Determinant and utilization of maternal and child health care services among women of reproductive age in Enugu State, Nigeria

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Abstract

Maternal and child health care refers to the treatment of the mother before, during, and after childbirth. In this study, the factors influencing maternal and child healthcare services in Enugu State were examined. Symbolic interactionist theory provides the study's theoretical framework. The design approach was ex-post facto, which is based on already documented pieces of evidence. Data were extracted and used from secondary sources like textbooks, journals, newspapers, and online organizational publications. The study's conclusions show that Enugu state residents underutilize maternal and child health care services. It also found some factors affecting maternal and child healthcare services such as income, accessibility/availability of healthcare services, education, employment, and inequality. The study recommends that accessibility/availability of health care services should be ensured by Governmental and non-governmental organizations. The free maternal and child health care policy, established by the government, should be properly implemented to be effective in all communities (both urban and rural).

Keywords: *social factors, maternal health, maternal health care services*

Introduction

Obstacles specific to Nigeria make it difficult for pregnant women and their offspring to access sufficient healthcare. Access to care is restricted by these obstacles, which also lead to health inequalities that worsen existing conditions and increase maternal and infant mortality. Primary Health Care (PHC) in Nigeria serves as the focal point of all medical treatments. To improve health and welfare, it addresses the most prevalent issues in the community by offering services for prevention, treatment, and rehabilitation (World Bank, 2011). Antenatal care (ANC), a trained attendant at delivery, and postpartum care are all crucial maternal health care services that must be provided in the primary health care setting to promote optimal health. ANC is the

most crucial method for identifying pregnancy issues in the early stages, helping to prevent unintended pregnancy outcomes. Unfortunately, these services are not provided in developing nations like Nigeria (WHO, 2007, Agus & Horiuchi 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, and Bhutta, 2014). The health status of children in a nation is a highly reliable index of the population's health. What is done for children today, especially at their younger age will in large part determines the course of the future of the country and its future citizens. In developing and developed countries, children should therefore be placed at the center stage in all developmental thinking and implementation (Mesfin, 2003).

Maternal and child health care is a topic of growing concern and interest around the globe, particularly in developing nations. The Alma Atta Declaration, which was produced by the International Conference on Primary Health Care in 1978 in Alma Ata, Kazakhstan, provided the framework for the primary care movement's mobilization of professionals and institutions, government, and civil society organizations, among others, who took it upon themselves to address the politically, socially, and economically unacceptable health inequalities (Federal Ministry of Information, 2014). The World Summit for Children in 1991, which gave the issue significant thought and specified key areas to be addressed in the provision of maternity and child health care services, further strengthened the commitment to maternal and child health care (Mesfin, 2003). The International Conference on Population and Development (ICPD), which took place in Cairo in 1994, also gave the effort to lower maternal mortality a boost by bringing up the subject of reproductive health. To encourage more people to use health facilities for prenatal and delivery care, the ICPD Programme of Action advocated for the distribution of information on reproductive health services (United Nations 1995). Again, since the 1995 conference on women's development in Beijing, the 1995 social summit in Copenhagen, which addressed the need for better health for women, has received recognition and numerous efforts have been undertaken in that direction. Consider the fact that "healthy mother and children" was the focus of World Health Day in 2005. (WHO 2005, Arlette, Merrick & Yazbeck, 2006).

Maternal health issues and their poor management are thought to be the cause of more than 7 million neonatal deaths in Sub-Saharan Africa (Mesfin, 2003, Cockburn & Mariara, 2010). An estimated three-quarters of all health care in Africa is provided at home, where women, especially in their roles as mothers, are typically in charge of improving the well-being and nutrition of their families. As the primary caregivers for their children, mothers in Nigeria play a crucial role in the timely seeking of health care for their children (Ghosh, Chakrabarti, Biswas, 2013).

Every year, around 585,000 women die needlessly while giving birth in the world. Sub-Saharan Africa is particularly affected by the situation (World Bank, 2013). Sadly, a WHO report on the trend in maternal death rates shows that Nigeria has one of the highest rates in the world. Nigeria is one of the top ten countries in the world from "1990-2013" for its contribution of about 60% of maternal mortality. Maternal mortality in Nigeria is approximately 560 per 100,000 live births, a slight improvement from the 630 per 100,000 recorded in 2010. 194 children may be given to mother earth within three to five years of their birth for every 1000 successful births, on average (World Bank, 2013).

In a hospital in Enugu East LGA, there were 9,150 live births and 59 maternal deaths between January 1, 2005, and December 31, 2010, for a maternal mortality rate of 645 per 100,000 live births. Almost 36 times higher than the average maternal mortality rate of 18/100,000 newborns in developed countries, the maternal mortality rate is still exceedingly high. The maternal death rate among pregnant women without prenatal care was 10 times higher (310/100 000 live births) (Ezeugwu, Agu, Nwoke&Ezeugwu, 2014). A total of 261 newborns were admitted to the same hospital during the one-year period between June 2012 and May 2013, and 37 of them died, giving the facility a mortality rate of 14.2 percent. In other words, the type of institution (whether in rural or urban settings) is not the only element that determines the outcome of maternal and child health care, since the manner of delivery, the timing, and the location at which the patient arrives at the ultimate referral center are all contributing factors. (Ekwochi, Ndu, Nwokoye, Amadi and Osuora, 2014). These results confirm the enormous disparity in Enugu State's access to and use of healthcare, which demands further study. Although problems during pregnancy and delivery account for the majority of maternal deaths in Enugu state, the sociocultural context in which these pregnancies take place also contributes to these complications and deaths (Ezeugwu et al., 2014).

Education, income (poverty), employment, accessibility, availability, and cost of health care services are a few social factors that have an impact on mother and child health care services. Women's education has some effects on mother and child health care, including attitudes regarding pregnancy, health-seeking behaviour, and employment options (WHO, 1994). The likelihood of utilizing complete ANC is significantly increased by the education of women. Women with secondary and upper secondary educational levels have roughly 3 and 7 times the likelihood of using the full ANC compared to women without those levels of education when all other predictor variables are taken into account (Chimankar & Sahoo, 2011). It is good knowledge that higher money has a beneficial impact on how often people use healthcare services (Chakraborty, Islam, Chowdhury, Bari, & Akhter, 2003). Transportation expenses, user fees (official and/or unofficial), drug costs, and other expenses may be incurred when obtaining medical attention. Women from low-income families or those with limited means may find it difficult to cover these expenses and may be discouraged from using maternal health care services as a result (Gabrysch & Campbell, 2009). Women's access to services for maternal health care is influenced by the workplace environment. It is commonly believed that working women will have greater financial independence and the ability to pay for services (Adamu, 2011).

The state government of Enugu State, including the Enugu State, developed the free maternity and child health care (FMCHC) initiative to provide free medical care to expectant mothers and children. In Enugu's primary healthcare facilities, this service is offered. There is still much work to be done in terms of mother and child health care, particularly in the Enugu State, despite the serious efforts made to improve care, particularly in rural regions. This study's foundation is the observation that socioeconomic and cultural factors affect the maternal and child health care services in this area. Therefore, the study's primary focus is on the socio-cultural determinants influencing maternal and child health services in Enugu.

Conceptualization and Key Features of Maternal health across Developed and Developing Nations

In the West, the word "health" is frequently used to refer to "bad health," that is, a pathological condition that can be confirmed through a clinical examination. However, health is essentially a complex state, and how it is conceptualized varies from nation to nation and even from person

to person. WHO defines health as "a condition of complete physical, mental, and social well-being and not only the absence of sickness and disability" in recognition of these several dimensions (Bergstrom and Goodburn, 2001).

Healthcare systems worldwide, particularly in poor nations, continue to be burdened by maternal mortality. In contrast to accidental causes, maternal death is defined as the death of a woman while pregnant or within 42 days of termination of her pregnancy, regardless of the length or location of the pregnancy. Maternal Mortality Rate (MMR) is the number of maternal deaths per 100,000 live births (WHO, 2005). Using the safe motherhood project, WHO has been promoting improvements in maternal health. The Safe Motherhood Initiative was created in Nairobi, Kenya in 1987 by a global coalition of United Nations agencies, governments, non-governmental organizations, and funders in response to the rising rates of maternal and newborn illness and mortality in the majority of developing nations. To minimize maternal mortality by 70% between 1990 and 2015, its primary goal was to ensure that the majority of pregnancies and births were handled safely both in the community and medical facilities (WHO, 2012). Millions of women around the world continue to experience maternal mortality and morbidity from preventable causes, although the majority of maternal and child fatalities can be avoided by following safe motherhood practices (Banta, 2013).

Overview of Some Programme Content of Maternal and Child Health Care Services

Maternal and child health care seeks to address the high risk that women in many contexts face concerning childbearing. It emphasizes the need for pregnant women to receive adequate prenatal care that protects them against the avoidable complication of pregnancy and allow them to undergo a safe delivery and 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, evidence also shows 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 interventions for preventing or treating pregnancy and birth complications, in particular emergency obstetric care (Tarekegn, Lieberman, and Giedraitis, 2014). The major purposes of

the provision of maternal health services are the 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 (Mesfin, 2003). As a result, family planning, the use of ANC, skilled delivery attendants, and PNC are recognized as key maternal healthcare services to improve health outcomes for women and children (Tarekegn et al, 2014).

Family Planning (FP) is an important aspect of maternal and child health care. Samuel (2010) defined family planning as the practice that helps individuals or couples to attain certain objectives such as avoiding unwanted pregnancies, bringing about wanted babies at the right time, regulating, the interval between pregnancies, controlling the time at which birth occurs with the ages of parents and determining the number of children in the family. Despite the hue and cry in and outside Nigeria about family planning or birth control, many people are still confused about its meaning, the methods involved, the advantages and disadvantages, and the factors hindering its wide application in Nigeria (Iffih and Ezeah, 2004). The use of contraceptives is one of the key determinants of fertility. Fertility is directly related to maternal morbidity and mortality. It is documented that if the existing demand for family planning services were met, maternal deaths in developing countries could be reduced by 20% or more (Baral, Lyons, Skinner, Teijlingen, 2012). The general consideration for Family Planning is a means of promoting the health of women and families and part of a strategy to reduce the high Maternal Mortality Rate, Infant Mortality Rate, and Child Mortality Rate. Accordingly, Information about FP should be made available to promote access to FP services to all individuals desiring them. Many reports indicate that contraceptive prevalence often rises among older, higher parity women, or those at greatest risk of abortion (Mesfin, 2003). Family planning ensures that pregnancies occur at the healthiest time of a woman's life and these pregnancies are wanted and planned, when this is the case, women and their newborns are more likely to survive. Family planning is the lowest-cost intervention with the biggest returns, with the ability to prevent up to two-thirds of maternal deaths (Wilson Centre, 2013).

Mesfin (2003) identified the various types of family planning methods which include: Natural methods (Breastfeeding as a contraceptive, abstinence, withdrawal (Coitus interrupts) periodic abstinence methods or safe days) Technical methods (Hormonal methods, Mechanical and chemical methods, Postcoital contraception) Permanent contraception (Female sterilization, Male sterilization). Family planning choices are often the first element of primary health care

that can be made available in a resource-poor setting. The provision of basic non-clinical contraceptives requires minimal skill and can be handled by community-based providers with appropriate training. The risk/benefit ratio of using methods such as oral contraceptives is in favour of nearly all women in such a setting, and a variety of cost-effective, distribution systems can be set up, from social marketing to community-based distribution programs focused on vulnerable groups (Mesfin, 2003).

Ante-Natal Care (ANC) is the care given to pregnant mothers so that they have a safe pregnancy and healthy baby. It also helps in minimizing complications of pregnancy, and labour during the post-partum and neonatal periods (Mesfin, 2003). Ideally, prenatal care functions to identify and monitor women at risk of future complications, detect and treat pre-existing and concurrent illnesses of pregnancy, provide preventive care and information to women and their families, and establish a relationship between providers and women early in pregnancy. Prenatal care services are part of the primary health care services of pregnant women which include regular medical checkups, medical advice regarding health, hygiene, nutrition, etc. related to pregnancy and childbearing. In developing nations, pregnant women who were registered for prenatal care and who visit regularly usually receive iron and folic acid tablets, and they are vaccinated against tetanus (Shanna and Olveña, 2004). The fact that more than 100,000 women in most developing countries are estimated to die every year from pregnancy and childbirth-related causes reinforces the importance of ensuring that all pregnant women receive adequate antenatal care during pregnancy and that deliveries take place under the supervision of trained medical personnel in a hygienic environment (Mesfin, 2003).

Delivery care is another important aspect of maternal health care service. Though most women experience no major problems during labour and delivery, complications that do occur can be unpredictable and of sudden onset, requiring immediate action. Maternal and perinatal outcomes in such instances are improved when such complications occur in the presence of a trained attendant. The provision of adequate medical attention during delivery is important for the well-being of the mother and child. The absence of such care and lack of hygienic conditions at the time of birth may lead to complications that would increase the risk of death of the mother, child, or both (Shanna et al, 2004). The most elementary knowledge in delivery care is the 3 c's Clean hands, clean delivery service, and clean cutting of the cord. One of the primary aims of trained birth attendant training programs throughout the developing world is

to promote clean delivery, through deduction and provision of basic supplies such as sterile razor blades and washable plastic sheets. It is, however, difficult to ensure cleanliness in all deliveries, particularly where access to clean water is limited (Mesfin, 2003).

The postnatal period is the time from immediately after birth up to 40 days. Mothers need to receive care at this time as it has been recorded that more than 60% of maternal deaths take place during the postnatal period (Gill, Pande, & Malhotra, 2007). A number of the problems women experience surrounding childbirth occur in the postnatal period, the six weeks following delivery. Such problems can be detected and treated through proper follow-up visits for women in the postnatal period (Shanna et al, 2004). The death of a mother exposes her newborn child to high risks of morbidity and mortality. Thus, receiving post-natal care (PNC) can make the difference between life and death for both mother and child. In developing countries, the most common causes of maternal deaths during the postnatal period are hemorrhage, infections, and hypertensive disorders (Gill et al, 2007). Technically, all of these conditions are treatable. Through examination of the mother after childbirth, PNC can identify these conditions and any other life-threatening or debilitating conditions that may require urgent medical attention (Shanna et al, 2004).

Literature Review on Issues of Utilization of Maternal and Child Health Care Services

The use of maternal health care services as it relates to the socioeconomic features of the population has been highlighted in several types of publications. Low antenatal care (ANC) service usage is the primary contributor to mother and infant mortality, according to scientific research conducted globally. Individual opinions of the effectiveness of modern health treatments and the religious beliefs of specific women have a significant impact on the usage of those services in such a situation (Advocacy Brief, 2007). The proportion of women who use antenatal care and a skilled attendant during birth increases in proportion to the household's economic position (Chimankar et al, 2011). Low usage of the maternity care services that are offered to expectant mothers in underdeveloped countries has also been identified as a concern, in addition to the absence of adequate maternity care services (Fenta, 2005). Poor health in developing nations is largely caused by inadequate access to and underuse of modern healthcare services (Agus et al, 2012).

According to a study done in Uttarakhand, 72 percent of women in urban areas and 36 percent of moms in rural regions got at least three prenatal care visits (Chimankar1 et al, 2011). Utilization of maternal and child health care services is typically made more difficult by women's perceptions of disease, which are influenced by their culturally ingrained ability to put up with pain. The perceived need for health care may be low even while the real need is high due to this tolerance for suffering. Less ANC visits are made to women in rural areas of developing countries compared to women in urban ones (Agus et al, 2012).

According to Fenta (2005), urban moms have greater access to a variety of health services and higher levels of education, which is why they use health services differently in urban and rural settings. Pregnancy was traditionally seen as a natural state by women in the majority of African nations rather than a condition requiring care and attention from a doctor. Such perceptions and convictions make up the "lay health culture," which acts as an intermediary between the existence of an illness and the appropriate course of treatment. The author also emphasized how the cultural perspective on using maternal health services shows that medical necessity is defined not only by the existence of physical sickness but also by the cultural perception of the illness. Women must select between the options because maternity health services and indigenous health care services coexist in the majority of rural African areas. ANC has long been seen as a fundamental element of any program providing treatment for reproductive health. (Fenta, 2005).

Around the world, several antenatal care models have been implemented. These models are the outcome of several sociocultural, historical, and traditional elements as well as the local economy. Additionally, the particular health system's people and financial resources contribute significantly to the development of the model (Shah and Say, 2007). The traditional prenatal care paradigm, which is focused on a greater number of visits—roughly 7–10 visits—is used in the majority of affluent countries. They consist of beginning antenatal care as soon as feasible, with monthly appointments up until 28 weeks, then weekly visits up until 36 weeks before delivery (Say &Raine, 2007). These high-income nations provide pregnant women with adequate prenatal care, which includes regular examinations and ultrasounds. Additionally, they receive fast access to emergency care should issues arise while giving delivery under the watch of medically qualified staff. Contrarily, the majority of low-income nations have implemented a new style of antenatal care termed targeted antenatal care into their health

systems (FANC). Most developing nations, including Nigeria, have had trouble with the traditional ANC; many people who go to prenatal care clinics only go once or twice, and occasionally they go late during pregnancy (Shah et al, 2007).

Theoretical Trust

Symbolic Interactionism Theory (SI) is the theoretical thrust unto which this paper is anchored. Symbolic interactionism was 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 decisions on how to react to these signs and symbols. According to Haralambros and Holborn (2008), the theory has been the most influential theoretical approach in analyzing health and illness, with studies focusing on the processes involved in people deciding to seek professional help, the interaction between the ill person and the medical professional in arriving at a definition of the illness, and the impact on the person, being labeled as ill. To symbolic interactionists, what constitutes illness is a result of social definitions. People may well have a serious disease, but this does not automatically result in the people defining themselves as ill.

This definition is a long process that involves sociocultural explanation. Thus, being ill, seeking help, and following advice or recommendation of the professional are the result of a complex interaction between the individual, their perceptions of health, illness, and the medical profession, and the views of the social network that surrounds the people (Haralambros et al, 2008).

A woman's decision to seek medical attention is not a result of a single, unrelated event; rather, it is the result of her requirements, social factors, the actions of healthcare professionals, and the location of available resources (Ghosh et al, 2013). As a result, women's experiences with their health and the health of their children are the result of complex interactions among the individual, their conceptions of health, sickness, and the medical profession, as well as their views of their social network. In other words, women respond to their own and their children's

health requirements following their understanding, perception, and interpretation of the relevant health conditions.

Discussion of Key Determinants of Maternal and Child Health Care Services (MHCS) applicable to Enugu State, Nigeria

A number of factors have been identified by scholars as determinants of maternal and child health services. These include family income size, employment, availability and accessibility of MHCS services, level of education of mothers and issues of social inequality among others. These factors are discussed below:

Family income

Mothers' and children's health care is significantly influenced by family income. There is a reduction in maternal mortality and morbidity because those who are employed and so have some income may afford transportation to the health facility (Adong, 2011). Even with the best of intentions, moms who live in joint families and families that fall below the poverty line frequently face obstacles before they can get their children the preventative or therapeutic healthcare they need (Ghosh et al, 2013). Studies also show that women are more likely to seek maternity care services if their husbands work in higher-prestige occupations (MHCS). This is because these professions are typically linked to larger wealth, making it simpler to afford healthcare expenses. However, several other researchers have found that women are less likely to use maternal healthcare services when they lack personal financial control (Furuta & Salway, 2006), pointing to an interaction between autonomy and family wealth as the cause of health service use. In general, women use health care more frequently as their economic status and level of autonomy rise (Fotso, Ezeh & Essendi, 2009).

Utilization rates significantly rise with rising income, according to several studies. Low income discourages millions of women from seeking care, even when issues emerge, and decreases the use of maternal health care services by women. There may be unofficial fees or other costs that significantly restrict women from using services, even though formal fees are little or nonexistent in health facilities. Poor women cannot afford these expenses since they may include the cost of the woman's transportation, medications, food, or accommodation, or that of her family members who assist in her care while she is in the hospital (Fenta, 2005).

Employment

Women's access to MHCS is influenced by the work environment in which they are employed. It is commonly believed that women who are employed and making money will have greater financial independence and will be able to pay for services. In addition to the job's ability to provide cash, this will also depend on the job's inherent qualities. In addition, a lot of working women don't get paid for the labor they do and, in many situations, women have no control over their income (Furuta et al, 2006). Additionally, employment may lead to poverty, indicating a resource shortage. Studies on the relationship between employment and the use of MHCS have yielded conflicting results due to the contextual disparities in women's work. The fact that formal employment among women and the usage of MHCS are positively correlated raises the possibility that empowerment brought on by the ability to earn may influence the use of MHCS. On the other hand, it has also been discovered that in various parts of the world, working women are less likely than non-working women to use some MHCS (Stekelenburg, et al, 2004). A few researches also suggest that women who work in low-paying professions like farming are less likely to use MHCS (Addai, 2000).

Accessibility and availability

Services for mother and child health are impacted by accessibility and availability. The disparities in the use of prenatal and delivery services are likely caused by the availability of services, along with a variety of cultural factors that affect the acceptance of particular services. Perhaps most important to slum communities is service access in terms of affordability (Magadi, n.d). One of the primary issues in places with poor health services is the lack of affordable maternity and child health care services for women. Awareness and investigation into the factors that contribute to maternal deaths have frequently stressed the importance of prenatal care and the requirement for experienced people to assist women during birth (Fenta, 2005).

Even in situations where attempts have been made to widen access to institutional care, the anticipated advancements in maternal/newborn health have not happened. Large investments in infrastructure and provider training have not yet resulted in the anticipated gains in maternal and newborn health in Ethiopia and India, the two nations that account for one-fifth of all maternal fatalities worldwide (Austin Langer, Salam, Lassi, Das, & Bhutta, 2014).

Education

Although generally speaking, women in higher socioeconomic groups show tendencies of using maternal health care more frequently than those in lower socioeconomic groups. According to studies, the mother's education is a significant social factor that positively affects the use of services for maternity and child health care. Women's education has a significant favourable impact on their likelihood of utilizing complete ANC. Women with secondary and higher secondary education levels have roughly 3- and 7-times higher likelihood of using the full ANC than women without any formal education when all other predictor variables are taken into account (Chimankar et al, 2011).

With the start of a new era, female education has broken free from domestic constraints and emerged as a key participant in the public health agenda. Similar research came to the same conclusion: female illiteracy was significantly associated with gender prejudice in children's health-seeking behaviour, with illiterate women contributing more to the gender divides. Other research has supported the beneficial impact of maternal education on the health and survival of children (Ghosh et al, 2013).

Inequality

Differences in health outcomes that are needless, avoidable, unfair, and unjust are referred to as health inequity. Health inequities are persistent differences in health or major social determinants of health between groups that experience varying degrees of underlying social advantage or disadvantage (for instance, as a result of being poor, female, or a member of a marginalized racial, ethnic, or religious group) (Association of State and Territorial Health Officials, 2012). Gender inequalities, or discrepancies between men and women, are caused by gender norms and values that systematically empower one group at the expense of the other (Ghosh et al, 2013). Since it is obvious that gender inequalities in health have been primarily socially generated rather than biologically given, it is crucial to this school of research to distinguish between sex (the biological idea) and gender (the social notion). Women are treated less favorably than men in India, with the gap between the sexes being greater in rural areas. The low girl-to-boy ratio (0.93), which is evidence of the difference in healthcare-seeking

behavior between genders, results in girls being overlooked and subjected to discrimination while accessing preventative and curative healthcare facilities (Ghosh et al, 2013).

Way Forward

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

1. The availability and accessibility of health care services should be ensured by the government, non-governmental organizations, and other stakeholders. This can be accomplished by setting up a program of sensitization, particularly in rural areas, that will assist women in understanding the importance of using any accessible medical facilities.
2. Implementing programs and policies that are focused on women is necessary for both rural and urban populations. This suggests that there is a need for action in the areas of employment, education, health, and other sectors.
3. In order for the government's free mother and child health care program to be effective across all communities, it must be properly implemented (both urban and rural). Women from low-income families will benefit from having free access to medical care whenever they need it.
4. To build health clinics for underserved communities, the government should identify those where there are no medical services. On the other hand, those already in place should be upgraded by giving them access to contemporary machinery, medications, and qualified medical personnel.
5. Programs for women's empowerment should be developed by both governmental and non-governmental groups so that women are empowered in all facets of their lives and can contribute their fair share to society. Evidence suggests that the greatest strategy to speed up growth and steadily lower poverty is to place economic resources in the hands of women. Women often contribute substantially more to their communities than do men, which enables them to more easily distribute money and improve their own and their families' health.

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 an adequate provision, on the one hand, while on the other hand, there is low and underutilization of these services in Enugu state. Factors such as accessibility/availability of health care services, education, place of residence, employment, and gender inequality.

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