or curative healthcare services for their children (Ghosh et al, 2013). Studies also indicate that women whose husbands have higher status occupations are more likely to use Maternal Health Care Services (MHCS). This is because such occupations are usually associated with greater wealth, making it easier to bear the costs of health care. However, various other studies have shown that women are less likely to utilize maternal health care services when they do not have personal control over finances (Furuta & Salway, 2006; Gage & Calixte, 2006) suggesting that an interaction between autonomy and family wealth produces health services utilization. Overall, women are more likely to use health services as their economic status and autonomy level increase (Fotso, Ezeh & Essendi, 2009).

Accessibility and availability affect maternal and child health care service. The differences in utilization of antenatal and delivery services is probably a factor of accessibility of services, in combination with a range of cultural issues which influence acceptability of specific services. Service access relating to affordability is perhaps of greatest relevance to the slum communities (Magadi, n.d). The unavailability of maternal and child health care services within the reach of women is one of the basic problems in areas of low health service coverage and research, identifying causes of maternal deaths have repeatedly emphasized the need for antenatal care and availability of skilled personnel to attend to women during delivery (*Fenta, 2005*).

Even in contexts where efforts have focused on increasing access to institutional care, the expected improvements in maternal/newborn health have not materialized. In India and Ethiopia, two countries that account for one-fifth of global maternal deaths, large investments in infrastructure and provider training have not yet yielded the expected improvements in maternal and newborn health (Austin et al, 2014).

With the advent of new era, female education has come out of domestic confinements and has become an important role player in public health agenda. A similar study concluded that there was a significant association between female literacy and gender bias with regard to the health-seeking behavior of children, with illiterate women creating the gender divides more. Various other studies have argued the positive effect of maternal education on child health and survival (Ghosh et al, 2013).

Distinction between sex (biology) and gender (the social concept) is essential to this tradition of research, as it is clear that gender inequalities in health have been in the most part socially produced rather than biologically given. In India, women are placed in a subordinate position to men, the disparity being wider in rural areas. Girls are neglected and discriminated against accessing preventive and curative healthcare facilities, a low girl to boy ratio (0.93) being a proof of the differential healthcare-seeking behavior between genders (*Ghoshetal. 2013*).

Theoretical Thrust

Symbolic Interactionist Theory (SI)

Symbolic interactionism was mainly propounded by George Herbert Mead (1863-1931), Charles Horton Cooley (1902), Ervin Goffman and W.I Thomas (Ritzer, 2010). An American philosopher, Herbert Blummer was the first to coin the term "symbolic interactionism". According to him, people act towards things based on the meaning those things have for them and this meaning is derived from social interaction and modified through interpretation. Symbolic interactionism is a theory that considers interaction or sees human interaction as evolving from the interpretation of the meanings of signs and symbols and making decision on how to react to these signs and symbols.

A woman's decision to seek healthcare is not an off isolated event but a composite result of her personal needs, social forces, actions of healthcare providers and the location of services (Ghosh et al, 2013). Therefore, the experience women have about their health and that of their children is as a result of complex interaction between the individual, their perceptions of health, illness and medical profession and the views of social network that surrounds her. In other words, women attend to their health needs and that of their children, according to the understanding, perception and interpretation of the health issues at hand (Haralambros & Holbom, 2008)

Materials and Methods

The study adopted concurrent mixed methods research design. The study area is Enugu East local government area. It is made up of 15 wards, namely: lbagwa, Abakpa, Amorji, Edem, Emene, Mbulujodo, Mbuluowehe, Mbuluiyiukwu, Federal Housing, Onuagu harmony, Iji, Ugwogo, Umuchigbo and Umuenwene. However, the target population for this study is women of reproductive age (15 - 45 years). Four communities were selected through simple random sampling technique namely: Emene, Ugwogo, Ibagwa and Iji. The villages in the four selected communities were numbered and through the application of simple random sampling technique, Izziah Onuogba, Umunameze, Amangwu and Aneke Ode were selected from Emene, Ugwogo, Iji and Ibagwa respectively. Compounds in the four villages were numbered and the systematic random sampling technique was employed to select every n^{th} (N/n) compound. However, 50 compounds were selected from each of

the four villages' in the selected communities. For any compound to be eligible for the study, there has to be at least a mother whether married or unmarried. A woman was selected from each compound. Hence, a total of two hundred respondents were selected from the four villages.

To select the hospital respondents for this study, the hospitals in the selected communities were numbered and one hospital, Ugwogo Health Centre, St Mary's Maternity, lbagwa Health Centre, Annunciation Hospital were selected from each of the selected wards: Emene, Ugwogo, Iji and lbagwa respectively through simple random sampling method. Then, 50 women present in the hospital were selected using availability sampling technique from each of the selected hospitals. Thus, a total of 200 respondents were selected from the four selected hospitals. The participants for IDI were purposively selected and they included: Four (4) health workers, one from each of the selected hospital. Hence, the sample size for the study was four hundred (400). Questionnaire however forms the quantitative instrument for the study while the IDI was used to complement the quantitative data. Quantitative data were processed using Statistical Package for Social Sciences (SPSS) and analyzed using percentages and frequency distribution tables while qualitative data obtained from the In-depth Interview (IDI) were analyzed using the manual thematic content analysis technique.

Research Findings/Results

Socio-Demographic Characteristics of the Respondents

The demographic data of the study participants are presented in table 1 below:

Table 1: Distribution of Respondents by Socio-Demographic Characteristics (n=376)

Variables	Frequency (F)	Percentage (%)
Age		
15-19	4	1.1
20-24	64	17.0
25-29	152	40.4
30-34	104	27.7
35-39	44	11.7
40-44	4	1.1
45-49	4	1.1
Total	**376**	**100.00**
Marital status		
Single	24	6.4
Married	348	92.6

Widowed	4	1.1
Total	**376**	**100.00**
Occupation		
Civil servant	48	12.8
Health worker	32	18.1
Self employed	68	25.5
Apprentice	16	4.3
Farming	56	8.5
House wife	96	14.9
Trader	32	8.5
Student	12	3,2
Others (specify)	16	4.3
Total	**376**	**100.00**
Educational attainment		
No formal education	72	19.1
FSLC	80	21.3
SSCE/GCE	72	19.1
OND/NCE	68	18.1
B.Sc/HND	56	14.9
M.Sc	20	5.3
Others (specify)	8	2.1
Total	**376**	**100.00**
Income		
0-200.000	244	64.9
200,000- 400,000	44	11.7
400,000- 600,000	24	6.4
600,000- 800,000	8	2.1
800,000- 1000,000	16	4.3
1000.000 and above	40	10.6
Total	**376**	**100.00**

The table above shows that out of the 376 returned questionnaire, majority (40.4%) of the respondents were within the ages of25-29, majority (92.6%) were married while majority (25.5%) were house wives. However, a critical look at the educational attainment of the respondents indicates that majority (21.35%) of the respondents were holders of FSLC and majority (64.9%) earned income between 0-200.00.

Analysis of Research Questions

The findings of this study are thematically presented in relation to the stated research objectives:

Research Objective One: To examine the extent to which maternal and child health care services are provided in Enugu East Local Government Area.

Table 2: Respondents' Views on the Provision of MCHCS in Enugu East LGA

How would you rate the provisions of maternal and child health care services in your community?	**F**	**%**
Very high	54	14.4
High	94	25.0
Undecided	46	12.2
Very low	29	7.7
Low	75	19.9
Fair	78	20.7
Total	**376**	**100.00**

Table 2 shows that a majority of the respondents 25.0% indicated that the provision is high, while the smallest number 7.7% indicated very low. Hence, the deduction here is that maternal and child health care services are available in Enugu East LGA and its provision is adequate.

This was confirmed by the responses from the qualitative data below:

This is a well organised hospital, we provide high quality MCHCS here. We have equipment, drugs, qualified doctors and nurses who are available 24 hours every day. So, women come around anytime any day to receive quality services here and we give them special attention without discrimination. Our goal is to have a healthy mother and child before and after delivery (Female, 39 years, Health Worker, Enugu East LGA)

Research Objective Two: To investigate the extent to which maternal and child health care services are utilized in Enugu East Local Government Area

Table 3: Respondents' Views on the Utilization of ANC in Enugu East LGA

Have you ever used antental care service?	**F**	**%**
Yes	264	70.2
No	112	29.8
Total	**376**	**100.00**

If your answer is 'yes' how many times?		
Once	60	16.0
Two times	79	20.7
Three times	36	9.6
Four times	33	8.8
Five times and above	56	14.9
Total	**264**	**100.00**

Table 3 shows that 70.2% have used antenatal care services while 29.8% have not. Out of the 376 participants, 70.2% have used antenatal care services in their last pregnancy, majority of the respondents 20.7% had two contacts while the lowest number 8.8% had four antenatal contacts respectively.

This was supported by a response from the qualitative data below:
Actually, women make use of MCHCS, but a good number of them don't use it well. For instance, most of them won't register for antenatal till their third trimester. When you book appointment for them, they normally miss it because they feel that all is well with them and their baby. In order to ensure their utilization of ANC, we try to make it compulsory that a woman will attend ANC clinic at least four times before we attend to her during delivery, yet many of them will not yield to this rule (Male, 37 years, Health Worker, Enugu East LGA).

Research Objective Three: To identify the social factors affecting maternal and child health care services in Enugu East Local Government Area

Table 4: Respondents' Views on the Social factors Affecting Maternal and Child Health Care Services (MCHCS) in Enugu East Local Government Area (LGA)

Question	**Frequency (F)**	**Percentage (%)**
What is the major social factor affecting maternal and child health care services?	264	70.2
Employment	27	7.2
Place of residence	46	12.2
Accessibility/Availability	102	27.1
Education	76	20.2
Income	107	28.5
Gender inequality	12	3.2
Don't know	6	1.6
Total	**376**	**100.00**

Table 4 shows that majority 285% of the respondents identified income as the major social factor, while the smallest number (1.6%) said that they did not know.

In affirmation to the above findings, a respondent noted:
To me, one of the social factors that affect women is: education. Some mothers that are illiterate don't really understand the importance of these services to them and their baby except they are properly informed. Another one is that when the hospital is. far from the woman, such woman might likely not obtain these services easily. Again, if a woman's family is poor, it will affect her use of the services. A lot of women who would want to come to the hospital are normally discouraged because of the cost of the services. (Female, 41 years, Health Worker, Enugu East LGA).

The implication here is that there are some social factors that affect maternal and child health care services in Enugu East Local Government Area LGA such factors include: income, accessibility/availability/affordability of health care services, education, place of residence, employment and gender inequality

Discussion of Findings
Remarkable findings were made in this study. Regarding the provision of MCHCS, a majority of the respondents indicated that the provision of MCHC is high, provision is high in Enugu East LGA. This is not consistent with the findings of **Nwala et al (2003**) who ascertained that available maternal and child health services known to mothers in the study area were not encouraging. However, it is in line with Simfukwe, (2008), who found that the services provided were satisfactory. In the study of Rum un (2013), majority of the respondents also applauded the quality of the services provided for them.

The result also shows that majority have used ANC. Out of the participants that have used antenatal care services in their last pregnancy; majority of the respondents had less than four contacts. WHO recommended at least four antenatal contacts for every pregnant woman but the above findings show that women in this area use ANC but a greater percentage of them had less than four contacts, thereby exhibiting underutilization of ANC services. This is supported by previous findings by Fenta (2005) who stated that the highest number of women sought at least one ANC from modem health care providers. However, a considerable number do not make the minimal number of visits (four) as recommended by the WHO.

Next, the study found that the respondents identified income as the major social factor, this is followed by accessibility/availability of health care services, education, place of residence, employment, and gender inequality. This is supported by Brown (2010) and Fenta (2005) who asserted that certain factors may explain why women choose or do not

choose to visit hospitals, including their educational level and whether they have their own income. Occupation of the mother is an important predictor for the utilization of ANC services. In general, women with no formal job were less likely to use ANC services as compared to housewives. It is also argued that women's work in developing countries are often poverty induced and therefore likely to have negative impact on the use of their health care services as it involves opportunity and monitory costs (Adamu, 2011). Ghosh et al (2013), Ugal et al (2011) and Rumun (2013) separately identified some of these factors.

This substantiates the symbolic interactionist theory. According to the theory, being ill, seeking help and following advice or recommendation of the professionals are the result of complex interaction between the individual, their perceptions of health, illness and medical profession and the views of the social network that surrounds the people. Thus, a woman's decision to seek healthcare is not an off isolated event but a composite result of services (Haralambros et al, 2008, et al, 2013).

Conclusion

In developing nations (Nigeria inclusive) maternal and infant mortality has been a challenge that has attracted international, national and local attention. Improved provision and use of maternal health care services is a clue to reducing maternal and child mortality. However, there is adequate provision, on one hand while on the other hand, there is underutilization of these services in Enugu East LGA, due to factors such as accessibility/availability of health care services, education, place of residence, employment and gender inequality.

Recommendations

Based on the findings of the study, the following recommendations were made;

1. Government, non-governmental organizations and other stake holders should ensure the accessibility and availability of healthcare services. This can be achieved by organizing sensitization programmes especially in the rural areas which will help women to understand the need to access any available healthcare services.
2. Government, non-governmental organizations should encourage female education. The process of being a mother begins from childhood so government and non-governmental organizations should award scholarship to girls so that they will eventually grow into enlightened adults who know when, where and how to access healthcare service.
3. There is need for policy makers to engage in women centred policies and programmes not only in the urban areas but also in rural areas. This entails a call

for action both in the health sector, employment, educational sectors and other areas.

4. The free maternal and child health care policy established by government should be properly implemented to be effective in all the communities (both urban and rural). This will help women from poverty stricken families to freely access health care services when they need it without hesitation.
5. Government should identify communities where there are no health facilities in .order to construct health centres for them. On the other hand, those existing health facilities should be improved by equipping them with modern equipment, drugs and professional health workers for easy access of health care services.
6. Governmental and non-governmental organisations should create women empowerment programmes so that women will be empowered in every aspect of their lives to contribute their rich quota to the society. Evidence shows that putting economic resources in the hand of women is the best way to accelerate development and sustainably reduce poverty. Women usually invest in their communities significantly more than men, as a result, they can easily spread wealth and increase the quality of health for themselves and their families

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